ABF PROGRAMME IMPLEMENTATION PLAN 2021-23

FOREWORD

We are pleased to publish the second Implementation Plan for Activity Based Funding (ABF) in Ireland, as part of a programme of work to support the delivery of the Sláintecare Implementation Strategy. This Plan, when implemented, will represent an important step forward in increasing transparency in funding, encouraging efficiency, value for money and sustainability, and ultimately providing greater accountability for the way resources are allocated in the Irish healthcare system.

Since the Government committed to introducing ABF in 2012, we have worked to build the skillsets and underlying data needed to do this, and to establish an annual price development cycle to support funding decisions. The first Implementation Plan (2015) laid the groundwork for this with the establishment of the Healthcare Pricing Office (HPO) centrally within the Health Service Executive (HSE) and the development of patient-level costing at 19 hospitals. 39 hospitals have been funded by ABF for 70% of their total funding, moving away from historic block funding and increasing transparency and accountability.

In 2018 the Government reconfirmed its commitment to ABF as part of the Sláintecare Implementation Strategy and included actions in the Strategy to progress ABF. This second ABF Implementation Plan provides a vehicle to continue to progress these actions including preparatory work around introduction of structured healthcare purchasing, taking foundational steps towards the necessary costing and data improvements needed to support pricing for community services, and building on the work already undertaken to further expand and enhance the costing and pricing of hospital services.

This Plan signals a shift from the necessary foundational and technical work around the costing and pricing of services towards creating a more holistic healthcare resourcing and purchasing process that links insights from key clinical, operational and patient stakeholders, with the core Sláintecare intent around integrated care, in the least complex setting appropriate, as close to home as practical.

COVID-19 has had a significant impact on the healthcare system and has created major challenges for in accounting for new and unknown patterns of healthcare usage and costs. Whilst emergency measures have included temporary increases to block funding, ABF and its building blocks have proved useful in providing the information needed to monitor the impact and effects of the disease and make important decisions as to where resources should be deployed, and will continue to be critical for health system insights and funding into the future.

However, COVID-19 has also demonstrated the significant capacity of the health system to respond effectively to the need for rapid change and improvement. Many aspects of the changes introduced over the last 21 months are fully consistent with the intent of Sláintecare, and will be maintained after the pandemic has ended. This period has also seen step changes both in the trust and confidence of the public in the HSE and in the Government's investment in both permanent additional health service capacity and COVID-19 response measures.

We look forward to working across the healthcare system to increase efficiency, transparency and value for service users, and welcome the opportunity which ABF provides to do just this.

Paul Reid
Chief Executive Officer
Health Service Executive

CONTENTS

Abbreviations and acronyms 3

Executive summary 4

1. Introduction 8

2. Reviewing progress to date 13

3. 2021-23 Programme mission, objectives and principles 17

4. Implementation Plan for 2021-23 20

5. Responsibilities and engagement 30

6. Dependencies and risks 34

7. Managing and reporting on this Plan 37

ABBREVIATIONS AND ACRONYMS

ABF	Activity based funding
COVID-19	Coronavirus Disease 2019
DoH	Department of Health
DRG	Diagnosis Related Group (in Ireland, the Australian Refined DRG system, AR-DRGs, is used)
HIPE	Hospital In-Patient Enquiry Scheme
HIQA Review	'Review of information management practices in the HIPE system', Health Information and Quality Authority, 2018
HPO	Healthcare Pricing Office
HSE	Health Service Executive
ICT	Information and Communications Technology
IFMS	Integrated Financial Management System
Pavilion Audit	'National Audit of Admitted Patient Information in Irish Acute Hospitals', Pavilion Health, 2016

EXECUTIVE SUMMARY

BACKGROUND

Activity based funding (ABF) is an approach which seeks to incentivise providers to be as efficient as possible by funding them for the activity that they are asked to deliver, rather than funding them by way of block budgets regardless of activity levels. In the hospital scenario, prices are set for a combination of diagnoses and procedures which occur in a patient episode based on the actual cost of the care provided, with the complexity of care factored into the cost, as more complex care involves more staff, more time, more medical and surgical supplies, etc. The same fundamental principles apply in the community scenario, for example, residential care of differing complexity and cost can be funded using ABF.

The goal of ABF is to increase insight and transparency around relative cost utilisation and funding and to encourage the efficient and effective allocation and use of resources, so that the maximum number of patients and service users can benefit from the funds the state entrusts on behalf of its citizens to the health service.

STRATEGIC CONTEXT

The Government's 2018 Sláintecare Implementation Strategy includes Goal 3: *'Ensure the health service is financially sustainable'*. This goal references the need for a consistent focus on productivity and achieving value for money, bearing in mind that safety and quality is a core element of value, with one of its three specific areas requiring action being:

- **Funding allocation models:** Expand activity-based funding across acute and community care settings and plan for a shift to population-based funding, in the longer-term.

It is expected that ABF and population-based funding will co-exist and complement each other in the longer term. In simple terms, regional health authorities would over time become funded on an overall population or 'per-capita' basis to 'keep people well and meet their health and social care needs'. Within each region, health authorities would use a mix of per-capita, block and activity based funding with the latter more likely for providers who deliver discrete components of care such as hospitals, home care providers, residential care providers etc.

ABF PROGRESS TO DATE

The HSE's first ABF Programme Implementation Plan was published in 2015, following the establishment of the Healthcare Pricing Office (HPO) within the HSE by the transfer and merger of the Hospital Inpatient Enquiry (HIPE) Unit from the Economic and Social Research Institute and the Casemix / Speciality Costing Unit from the Department of Health (DoH). That Plan focused on the hospital system with progress being made including:

- 39 hospitals receiving 70% of their funding via the ABF approach, that is, based on target activity levels – a significant reduction in the use of historic block funding.
- Hospitals and Groups can compare actual and target performance levels and interrogate their HIPE data flexibly, down to the level of individual consultants and patients through a monthly reporting system.
- The national average admitted base cost for combined inpatient and day case has risen by just €235 or 10.4% over the seven years from 2011 (€2,246) to 2018 (€2,481). This is a fraction of the increase in the cost of the healthcare or hospital systems over the same period.
- There has been a continued improvement in the cost and activity data underpinning the ABF process which augurs well for future expansion and improvement.

While there has been less ABF-related progress in the community sector it is worth noting the approximately €1 billion paid out on an activity basis each year via the Nursing Home Support Scheme established in 2009 and the approximately €3 billion paid out by the Primary Care Reimbursement Service, much of it in line with ABF principles.

It is also noted that COVID-19 has seen hospital budgets, in Ireland and internationally, return temporarily to block funding.

CORE ELEMENTS OF THE 2021-23 IMPLEMENTATION PLAN

ABF can be described, very simply, as:

Costing data	**+**	**Activity data**	**=**	**Pricing, or 'what are we prepared to pay for activity outputs at a given level of quality?'**

However, it is important that there is clarity on what it is we want to commission, or purchase in a structured way, from providers of discrete healthcare services, Otherwise, there is a greater risk that patients may receive services they do not need or, or services of sub-optimal quality, or services that they could have accessed closer to their own homes in less complex and less costly settings.

Therefore, put simply, the results of ABF can be implemented within the healthcare system as follows:

Pricing	**+**	**Demand and capacity, analysis, and modelling**	**+**	**Clinical, operational and service user insight**	**=**	**Structured purchasing**

The existence of a structured purchasing capacity within the HSE is aligned with Goal 2 of the Sláintecare Implementation Strategy: *'Provide high quality, accessible and safe care that meets the needs of the population*'. The shift to more integrated care between hospital and community and for more of that care to be provided in the community closer to people's homes under this goal needs to be planned and directed. This is not a once-off transformation exercise; it will require ongoing structured purchasing efforts, that is, providing ongoing clarity to the overall system about what types and volumes of care and other services, delivered to what specification (including quality specification) and in what setting are required and will be paid for each month. Ten years ago this would have perhaps seemed like an impossible task; however, advances in recent years, including clinical programmes, an overarching policy (Sláintecare), improvements in systems and a step change in investment (National Service Plan 2021), mean that elements of what is needed for structured purchasing are already in place or being developed.

PROGRAMME OBJECTIVES

For 2021 to 2023, the ABF Programme comprises of four objectives: two of which are designed to support and progress the existing Programme base, and two of which expand it to new areas of focus:

1. Further enhance hospital costing and pricing
2. Support and enable the existing ABF Programme
3. Develop a roadmap for structured purchasing
4. Scope and implement foundational costing and activity measures for a community costing and pricing programme

These are detailed on the next page, with corresponding actions set out in Chapter 4.

DRIVING THE PROGRAMME

Delivering on the three core objectives of this ABF Implementation Plan will require significant involvement from a range of internal and external stakeholders, with leadership within the HSE being co-ordinated as follows:

- Structured purchasing: HSE Chief Strategy Officer[1]
- Hospital and community costing and pricing: HSE Chief Financial Officer

An HSE ABF Implementation Steering Group will be established. It will be co-chaired by the HSE Chief Financial Officer and the HSE Chief Strategy Officer and will include representatives of the HSE Executive Management Team, Community Healthcare Organisations, Hospital Groups, and the DoH.

Periodically this Steering Group will provide updates to, and seek input from, the current HSE Finance Reform Program Board chaired by the Chief Executive Officer and of which the Secretary General, DoH and Assistant Secretary, Department of Public Expenditure and Reform are members along with other senior officials from the HSE and DoH.

PROGRAMME OBJECTIVES

PROGRESS THE ABF CORE PROGRAMME

Work to progress the existing ABF Programme must continue, to ensure that it is fully integrated and understood across the healthcare system. Two objectives will deliver on this:

Objective 1: Further enhance hospital costing and pricing, which includes:

- Improving the benchmarking of costs to enable hospitals to see the detail of how and why their costs vary from other hospitals so they have insight into where and how they can safely reduce unit costs.
- Broadening the activity areas covered by ABF to include outpatient care and emergency departments.
- Reducing interim transition adjustments previously designed to support hospitals' transition to ABF whilst also refining the ABF pricing model to ensure legitimate structural costs, including complexity driven costs, are better provided for in the ABF system.

Objective 2: Support and enable the existing ABF Programme, which includes:

- Enabling the transition from block budgets to ABF in a sustainable and stable way.
- Supporting the development of ABF data for use in healthcare planning, funding and broader decision-making, including around service improvement and new service development.
- Ensuring provider readiness by supporting key healthcare providers as they fully implement an ABF approach.
- Ensuring the ABF Programme has the appropriate resources and governance to deliver its priorities.
- Undertaking a programme of communications, engagement and change management with key stakeholders, including hospitals, individual clinicians and medical schools.

LEVERAGE TO NEW AREAS

The ABF Programme must be ambitious, using its data and analysis as a lever to make more informed decisions across the health system. Therefore, two objectives will expand ABF further:

Objective 3: Develop a roadmap for structured purchasing, which includes:

- Research and stakeholder engagement to determine the current status, health sector appetite and ambition around structured purchasing.
- Setting out a roadmap to design and implement whatever level of structured purchasing emerges from the research and stakeholder engagement exercise.

[1] ***Note:*** *Responsibility for the actual implementation of any agreed roadmap towards structured purchasing, including acting as the purchaser for the healthcare system, is expected to rest with the Chief Operations Officer.*

Objective 4: Scope and implement foundational costing and activity measures for a community costing and pricing programme, which includes:

- Supporting better cost collection and reporting across all community services, via the Integrated Financial Management System (IFMS) programme.
- Assessing the availability of costing relevant activity data and inputting to improvements, and setting out costing principles and standards for community services.
- Providing expert costing input to priority projects including in relation to home support and long term residential care.

1. INTRODUCTION

1.1 WHAT IS ABF?

ABF is an approach which sees providers funded in line with the activity that they undertake. Prices are set for the combination of diagnoses and procedures which occur in an episode based on the actual cost of providing services, taking into account patient complexity, and providers are funded based on how many patients they treat. ABF, or variations on it, is used for hospital funding in many countries including Ireland, Australia, Canada, Germany, France, England and the Netherlands.

The goal of ABF is to increase transparency in funding, to encourage efficiency, value for money and sustainability, and provide greater accountability for the way money is spent. It can also increase provider autonomy to deliver care in the most appropriate, localised way, by separating out the roles of funder and healthcare provider, allowing service managers to allocate their budgets based on real levels of patient care and inform strategic decision making.

Under ABF, prices are set based on the average cost of providing care for diagnoses and procedures, so providers have an incentive to explore ways to become more efficient, as they will not be fully reimbursed for unnecessarily costly care. ABF allows detailed comparisons between hospitals in terms of costs and efficiency, to enable systems managers to identify opportunities for improvements and for benchmarking across services. For example, since ABF was introduced nationally in Australia, the rate of growth in hospital costs has decreased significantly, from 4.4% between 2006 and 2011, to 1.3% between 2011 and 2016.

ABF has a number of safety mechanisms, both in price setting and in reporting to help ensure that the price is not one that compromises on patient care. In a sophisticated and mature model, these might include:

- Reviewing prices across inpatient and outpatient procedures for the same DRG, promoting more outpatient care which is both more cost effective and likely to improve patient outcomes, rather than unnecessarily lengthy and costly inpatient stays.
- Disincentivising avoidable readmissions.
- Identifying and adjusting for inefficiencies within a price based on the average (for example, complications due to poor quality care or poor care planning).

Mechanisms can also be built into funding processes to maintain stability in funding, particularly in the early stages of ABF implementation, for example through capping overall percentage changes to funding from year to year at the hospital level.

When these are combined with other quality reporting mechanisms, they work to support efficiency and quality (rather than simply cheaper care). The data generated by ABF can also be used to explore even more developed funding systems, include best practice pricing and outcomes-based funding. ABF can work as part of a range of policy approaches and levers in a complex, modern health system to incentivise movement of care to the most appropriate locations, and support wider value- and population-based initiatives.

When it is first introduced, ABF can appear relatively limited as it focuses on only the average cost of care, but over time as the quality and scope of supporting data collections increases, it can become increasingly sophisticated with quality measures built in, either for monitoring or funding purposes. This can again be seen in Australia, where in 2018 safety and quality measures were introduced into the national ABF model to both adjust funding for hospital acquired complications and provide data back to hospital staff to allow them to interrogate the reasons for discrepancies in costs or complications rates, with work currently underway to also incorporate funding adjustments for avoidable readmissions. The benefits have also been seen in England where Payment by Results cost data has been used to develop Best Practice Tariffs for use in funding alongside traditional ABF.

Ultimately, the focus can shift from measuring to managing patient care. As it becomes better understood and incorporated into hospital systems at the local level, ABF can be used for 'Activity Based Management', that is, the active day-to-day management of a health system using patient-level activity

and cost data for business modelling, forecasting, service optimisation, and to give greater insights into the links between clinical decisions, performance indicators, patient outcomes and quality, as can be seen in the NSW Health system in Australia.

1.2 ABF IN IRELAND

In 2014, the HPO was established within the HSE to set the national DRG prices on which the ABF system is based and manage the HIPE dataset. Since then, it has worked with hospitals and Hospital Groups to support the implementation of ABF across Irish hospitals, guided by the ABF Programme Implementation Plan 2015-17. Progress to date is discussed in detail later in this document.

In 2017 the all-party Sláintecare Report proposed a ten-year plan for reform towards universal healthcare and recommended the continuation of ABF. The Government committed to the ongoing implementation and expansion of ABF in the 2018 Sláintecare Implementation Strategy which commits (under action 7.1) to expanding ABF to other parts of acute services, significantly increasing the ABF proportion of hospital budgets, examining the use of ABF for outpatient services and advancing the costing programme for community healthcare services.

The introduction of ABF represents a significant change from the previous block-grant allocation process to a fairer and more transparent system of resource allocation. It replaces the budgeting model which previously applied in acute hospitals. Under the old budgeting model, hospitals were funded based on block allocations that were determined, predominantly, by historic factors with some limited financial adjustments based on casemix. The old budgeting model has been criticised because it is unable to link funding with activity and support hospitals to stay within budget.

The intention of the ABF Programme is to change to a model which instead allocates funding based on contracted activity. This means that the focus is on funding of patient care. Hospital revenue is determined based on agreed target levels of activity using national average prices for each DRG.

Hospitals are encouraged, subject to overall budgetary ceilings, to pursue the most cost-effective means of achieving this standard of performance. Budgetary discipline is delivered through specified budgets for ABF activity. If efficiency gains allow providers to do additional work, within their envelope of funding, this is supported by ABF.

SLÁINTECARE IMPLEMENTATION STRATEGY

Action 7 of the Sláintecare Implementation Strategy is to 'Reform the funding system to support new models of care and drive value to make better use of resources'. This includes the following sub-actions to develop new funding allocation models which require the implementation of ABF.

7.1.1 Expand ABF for inpatient and day-cases to other acute hospitals.

7.1.2 Significantly increase the ABF proportion of hospital budgets by reducing transition payments and introducing stronger and more real-time financial incentives for productivity to drive value.

7.1.3 Examine the use of ABF for outpatient services.

7.1.4 Advance the community-based costing programme to measure unit costs and productivity in community-based services.

There are also other actions outside of the ABF Programme and therefore outside of the scope of this Implementation Plan. These are actions which ABF can support or should work alongside, to ensure the sharing of skills and consistency in approach.

These include Sláintecare actions to develop a plan to move to a system of population-based funding (7.1.5), develop proposals for multi-annual budgeting in the healthcare system (7.2.1) and develop an activity and cost database for health and social care in Ireland (7.3.1). These actions will further support integration and incentivisation of care in the most appropriate setting by providing more detailed data on activity and improved means of setting budgets and making funding decisions. The national ABF Programme should integrate with this work; however, is not responsible for leading these actions under the Sláintecare Implementation Strategy.

It is important to note that while the ABF Programme encourages hospitals to use resources at their disposal more efficiently, it does not seek to reduce overall expenditure in the acute hospital system. Instead, it provides a more transparent funding mechanism and it more fairly rewards hospitals for the activity that they undertake.

1.3 COMPONENTS OF ABF

The ABF Programme is comprised of four core components, which must all work together in order to enable ABF to function: data collection, costing, pricing and purchasing (also referred to as commissioning).

Data collection

ABF is underpinned by patient-level activity and cost data. This data is provided by hospitals and describes patient characteristics, care provided and the cost of that care.

Costing

For ABF to operate, providers must be able to determine their unit-costs. This critical information allows providers to understand why they are making surpluses or deficits under the new funding system when they are paid at the national average price for each episode of care, and how the cost of care varies between sites.

Pricing

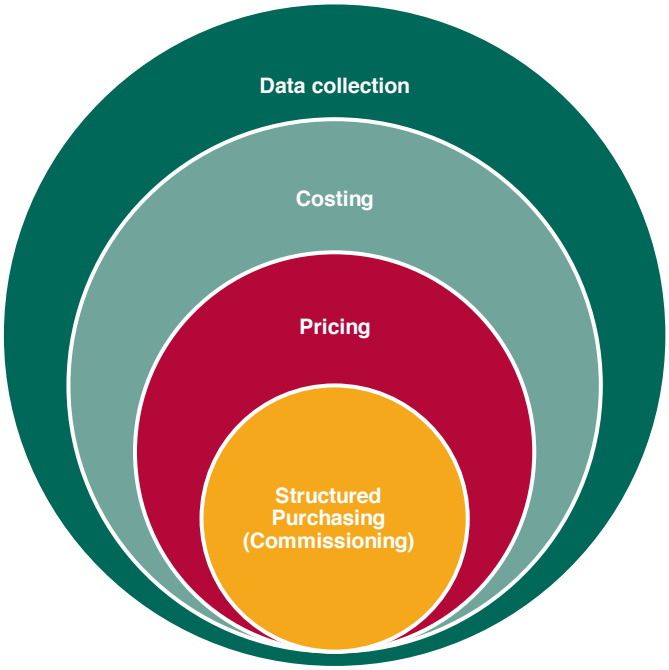
Prices are set for each episode of care (as classified by the DRG for acute care) based on the average cost of all hospitals with activity in that DRG. These prices are determined by the HPO.

The prices are set to incentivise adherence to clinical and care objectives and therefore maximise benefits to patients, both in terms of their experience of health care and the quality of the care that they receive. New systems will be required to capture quality and outcome data. Critically, the ABF system links volume and complexity with price and allows funders and providers to see clearly what is being delivered for the price being paid. The variation in complexity means that there is an associated variation in the level of payment for episodes of care. For example, in hospitals a birth can cost €2,300 while an Intensive Care Unit case can cost over €100,000.

Structured Purchasing (Commissioning)

At the national level, the system requires an assessment of need and negotiation between the funder and providers in order to set the appropriate level of activity. This process is called commissioning or purchasing. Enhanced financial control is achieved through this process by setting appropriate activity targets, related to need-assessment, for each provider and ensuring that they do not exceed those targets. This allows the health system to budget in a much more explicit and accurate manner and to monitor performance more effectively. In time, payments can be linked with clinical objectives, driving better outcomes for patients.

Figure 1: Components of ABF



It is important that there is clarity on what will be commissioned or purchased, in a structured way, from providers of discrete healthcare services. Otherwise, there is a potential risk that patients may receive services they do not need or that they could have accessed closer to their own homes in less complex and less costly settings.

Whilst this is part of the broad ABF programme, the purchasing function should be undertaken separately to pricing.

1.4 INTENDED BENEFITS OF ABF

Table 1 sets out the intended benefits of ABF when fully implemented. Identification of these benefits provides a basis for future assessment of the ABF Programme's effectiveness.

Table 1: Intended benefits of ABF in Ireland

Intended benefit	Description
Drive structural and efficiency improvements in the health system **Requires transition payments at a substantially reduced level.**	Traditionally, hospital care has been provider-driven in many respects, with funding connected to hospital buildings rather than the number and mix of patients treated. ABF incentivises care system innovation by reorganising the funding of care from a block grant system to case-based funding, encouraging providers to redesign their services around the patient's treatment and care pathway, ultimately investing in resources and facilities to improve efficiency and increase margins.[2] ABF seeks to create an environment within which a greater understanding and control of care provision and cost is required. This also incentivises providers to innovate to improve the efficiency, safety and quality of care – initially to adapt to the new funding model and subsequently to remain competitive in the new market.
Drive improved quality **Requires a move to a more structured approach to purchasing.**	The commissioning or structured purchasing function agrees Service Level Agreements and performance contracts with providers, setting out strict activity targets including quality targets underpinned by financial incentives and sanctions. The Service Level Agreements and performance contracts form the basis for an Integrated Performance Management System, ensuring that clinical managers are incentivised to continuously review and monitor data from a quality perspective. DRG prices can be set to reflect the optimal level of quality in overall patient experience and outcomes as opposed to the lowest possible cost.
Greater transparency and efficiency in the allocation of resources	Providers are paid the national price (DRG based in the case of hospitals) on receipt of confirmation that pre-agreed activity has been delivered ensuring fair and transparent reimbursement rather than a historically determined block grant. ABF improves accountability in health system resourcing as poor performance is identified and addressed and the most efficient and effective healthcare providers are rewarded. The ABF national price list is now published allowing a wide range of stakeholders to have maximum insight into costs and pricing for public hospital care.

[2] This means the gap between what the HPO will pay for a treatment and the cost at which the hospital can deliver it. Each year in which a provider reduces their unit cost, they increase the amount of 'gain' to the hospital for that year. Once the prices are set again the following year, their efficiency will be absorbed into the price. If a hospital does not continue to focus on efficiency, it will become uncompetitive.

Intended benefit	Description
Greater transparency leading to allocation of resources based on quality of care and improved patient outcomes	ABF ensures the State gets good value and supports positive health outcomes by redesigning payments so that they are made in return for individual episodes of care, which can, in a sophisticated system, be tied to clear quality standards. Improved patient-level analytics provides visibility to clinicians and hospitals performing at high volume and high quality. ABF offers high-quality performers the means to justify improved resourcing in the future. ABF is a system that in time will support incentivising a preventative approach to healthcare across all care settings, focusing initially on acute care by identifying cost variation, driving improvements in data which identify clinical variation, and encouraging system managers to look for opportunities to increase efficiencies in the system.
Improve national healthcare data	ABF will drive demand for patient-level analytics across the Irish health system as providers seek a greater understanding of the various costs and outcomes associated with each element of a patient's treatment. Activity and patient-level cost data collected by the HPO will allow policymakers and providers to compare and benchmark current and historical service provision across the system and identify areas of progress or concern at system level down to specific care settings. This National Dataset can feed back into national policymaking, service planning and the commissioning and performance management processes, for example, identifying activity and costs for specific populations groups, such as those suffering from chronic disease, to support the design of integrated and community-based policy approaches with high quality data.

2. REVIEWING PROGRESS TO DATE

2.1 PROGRESS MADE

The HPO was established in 2014, and in 2015 a first ABF Programme Implementation Plan was published. In 2021, improvements can be seen across the system.

- 39 hospitals have been funded by ABF for 70% of their total funding, moving away from historic block funding.
- The ABF component of budgets are now set using target activity levels derived from the latest 12 months HIPE data.
- The national average admitted base cost for all admitted activity (i.e. combining inpatient and day-case cost and activity) has remained almost flat between 2011 (€2,246) and 2018 (€2,481).
- Hospitals and Hospital Groups can compare their actual performance against their target and interrogate their HIPE data flexibly and quickly, down to the level of individual consultant/patient, length-of-stay, etc. through a new monthly reporting system, with almost 300 users now registered.
- Monthly performance meetings are now held between the HSE and Hospital Groups where ABF performance against targets is reviewed.
- There has been continued improvement in the quality of the data underpinning the ABF process. This is as a result of the HPO's ongoing efforts and in addition the national audit of admitted data carried out by external consultants and the expansion of audit programmes for costing and coding by the HPO and will assist in the elimination of measurement factors when comparing the relative efficiency of hospitals in ABF.

A significant programme of work was undertaken to enable these improvements in line with the objectives and actions set out in the previous Implementation Plan. This included activities to improve the accuracy and reliability of hospital activity and cost data, build and improve underpinning classification systems, as well as investment in staffing at the hospital and HSE level to support ABF. For example:

- The acute classification system has been updated from AR-DRG version 6 to version 8. AR-DRG version 10 will be adopted within the life of the new Implementation Plan, with an implementation schedule under development.
- There has been continuous training of the clinical coding workforce, with a revised clinical coder national education programme, including a training and mentoring course for experienced clinical coders in place since 2018. A training strategy will be launched in 2022.
- The Performance Indicators of Coding Quality (PICQ™) tool has been rolled out to hospitals to improve coding quality.

BEST PRACTICE TARIFF FOR HIP FRACTURE CARE

The HPO, National Office of Clinical Audit and the National Trauma and Orthopaedic Clinical Programme are collaborating on a trial Best Practice Tariff for hip fracture care, informed by ABF data. In 2019, 548 cases were funded using the Best Practice Tariff, indicating that care in each case met the Irish Hip Fracture Standards.

LAPAROSCOPIC CHOLECYSTECTOMY

On 1 January 2018, an ABF pricing mechanism was introduced to incentivise the performance of laparoscopic cholecystectomy on a day-case basis, with many uncomplicated procedures performed as an inpatient procedure unnecessarily.

Between 2017 and 2018, the number of hospitals meeting the 60% day-case rate increased from 11 to 14, suggesting that pricing incentives can be used to influence behaviour. Success has been limited compared to the targets set for the hip fracture Best Practice Tariff. 21 hospitals met the 60% day-case rate target in January 2018; however, this initial change was short lived and not maintained throughout the year, indicated that pricing signals should be combined with clinical leadership to be most effective.

This represents an important trial in learning which factors are critical in implementing quality pricing measures.

- A benchmarking tool for patient-level costing data was rolled out in late 2018 to allow hospitals to critically engage with cost data, improve data quality and use the information to drive efficiency and better patient care.
- Patient-level costing is used for DRG pricing, with patient-level costing data being provided by 19 hospitals.
- The pricing model has been further developed with (a) the introduction of an ABF pricing mechanism to incentivise the performance of laparoscopic cholecystectomy on a day-case basis, and (b) cross-agency collaboration on a trial Best Practice Tariff for hip fracture care, informed by ABF data.
- ABF conferences were held in 2015, 2016, 2017 and 2019 to educate and inform stakeholders about ABF.

2.2 FURTHER CHALLENGES

However, challenges remain with many goals set by the previous Implementation Plan not yet reached.

- A renewed focus is required on the development of a classification and funding approach for outpatient care, with progress to date limited due to significant variability in the quantity and quality of outpatient data, and lack of consistency in reporting specifications. The HPO has commenced a pilot to collect data at patient level, with this work to be made a priority under this Implementation Plan.
- Actions such as integrating performance management of ABF into organisational performance management require a more established and mature ABF system before they can be implemented.
- Other actions, such as transitioning of individual hospitals towards national pricing (or understanding and quantifying why ongoing adjustments may be appropriate for some services) are still in progress, critical to the successful implementation of ABF and have been prioritised in the new Implementation Plan.
- Progress on classifying and costing community and homecare services has been limited. This work will transfer to the HPO from 2021.
- While an extensive programme of engagement has taken place with key stakeholders in the hospital system with ABF now established centrally, it is important to ensure the system understands how ABF works in order that they can participate in it. Publication of the price list, together with a stakeholder engagement strategy including educational materials, clinical champions, a reinvigorated annual ABF conference and an increased focus on hospital-level leadership will assist with this. ABF-generated data also needs to be integrated into normal business and decision-making practises so that the data has broader value to the system and continues to improve in breadth and quality.
- Additional focus needs to be given to improving the governance of the ABF Programme, and to workforce development within the HPO to ensure that it can attract and attain appropriately skilled staff.

SEPSIS PROGRAMME

Following major changes to the coding rules in 2015, collaboration between the HSE Sepsis Program and the HPO has meant that both have been able to realise the benefits of accurate and thorough coding of sepsis to ensure that complexity is properly recorded.

By clinicians supporting and assisting with coder training, both groups have been able to understand the importance of accurate record keeping and translation of this to the coded record.

This is important for ABF purposes to ensure that the price reflects complexity and for quality and safety monitoring, the latter of which is crucial for clinicians and system managers given that the fast diagnosis of sepsis is critical in these life-threatening and sometimes fatal conditions.

Through this collaboration the HSE published the first National Outcome Report on the Sepsis Programme in 2016 using HIPE data. Annual reports are now published on the HSE website.

These reports show a year-on-year improvement in the reporting of sepsis, which is now at expected levels (when compared internationally).

2.3 KEY REQUIREMENTS FOR ABF

Implementing a system as complex and resource-intensive in its initial phases as ABF requires:

- continued and consistent leadership at a senior level
- clear governance and accountability
- resourcing of and engagement with the system at all levels
- education and training at all levels and across disciplines.

ABF requires investment throughout the system: it is dependent on the quality of input data, it relies on committed application, and its ultimate success and longevity lies in the use of its output and outcomes data for broader use. However, it can appear initially complex to an outside observer, and it is clear from implementation in other jurisdictions people in the system needs to first understand ABF (beyond simply the reporting burden) to see the benefit and be assured that as a system it is 'here to stay' in order that sufficient investment is made.

The publication of the price list in 2019 is an important step for hospitals and Hospital Groups to understand how funding is distributed between services, and to identify which of their services cost above the average. Publication also provides an opportunity to query the price list: to identify opportunities for improvement or clarify misunderstandings.

In other jurisdictions, for example, Australia and England, consultation on and publication of the National Efficient Price and the National Tariff Payment System have proved critical elements in the successful implementation of the pricing system. The publication of the Irish price list for the first time in 2019 provides an excellent opportunity for stakeholder engagement and review and refinement of the pricing model: a step change in the implementation of ABF in Ireland.

- ABF represents a challenge to a system that has traditionally been focused on 'budget versus actuals' and significant change and re-prioritisation is needed to embed ABF principles and understanding in all levels of the system.
- The complexity of ABF and lack of understanding about it is causing delays and lack of clarity in day-to-day implementation, such as the annual incorporation of ABF into budget allocation processes. Considerable work is needed to educate and engage stakeholders across the system to take full advantage of ABF, better engage in funding discussions, and value good quality, timely data as a tool for decision making.
- Lines of responsibility for the implementation of ABF across the hospital system need to be clearer, with this a critical factor in the future success of ABF.
- Whilst most initial actions to establish the HPO were completed, progress on actions to deliver interim and long-term governance and organisational structures has been limited. Stakeholder engagement is therefore a focus for this Implementation Plan, supported by improved governance structures and clear accountabilities.
- The lack of an existing ABF workforce in Ireland has placed limitations on the expansion of the ABF work programme centrally.

CODING QUALITY TOOLS

A range of data quality tools are provided to hospitals by the HPO including data entry edits and tools to validate and audit HIPE data after the case has been coded, with a high uptake of use.

The HPO's HIPE Coding Audit Toolkit (HCAT©) provides standardised auditing of HIPE coded activity and has been used by 35 of the 39 HIPE ABF hospitals, and the HIPE Checker© tool is used by all 39 HIPE ABF hospitals to check administrative, demographic and code level data prior to submission of HIPE data to the HPO.

In 2018 the HPO started roll out of the Performance Indicators of Coding Quality (PICQ™) coding tool, one of a range of data quality tools which help coders to review their work to ensure that data submitted to HIPE meets the required standards with all information on medical records coded accurately.

The PICQ tool includes 582 checks and is used by hospitals on a daily basis. For the first quarter of 2019, 366,273 HIPE episodes were checked by the tool, of which 5.74% triggered a PICQ indictor.

Finally, there have been challenges because of the economic environment in which ABF has been implemented in Ireland, where overall funding could not meet the volume growth and demands on the system and the budgetary situation has led to a focus on expenditure control.

However, the inclusion of ABF commitments within the 2018 Sláintecare Implementation Strategy provides an opportunity to connect high-profile government objectives and accountabilities to ABF implementation requirements, and a requirement to do more and/or do things differently in order to deliver on Sláintecare commitments. This Plan seeks to leverage on this.

ST JAMES'S USE OF COST DATA WITH CLINICIANS

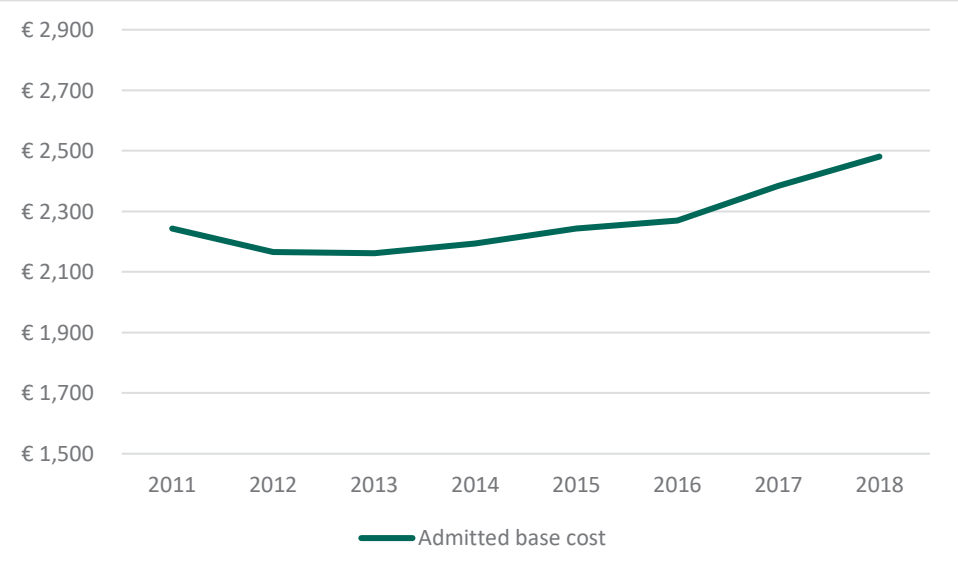
In St James's Hospital, patient-level cost data is being used to ensure that the correct funding is being received by the hospital for each patient, to identify potential efficiency gains so as to free resources for other areas, support business cases for new equipment/products and develop new processes for patient care.

Patient-level costing has also been used to promote the adoption of patient-level data gathering in theatres with the Scan for Surgery Project improving patient safety as products and their related costs can be electronically traced to patients.

STABLE BASE COSTS ACROSS ADMITTED ACTIVITY

The national average admitted base cost for all admitted activity (i.e. combining inpatient and day-case cost and activity) has remained almost flat between 2011 (€2,246) and 2018 (€2,481), noting the effects of the economic crisis and the gradual recovery (Figure 2).

Figure 2: Admitted patient base cost profile, 2011-18. Source: HPO



3. 2021-23 PROGRAMME MISSION, OBJECTIVES AND PRINCIPLES

The ABF Programme's mission, principles and objectives have been reviewed as part of this Plan and have been updated to support the transition from ABF as a new idea within the health system to a core component of 'business as usual'. Support for and understanding of these statements across the healthcare system from policymakers to system managers and clinical and administrative staff is critical to the success of the Programme.

3.1 ABF MISSION STATEMENT

The ABF Programme cuts across the everyday roles of service-users, service-providers, funders and policymakers alike. The mission statement communicates what the Programme does, how it runs and who it is for. It has been developed based on direction provided by national policy documents from the DoH, including 'Future Health' and the Policy Paper on Hospital Financing, and reviewed against the commitments in the 'Sláintecare Implementation Strategy'.

The mission of the ABF Programme is:

- To establish and facilitate an evidence-informed system of healthcare resourcing that drives transparency, equity and efficiency.
- To promote stakeholder cooperation and trust, healthy competition and the greater use of quality health data in the Irish health system.
- To improve the health status of service-users by, in time, combining accurate cost measurement systems with the systematic measurement of outcomes.
- To improve patient access to care together with the overall quality and safety of care they receive.

The further development of ABF will result in the distribution of funding in a fair and equitable fashion that maximises quality of care and improves access to care for patients. In the longer term, by incentivising prevention (as providers are able to make more informed decisions about where to utilise funds, and funding models can include incentive measures for this), hospital avoidance, quality and patient safety and the use of guidelines for appropriate care pathways, ABF will help to maximise outcomes for patients.

Secondly, ABF seeks to introduce an approach to the resourcing of healthcare that is open, fair and transparent, and in which service providers can have confidence, thereby facilitating improvement in the planning and design of care delivery, use of resources and overall value for money.

Finally, in its development and implementation the ABF Programme aims to strengthen trust in a system of healthcare resourcing that is more rational and evidence based. This requires extensive engagement with and support of the hospital network in the transition to full implementation and ongoing consultation to ensure that the ABF system and the prices it sets remain accurate, current and fair.

3.2 OBJECTIVES

The objectives of this Plan are relevant to all those responsible for delivering the ABF Programme, centrally through to the local level.

For 2021 to 2023, the ABF Programme comprises of four objectives: two of which are designed to support and progress the existing Programme base, and two of which expand it to new areas of focus.

Work to progress the existing ABF Programme must continue, to ensure that it is fully integrated and understood across the healthcare system. Two objectives will deliver on this:

Objective 1: Further enhance hospital costing and pricing, which includes:

- Improving the benchmarking of costs to enable hospitals to see the detail of how and why their costs vary from other hospitals so they have insight into where and how they can safely reduce unit costs.

- Broadening the activity areas covered by ABF to include outpatient care and emergency departments.
- Reducing interim transition adjustments previously designed to support hospitals' transition to ABF whilst also refining the ABF pricing model to ensure legitimate structural costs, including complexity driven costs, are better provided for in the ABF system.

Objective 2: Support and enable the existing ABF Programme, which includes:

- Enabling the transition from block budgets to ABF in a sustainable and stable way.
- Supporting the development of ABF data for use in healthcare planning, funding and broader decision-making, including around service improvement and new service development.
- Ensuring provider readiness by supporting key healthcare providers as they fully implement an ABF approach.
- Ensuring the ABF Programme has the appropriate resources and governance to deliver its priorities.
- Undertaking a programme of communications, engagement and change management with key stakeholders, including hospitals, individual clinicians and medical schools.

The ABF Programme must be ambitious, using its data and analysis as a lever to make more informed decisions across the health system. Therefore, two objectives will expand ABF further:

Objective 3: Develop a roadmap for structured purchasing, which includes:

- Research and stakeholder engagement to determine the current status, health sector appetite and ambition around structured purchasing.
- Setting out a roadmap to design and implement whatever level of structured purchasing emerges from the research and stakeholder engagement exercise.

Objective 4: Scope and implement foundational costing and activity measures for a community costing and pricing programme, which includes:

- Supporting better cost collection and reporting across all community services, via the Integrated Financial Management System programme.
- Assessing the availability of costing relevant activity data and inputting to improvements, and setting out costing principles and standards for community services.
- Providing expert costing input to priority projects including in relation to home support and long term residential care.

The actions set out in this Plan seek to deliver on these objectives.

3.3 OPERATING PRINCIPLES

The ABF Programme operating principles act as a navigation aid that will provide continual guidance to stakeholders on how ABF needs to operate in order to support changing the trajectory of the Irish health system. The principles also communicate choices that have been made and will assist in the translation of this Implementation Plan into everyday actions.

1. **Engagement**
    - Ongoing health stakeholder consultation, collaboration and respect.
    - A culture that supports key stakeholders.
    - Promotes transparency and trust of stakeholders in ABF processes.
2. **Responsiveness**
    - A dynamic system incorporating ongoing review and updates in response to emergent and evidence-informed healthcare innovation and to demographic trends.

3. **Independence**
    - A price-setting function that is independent of the purchasing function.
4. **Support integrated care in the appropriate setting**
    - Implementing and maintaining funding processes that support the delivery of integrated care including care outside of the acute setting.
    - Incentivising timely transition to provision of care in the most appropriate setting.
5. **Support health service redesign**
    - Design and implementation of ABF in a manner that supports government objectives including the Sláintecare Implementation Strategy and the transition from Hospital Groups and Community Healthcare Organisations to new regional health bodies.
    - A system that encourages the development of the hospital/primary care interface including supporting use of the Individual Health Identifier and the national Electronic Health Record programme.
    - A system that improves the management of healthcare by facilitating greater analysis and understanding of resourcing decisions and impact.
6. **Feasibility**
    - Managed/phased and stable implementation and growth based on pilot projects and testing.

4. IMPLEMENTATION PLAN FOR 2021-23

The Sláintecare Report and the Sláintecare Implementation Strategy have made clear the need to strengthen the implementation and expansion of ABF across the Irish healthcare system.

The analysis in this report identifies that while significant progress has been made since the HPO was established in 2014 with good foundations built on in terms of HIPE and cost data collection and a pricing model, for ABF to be successful in the future it must be seen as the responsibility of the whole healthcare system. This requires improved leadership and governance, better stakeholder education and engagement, and agreement on the level of commitment required across the system in a challenging funding and operational environment.

This Plan seeks to do this by building on the commitments of Sláintecare and the lessons learnt from the 2015-17 Plan. It incorporates actions and commitments under the previous Implementation Plan and other reviews undertaken since 2015 (including the Pavilion Audit[3] and HIQA Review[4]) and includes new areas of focus, including in relation to structured purchasing and community costing and pricing.

4.1 PRIORITY AREAS FOR 2021-23

Table 2 details the range of actions that will be undertaken as part of this Plan, including the following key focus areas.

Embedding and further developing ABF and structured purchasing

- Undertaking a series of actions to determine the current status, health sector appetite and ambition around structured purchasing and setting out a roadmap based on these results.
- To enable this to happen, working to transition hospitals further to ABF, including by reviewing transition payments and introducing stronger and more real-time financial incentives for productivity to drive value, and expanding ABF for inpatient and day-cases to other acute hospitals.
- Hospital-led development of local ABF implementation plans to further support the transition to ABF as 'business as usual' across the Irish hospital system and utilisation of ABF data.
- Ongoing refinement of the ABF pricing model driven by publication of the price list for the first time in 2019. This will include the development and implementation of an annual consultation process to inform the model methodology and building and strengthening structures to ensure both clinical involvement and transparency in the price.
- Developing the components for ABF in emergency departments and outpatient care, by designing new classification systems for each setting.
- Costing community and homecare services as a precursor to pricing, with responsibility for this to be transferred to the HPO.

Improving data and data collection

- Continued improvement of supporting data, through implementation of recommendations from the Pavilion Audit and HIQA Review for HIPE, a review of HIPE to ensure that it meets the demands of the future operating environment (including, for example, accounting for care outside of the acute setting), and the development of an Acute Hospital Costing and Activity Data Quality Development Plan.
- Building stakeholder understanding and support for the value of ABF data across the health system and the importance of reporting good quality data in a timely manner to consistent data standards.

[3] The 2016 Pavilion Audit aimed to assess the validity of the HIPE data underpinning the Irish ABF model.

[4] The 2018 HIQA Review aimed to assess the compliance of the HIPE scheme with the 'Information management standards for national health and social care data collections', as part of a review programme to assess compliance in all major national health and social care data collections within the HSE.

Strengthening leadership, understanding of ABF and the supporting workforce

- Strengthening leadership of and engagement in the ABF Programme by refreshing its governance framework.
- A series of education and awareness actions to support HPO engagement with key ABF stakeholders and broader understanding of ABF, including for systems managers, clinicians, technical staff, finance managers, policymakers and researchers, to enable increased understanding of and engagement in ABF data, systems and processes and embed ABF in hospital management culture.
- Developing an HPO workforce recruitment and retention strategy to ensure that the skills and experience needed are available and cultivated centrally to lead and support ABF.
- Additional hospital, Hospital Group/ regional health body and HPO staff to support the expansion of ABF.

Working to support a broader policy context

- Supporting work to develop a plan for moving to a system of structured purchasing and population-based funding in the medium term as outlined in the Sláintecare Implementation Strategy, for which ABF can provide the building blocks.

4.2 STRUCTURED PURCHASING

The existence of a structured purchasing capacity within the HSE is aligned with Goal 2 of the Sláintecare Implementation Strategy: *'Provide high quality, accessible and safe care that meets the needs of the population*'. The shift to more integrated care between hospital and community and for more of that care to be provided in the community closer to people's homes under this goal needs to planned and directed. This is not a once-off transformation exercise; it will require ongoing structured purchasing efforts, that is, providing ongoing clarity to the overall system about what types and volumes of care and other services, delivered to what specification and in what setting are required and will be paid for each month

This Plan includes a series of actions to consult on and develop a roadmap to progress structured purchasing.

Location of services

This planning process includes consideration of where services should be placed and prioritised. For example, waiting lists have increased as a result of COVID-19 and it will be essential to purchase services where the need is greatest. A first step in the process will involve the HSE analysing waiting lists to identify the procedures that have the highest numbers as well as the longest waiting times and their locations. Working closely with all relevant stakeholders including public hospitals, private hospitals and the National Treatment Purchase Fund will be an essential component of the process.

The impact of COVID-19 has also impacted on occupancy levels in hospitals, and this becomes a factor in considering where services should be located. Through structured purchasing the procurement of such services may be a combination of local and national competitions. There may also be a requirement to procure services outside of the hospital setting as part of the 'shift left' to the treatment of patients included in the Sláintecare vision.

Clinical quality

Structured purchasing can also be used to encourage and support good clinical pathways, for example through the provision of Best Practice Tariffs. To date, a Best Practice Tariff has been implemented for hip fractures where an additional payment is made where an agreed care pathway has been followed based on standards set out by the Hip Fracture Governance Group (see Chapter 2). Other clinical areas as agreed by the ABF Clinical Advisory Group could avail of the Best Practice Tariff policy. This Plan includes an action to expand policy development in this area.

Additionally, this plan seeks to expand the clinical quality dimension of structured purchasing through actions to use the setting of DRG prices to incentivise the shifting of activity from inpatients to day cases, and to explore further safety and quality pricing dimensions such as adjustments for avoidable hospital acquired complications or inappropriate readmissions.

Central to decision-making

Value for money must remain a key requirement of any structured purchasing policy, and treatments should be assessed for funding according to the principles of clinical effectiveness, safety, cost-effectiveness, and be prioritised in a way which supports consistent and affordable decision-making.

Structured purchasing has the potential to be central to the HSE meeting the challenges it faces today and in the future; and to ensuring that the HSE delivers the aims of improved population health, quality of care and cost-control. A governance structure will be put in place to assess the requirements, capabilities and appetite for structured purchasing. The development of a roadmap to design and implement structured purchasing will form the output from this assessment.

4.3 COMMUNITY HEALTHCARE SERVICES

Community healthcare services include primary care, social inclusion, older persons' and palliative care services, disability and mental health services. Reducing our dependence on the current hospital-centric model of care and supporting capacity building in the community is key to realising the vision of Sláintecare.

COVID-19 has fundamentally changed the way that healthcare services can safely be delivered and accessed. Despite the associated challenges, it has influenced the accelerated delivery of many service transformations, fully aligned to the vision of Sláintecare, that have been advocated for many years. These are particularly evident in the areas of eHealth, community delivered care and service integration.

Whole-system reform – from supporting people to live healthy independent lives in their communities, through to the provision of specialist hospital care – is critical to address the long-standing challenges of our health service. This reform will involve a demonstrable shift in the provision of care from hospital to community settings, with a greater emphasis placed on prevention, supporting people with life-long conditions in the community, working to improve access across the board and expanding services that support people to remain at home.

Enhancing primary and community services to help care for people at home, especially older people and people with chronic conditions will, over time, reduce visits to and hospital admissions. In line with this shift in the provision of care there is a need to better understand activity and cost in the community with an evaluation of approaches to classifying and costing community healthcare as a starting point for further developmental work. The Sláintecare Implementation Strategy reaffirmed the importance of this work with the inclusion of an action to 'advance the community-based costing programme to measure unit costs and productivity in community-based services' (Sláintecare action 7.1.4).

While there has been less ABF-related progress in the community sector it is worth noting the approximately €1 billion paid out on an activity basis each year via the Nursing Home Support Scheme established in 2009 and the approximately €3 billion paid out by the Primary Care Reimbursement Service, much of it in line with ABF principles.

As with hospital care, increasing the availability of high-quality activity and cost data in the community sector will provide a basis for more informed system planning and opportunities to increase efficiency in the system with providers in a position to manage costs more effectively and adopt a more efficient approach to resource allocation. This will also provide increased accountability for the resources invested, and enable monitoring, analysing and managing of trends over time.

However, unlike hospital acute care there is not an established and nationally consistent dataset such as HIPE (along with its associated infrastructure) on which to build a costing system. The technical, ICT, infrastructure and skills requirements in the community setting are significantly less developed than the equivalent hospital systems, where episodes of care are clearly defined, more advanced classification systems are in place, coding and costing systems are available and the required skill mix is at a more mature stage of development. Furthermore, the potential scope of a community costing programme is extensive, covering a diverse range of services where different costing models may be required potentially including primary care, mental health, older persons services and disability services (and possible varying approaches within each of these).

For example, the costing approach to be adopted in a service which is built around long-term 'life-cycle care' such as intellectual or physical disability services will be very different to acute hospital costing which is based on a hospital admission, or immediate short-term community care to support a patient

post-discharge. Costing of *activity* may not be either desirable or relevant in all sectors, and it is important to strike the right balance between consistency to support analysis and flexibility to meet the needs of a particular service area.

Community costing and pricing under this Plan

In providing a new system for costing community healthcare services, the community costing programme cuts across the everyday roles of service-users, service-providers and policymakers alike. The potential scope of a community costing programme is extensive covering a diverse range of community care services, where different costing models may be needed to cost different community services.

Under this Implementation Plan, responsibility for scoping a community costing and pricing programme will transfer to the HPO with an objective to scope and implement foundational costing and activity measures.

As a first step in this process, a scoping exercise will be required to determine which services should be costed, informed by the availability of cost and activity data nationally, the potential for consistency in data collection and classification, the identification of a meaningful and useful unit of count, and the scale of the expenditure on the service. Previous work undertaken within the HSE in relation to community costing will be an important first step in this process.

Once such areas are identified, there will be a need for a data dictionary and costing standards to ensure like-with-like comparison of costing and the products costed by different providers. Detailed consideration will need to be given to classification requirements. Costing returns will need to be submitted in a similar manner to ensure comparability and this will require the development of a costing file in a manner similar to the acute hospital sector, as well as mechanisms for validation and review of data.

Scoping work will be led by the HPO in partnership with the broader HSE, IFMS Quality, Standardisation & Compliance, Community Health Organisations and community service providers. As the programme progresses from scoping to implementation, responsibilities and governance will be reviewed to ensure these match with the shifts in responsibility.

In addition, the programme's effective implementation will require a phased increase in volume and complexity of financial work which community healthcare providers will have to deliver on an ongoing basis. This additional 'new' work will have to be undertaken in addition to the current requirements of organisations, both centrally and locally. Therefore, additional investment will be required to reflect the increase in workload in order to support effective management and delivery. The specific financial, staffing and ICT requirements will need to be detailed as the programme develops.

In relation to the ICT requirements, the Community Digital Oversight Group has been working to align ICT investment across community services for an ICT system that can enhance patient care across each community care group and, critically, interface with both GP and acute services to ensure an integrated community ICT system with the patient at the centre.

4.4 ROADMAP FOR TRANSITION ADJUSTMENTS

To ensure financial stability for hospitals when ABF was introduced, temporary transition adjustments were put in place for hospitals operating above and below the national price. The 2015-17 Implementation Plan required that hospitals operating above the national price make plans to reduce their unit-costs and associated need for transition payments. At the same time, the HPO would work with hospitals to identify any structural disadvantages (for example, operating in a remote location) which could result in legitimately higher operating costs which should be accounted for in the ABF system. Transition adjustments would be implemented alongside ABF in 2015, with phasing out to commence from 2016.

Concurrent with this, the HPO would continue work to examine potential links between clinical data and provider reimbursement, the development of pricing structures to incentivise a shift from inpatient to day-case services and implement ABF for outpatient care as part of the further development of ABF in Ireland. Progress on these actions include the introduction of a pricing mechanism to incentivise the performance of laparoscopic cholecystectomy on a day-case basis, collaboration on a trial Best Practice Tariff for hip fracture care and commencement of a pilot to collect patient-level outpatient data to provide the basis for classification and costing development.

The transition adjustments sit alongside the ABF pricing system to either inflate or deflate payments to hospitals. Under the transition adjustment system, some hospitals' funding is increased because their expenditure is higher than ABF prices, with some funding decreased where ABF prices are above expenditure and providing funding at the ABF price level would represent a 'profit' for the hospital.

This approach is counter to the principle of ABF that efficiency in the system is rewarded. This was appropriate at the introduction of ABF in Ireland to allow the system to adjust to the new way of funding: to smooth the transition for inefficient hospitals, to allow time for improvements in activity and cost data reporting, and to enable the HPO and hospitals to better understand and account for legitimate variations in costs. However, over time these factors need to be addressed in the ABF system.

Under the Sláintecare Implementation Strategy, the ABF proportion of hospital budgets is to be significantly increased by reducing transition payments. Planning for ABF in the midst of a pandemic is difficult given the level of upheaval that is imposed on the healthcare system. Despite this, it is important that the annual ABF processes continue as normal with the aim of returning from block grant to ABF-based budgets as soon as is feasible. Therefore, this Implementation Plan includes an action for the DoH, HSE, HPO and Hospital Groups to work together to review transition adjustments and develop a timetable for incremental reduction of transition adjustments to 2023, taking into account the impacts of COVID-19 on funding processes.

The HPO will also work with hospitals to identify any legitimate structural costs not accounted for in the ABF system which are currently being covered by transition adjustments. Where these exist, the HPO should account for them in the ABF pricing system. Particular effort will also be made to identify and isolate COVID-19 related expenditure so that it can be appropriately handled and the principle of matching cost with activity can be maintained.

4.5 HIGH LEVEL ACTION PLAN

Table 2 sets out the work that will be undertaken to support the ABF Programme objectives and transition adjustments roadmap. These actions have been informed by a review of the current ABF operating environment, progress against actions identified in the previous Implementation Plan, and actions or recommendations from other reviews and reports including the Sláintecare Implementation Strategy, the Pavilion Audit and the HIQA Review.

The cooperation of different parts of the health system is crucial for the success of ABF, and so this Implementation Plan includes actions for the HPO, HSE (including specific Divisions) and the Office of the Chief Information Officer, DoH, Hospital Groups/ regional health bodies, community service providers (as partners) and the ABF Clinical Advisory Group. The agency or group responsible for leading implementation of each action is listed first, together with key partners which are required to actively work with the 'lead' to deliver on the action. Committees established as part of the new governance structure specified in this Plan should have oversight and/or other responsibilities in relation to Implementation Plan actions set out in their terms of reference. Where Hospital Groups are referenced in the table below, responsibility for that action will transfer to regional health bodies once established.

Table 2: High level action plan

No.	Action	Timeframe	Lead with key partners
OBJECTIVE 1: HOSPITAL COSTING AND PRICING			
1.1	Continue to review and refine the ABF pricing model methodology	Ongoing	HPO
1.2	Publish the ABF price list on an annual basis	Annually in Q1	HPO
1.3	Develop and implement an annual consultation process to inform the ABF pricing model methodology	Annually from 2022	HPO
1.4	Establish an ABF Benchmarking Review Group to improve understanding of the ABF benchmarking adjustments and to ensure legitimate and unavoidable costs are provided for in the ABF system.	Q2 2022	HPO with Hospitals and Hospital Groups
1.5	Produce a Roadmap for the phased reduction of transition adjustments for existing hospitals to 2023 (progress on implementation of this plan should also be reported as part of the ABF Implementation Plan reporting framework) (Sláintecare action 7.1.2)	Q4 2021	HPO with DoH, HSE Acute Hospital Finance and HSE Acute Operations
1.6	Identify legitimate structural costs not accounted for in the ABF system which are currently being covered by transition adjustments and incorporate them into ABF	Q4 2022	HPO with Hospitals and Hospital Groups

No.	Action	Timeframe	Lead with key partners
1.7	Further develop and refine the coding and classification system for acute hospital care in line with best practice	Ongoing	HPO
1.8	Pilot a classification, costing, price-setting and payment system for emergency care	Q4 2023	HPO with the Office of the Chief Information Officer and the Emergency Medicine Programme
1.9	Pilot a classification, costing, price-setting and payment system for outpatient care (Sláintecare action 7.1.3)	Q4 2023	HPO with the Office of the Chief Information Officer and the ABF Clinical Advisory Group
1.10	Develop and publish a national ABF data requirements plan for activity and cost data, to be updated on an annual basis	Q4 2021	HPO with the Office of the Chief Information Officer and DoH
1.11	Develop a long-term data development strategy to identify areas where data development or improved reporting is required to support the pricing model	Q2 2022	HPO with the Office of the Chief Information Officer
OBJECTIVE 2: SUPPORT THE EXISTING ABF PROGRAMME			
2.1	Develop a framework to determine the thresholds for the inclusion of hospitals in the ABF system	Q4 2021	HPO with HSE Acute Operations
2.2	Expand ABF for inpatient and day-cases to other acute hospitals (Sláintecare action 7.1.1)	Q4 2021	HPO with HSE Acute Operations
2.3	Integrate performance management of ABF into Performance Contract and organisational performance management and assurance process	Q4 2022	HPO with DoH, HSE Acute Hospital Finance and HSE Acute Operations
2.4	Commence an education and awareness plan to increase understanding of ABF funding and secondary uses of ABF data across hospitals, including for clinicians, accountants, systems managers and administrators	Q1 2022	HPO with Hospitals and Hospital Groups
2.5	Publish HPO/ABF policies and procedures to improve understanding of, and engagement with ABF	Ongoing	HPO

No.	Action	Timeframe	Lead with key partners
2.6	Undertake a review of HIPE to ensure that it meets the demands of the future operating environment, with this to include publication of a future strategy document	Q4 2021	HPO with DoH, HSE Acute Operations and the HIPE Governance Group
2.7	Improve coding quality by utilising data quality tools at the hospital level and monitoring use of these	Ongoing	HPO with Hospitals and Hospital Groups
2.8	Strengthen audit and probity mechanisms for HIPE and costing data	Ongoing	HPO
2.9	Develop an Acute Hospital Costing and Activity Data Quality Development Plan to increase the scope of ABF to all acute hospitals and ensure the efficient generation of high-quality and timely costing data for ABF	Q1 2022	HPO with Hospitals
2.10	Improve costing skills and the profile of the costing workforce by developing a costing education and training programme	Q4 2021	HPO with Hospitals
2.11	Develop hospital-level ABF implementation plans, including for governance, workforce and infrastructure	Q1 2022	Hospital Groups with HPO and HSE Acute Operations
2.12	Align communications planning between the HSE and the DoH in relation to ABF and ABF-related data and resources	Q1 2022	HPO with HSE Acute Operations and DoH
2.13	Publish ABF educational resources, data and other materials to improve understanding of ABF and the value of ABF data for a range of stakeholders	Ongoing	HPO
2.14	Establish a network of ABF clinical champions, backed by senior leadership within the DoH and HSE	Q1 2022	ABF Clinical Advisory Group with HPO, HSE Acute Strategy & Planning and DoH
2.15	Incorporate ABF education materials into standard training for clinicians and hospital administrators	Q1 2022	HPO with HSE Acute Strategy & Planning, Hospital Groups and Hospitals
2.16	Deliver an ABF conference annually to facilitate discussion and build understanding and knowledge in the system about ABF	Annually (resuming 2022 due to COVID-19 impacts)	HPO

No.	Action	Timeframe	Lead with key partners
OBJECTIVE 3: STRUCTURED PURCHASING			
3.1	Establish a governance structure and assess the requirements, capabilities and appetite for structured purchasing, including in relation to demand, capacity quality and funding	Q4 2021	HSE Chief Strategy Officer with HSE Acute Operations, HPO, HSE Acute Strategy & Planning, HSE Quality Improvement and DoH
3.2	Develop a roadmap to design and implement structured purchasing based on the outcomes of action 3.1	Q4 2022	HSE Chief Strategy Officer with HSE Acute Operations, HPO, HSE Acute Strategy & Planning, HSE Quality Improvement and DoH
3.3	Continue the programme of policy development to progress quality and safety initiatives related to ABF and to inform a future structured purchasing approach, including (but not limited to) Best Practice Tariffs, hospital acquired complications and avoidable readmissions (Sláintecare action 7.1.2)	Ongoing for annual consultation from 2022 through the Pricing Framework	HPO with DoH, HSE Acute Operations, HSE Acute Strategy & Planning, HSE Quality Improvement and the ABF Clinical Advisory Group
3.4	Develop pricing structures which incentivise shifts from inpatient to day-case in line with current ABF policy, and scope further 'shift left' opportunities to support future structured purchasing priorities	Q3 2022	HPO with the ABF Clinical Advisory Group and HSE Acute Operations
OBJECTIVE 4: COMMUNITY COSTING AND PRICING			
4.1	Undertake preparatory work for the costing of community healthcare services, including homecare and elderly residential services, by determining the scope of those services which should be costed (Sláintecare action 7.1.4)	Q1 2022	HPO with HSE Community Operations, Community Health Organisations and community service providers
4.2	Build costing requirements into the IFMS for existing acute costing processes and future community costing requirements. Support the process to finalise the IFMS Enterprise Structure.	Q1 2022	HPO with IFMS Quality, Standardisation & Compliance and HSE Community Operations
4.3	Develop cost coding and costing manuals and standards, and develop a costing return for community costing to ensure a consistent costing approach for the services identified in action 4.1	Q4 2022	HPO with HSE Community Operations, Community Health Organisations and community service providers

No.	Action	Timeframe	Lead with key partners
4.4	Work with community service providers and resources to assess the quality and consistency of community returns received and further scope other services that can be included in the costing studies	Q4 2023	HPO with Community Health Organisations and community service providers

5. RESPONSIBILITIES AND ENGAGEMENT

5.1 WHOLE OF SYSTEM RESPONSIBILITIES

The successful implementation of ABF is the responsibility of the whole healthcare system. Whilst this has always been fundamental to how ABF works, this Plan represents a significant shift for ABF in the Irish system, with the move from 'start up' phase with its focus on the development of ABF centrally through the HPO and a progressive roll out to and education for hospitals, to 'business as usual'. This requires a shift to those across the system actively participating and taking responsibility for driving their components of ABF on an ongoing basis, with the HPO as a leader driving change.

A central team responsible for delivering the pricing, data collection and classification functions and strategic change is fundamental. However, ABF also requires staff and systems at hospital and Hospital Group/ regional levels in order to ensure that sufficient good quality data is collected as the basis for the HPO's work. The HPO can support education and training of local staff, for example, training of clinical coders and costing staff, and advise on ICT infrastructure needs; however, it is not responsible for recruitment and management of those staff, or for ICT projects. Likewise, the HPO can support hospitals in developing their data collection systems and analytical abilities; however, it is hospitals and Hospital Groups/ regional health bodies which are responsible for providing good quality, timely data for national ABF, and reviewing that data to inform local decision making.

For ABF to be effective, it also needs commitment at senior levels, nationally to ensure that the prices set by the HPO are appropriately incorporated into healthcare funding, and more broadly, to ensure that the 'ABF message' is understood across the healthcare system and all levels are held accountable for fulfilling their roles. Where inputs are not the responsibility of the HPO, such as ICT development, the needs of ABF and its supporting data need to be considered in project development.

Further, clinical input is crucial to the ABF Programme, to ensure that the pricing system makes clinical sense and is useful, and to ensure that ABF has clinical integrity. This should be at both the policy level, through Clinical Leads in the DoH and HSE, and at the local level, through clinician education and involvement in ABF implementation and value-based care initiatives, so that these are clinically meaningful and useful.

Table 3 sets out the responsibility of each part of the system in implementing ABF.

Table 3: Responsibilities of each part of the healthcare system in implementing ABF

Organisation	Responsibilities
Department of Health	The DoH is responsible for providing policy leadership for the ABF Programme, including in relation to Sláintecare and other health system policies and reform programmes, as well as policy relating to Ireland's health information system, of which HIPE is a strategic part. The DoH is responsible for the total funding to be provided to the HSE, of which ABF forms a part.
Health Service Executive	The priorities of the HSE Board, established in 2019, include exercising effective budgetary management and ensuring the HSE's full support for and implementation of the Government's programme of health reform as set out in the Sláintecare Implementation Strategy. To deliver on this, the HSE is responsible for setting targets for hospital activity and prices (the latter of which are set via the HPO), and for ensuring that the objectives of the ABF Programme are delivered. The HSE is also responsible for providing input into the ABF Programme to ensure that it aligns with the work of clinical, planning and performance.

Organisation	Responsibilities
	Under this Plan, the HSE Chief Strategy Officer will be responsible for leading work on structured purchasing, whilst the HSE Chief Financial Officer will lead on hospital and community costing and pricing.
Healthcare Pricing Office	The HPO is part of the HSE and plays a role in providing leadership for and management of ABF, setting the national DRG prices on which the ABF system is based and being a strategic driver for change. Underpinning this, the HPO is responsible for a range of central ABF functions, and will lead scoping work in relation to community costing and pricing.
Hospital Groups and planned regional health bodies	At the commencement of this Plan, each of the seven Hospital Groups is responsible for the governance and management of the hospitals within the group, including in relation to ABF. They are the contracting entities for ABF, with funding flowing from the HSE to the Groups, rather than individual hospitals. The Groups therefore determine how funding is distributed amongst hospitals. They are also key partners in change and can advocate with the HPO for a shift in the funding model. Hospital Groups are also responsible for submitting ABF cost data to the HPO, with the previous Implementation Plan including provision for the recruitment of ABF Group accountants. Hospital Groups are also able to benchmark hospitals using the Patient-Level Costing Benchmarking Tool and should support ABF nationally by ensuring that the local workforce is able to understand and utilise it to best effect, for example in relation to planning and budgeting, or clinical decision making where ABF data can provide insights into current practices and opportunities for improvement. Over the lifetime of this Plan, six new regional health bodies will be established. These bodies will be responsible for planning and delivering health and social care in their regions and will replace Hospital Groups and Community Healthcare Organisations. The responsibilities of Hospital Groups under this Plan will transfer to the new regional health bodies.
Hospitals	Hospitals are responsible for collecting the activity and cost data which underpins ABF in an accurate and timely manner. This includes: • recruitment and ongoing training of HIPE clinical coders and coding managers, ABF accountants and data analysts • quality assurance of activity and cost data, and compliance with national standards and guidelines • ensuring that ICT systems enable the provision of accurate and timely ABF activity and cost data • ensuring that the workforce can understand and utilise ABF to best effect, as with Hospital Groups/ regional health bodies.
Community Health Organisations and HSE Community Operations	The role of Community Health Organisations to enable and support integrated care within community health services and between community and acute hospital services, with the wider public service organisations. Community health organisations will be responsible for working with other relevant parties in community costing and pricing. Detailed responsibilities will be developed as part of this Plan.
Community healthcare providers	The responsibilities of community healthcare providers in contributing to the development of costing systems for community-based care will be determined in consultation with all relevant stakeholders as part of this Plan.

5.2 GOVERNANCE AND OVERSIGHT

Delivering on the three core objectives of this ABF Implementation Plan will require significant involvement from a range of internal and external stakeholders, with leadership within the HSE being co-ordinated as follows:

- Structured purchasing: HSE Chief Strategy Officer[5]
- Hospital and community costing and pricing: HSE Chief Financial Officer

An HSE ABF Implementation Steering Group will be established. It will be co-chaired by the HSE Chief Financial Officer and the HSE Chief Strategy Officer and will include representatives of the HSE Executive Management Team, Community Healthcare Organisations, Hospital Groups, and the DoH.

Periodically this Steering Group will provide updates to, and seek input from, the current HSE Finance Reform Program Board chaired by the Chief Executive Officer and of which the Secretary General, DoH and Assistant Secretary, Department of Public Expenditure and Reform are members along with other senior officials from the HSE and DoH.

In due course, this structure will be reviewed in in line with the wider review of the HSE to ensure that it continues to deliver on these objectives, and to ensure that management and governance of structured purchasing and community costing and pricing programmes are appropriately positioned as they move from scoping to implementation phases.

5.3 CLINICAL ENGAGEMENT AND HEALTH SERVICE CULTURE

The previous Plan identified that the ABF technical work programme would need to be:

- Clinically driven to ensure that its design aligns with the work of the clinical programmes and medical schools, and creates incentives for the right changes in clinical practice.
- Matched by a wider culture change programme led politically and at the most senior management and clinical levels.

Since 2014, the HPO has engaged with clinicians and the broader health system predominantly through annual ABF conferences (in 2015, 2016, 2017 and 2019), at senior levels through the ABF Clinical Advisory Group and the HSE Acute Strategy and Planning Division and on a day-to-day basis through ad hoc working relationships with finance, data and ICT hospital and Hospital Group staff. Day-to-day engagement with clinicians has been limited due to a lack of formal networks beyond the senior leadership-focused ABF Clinical Advisory Group, and awareness and/or understanding of ABF and its supporting data by clinicians and other stakeholders in the system. This has resulted in pockets of clinical engagement across the system, but no comprehensive approach.

The release of the Patient-Level Costing Benchmarking tool in late 2018 and the annual price list for the first time in 2019 provide significant opportunities to encourage clinical engagement, critical review of supporting data and to shift the culture from fixed budgets to a focus on outputs and outcomes.

Significant work is required over the life of this Implementation Plan to renew and/or develop clinical and senior leadership engagement with ABF.

The ABF Clinical Advisory Group will be reconstituted and will be responsible for a number of actions under this Plan, as well as providing broad advice to the HPO and HSE on ABF clinical matters.

The Plan also includes a series of actions to improve communication and engagement with a range of stakeholders across the healthcare system, so that ABF is understood, used and valued.

[5] ***Note:*** *Responsibility for the actual implementation of any agreed roadmap towards structured purchasing, including acting as the purchaser for the healthcare system, is expected to rest with the Chief Operations Officer.*

5.4 COMMUNITY HEALTHCARE SERVICES

Stakeholder engagement will be critical to data collection and costing in the community sector.

Much has been learnt from the rollout of ABF to hospitals and experience suggests that delivering on the cultural changes required to implement the community costing programme may be even more significant than the extensive technical changes required. While measuring and costing activity can be seen objectively as a technical exercise, it is important that budget-holders and service providers are involved in the process from policy and operational perspectives too. This requires education and support to enable informed contributions, as well as skilled and sensitive change management as the results of analytical stages are later converted into procurement or payment processes.

Actions under this Plan to undertake preparatory work for the pricing of community healthcare services include the development of a project and resourcing plan which should include detailed consideration of stakeholder engagement.

6. DEPENDENCIES AND RISKS

Successful implementation of the ABF Programme requires:

Leadership, accountability and engagement

- The ABF Programme needs continued and consistent leadership, with clear governance and accountability.
- The ABF Programme needs to align with broader government and health system objectives to support a more efficient healthcare system.
- There needs to be understanding of and support for ABF within the system from senior leadership through to system managers, clinicians and administrators.

Good quality, timely data

- Input data must be of sufficient quality and timely enough to ensure the integrity and relevance of the pricing model.
- Stakeholders must ensure appropriate resources to prioritise the provision of quality and timely data.

Relevant and useful outcomes

- The price and the application of ABF must have financial significance across the system.
- The data that is collected and the results of analysis must have clinical relevance and usefulness.
- Data and results should be able to be benchmarked.

The key dependencies for the success of the ABF Programme are set out in Table 4.

With the expansion of the Programme, priority should be given to undertaking a full analysis of programme risks.

Table 4: Key ABF Programme dependencies

Dependency	Description
Leadership and accountability across all parts of the system	Senior leadership across all areas of the system is fundamental to the success of ABF. The ABF Programme remains in a development phase, requiring increased resourcing, education and training from many people. To maintain this requires leadership and commitment, as well as accountability and governance structures to maintain momentum over the long term.
The ongoing input and support of clinicians	For ABF to be meaningful, clinicians need to see, understand and engage in the outputs of ABF, including high quality comparable activity and cost datasets which can be benchmarked and analysed to improve efficiency and quality of care, as well as have input to the pricing methodology to ensure that it has clinical meaningfulness and does not deliver unintended consequences for the system or patient care. The success of ABF relies on the support of clinicians providing patient-level activity data required for the system to function effectively, particularly in the area of quality and health improvement. Stronger clinical representation is required at governance level in the HPO as well as at all operational levels of ABF.
Detailed, accurate and accessible recording of activity and cost	The accuracy and quality of ABF prices, activity targets and the ultimate funding of hospitals depends on the degree to which each step in a patient's care is recorded on their chart and the

Dependency	Description
	corresponding quality of the subsequent coding or recording of that information so that it can be correctly reported and reimbursed. Hospitals need to continue to build and maintain their resources to improve patient-level analytics, in particular their patient-level costing capacity, for the accurate financial interpretation of activity data and its separation from fixed overheads and other costs. Providers will further need to expand their ABF data collections to emergency and outpatient care to support the expansion of ABF to other streams and incorporate the Individual Health Identifier into record keeping, as well as develop systems to enable the costing of community healthcare.
A system-wide cultural change in the way care is designed and delivered	The success of ABF relies heavily on the support of healthcare professionals, from frontline staff to administration and senior management at local and national levels, in adapting to the new system and its requirements. From the collection and recording of health data and accurate coding to input into ABF prices at the national level, healthcare professionals determine both the accuracy with which the system operates and its acceptance and continuation as the primary means of determining hospital funding. Education on and the availability of data to the system to enable benchmarking and broader research will help to support the implementation of ABF as users find value in the data and analysis it produces. This requires leadership and continued efforts at all levels to adjust to a funding system which is more obviously driven by care models and patient episodes than by traditional provider delivery systems, including a commitment to education and training and leadership across disciplines. Significant issues also continue to need to be addressed in terms of commissioning expertise for both providers and the HSE and the ongoing move to a transactional culture with a wide range of new skillsets not traditionally required under the block-grant funding approach. This type of skilled workforce is in short supply in Ireland, and the ability to attract, retain and develop ABF staff at central and hospital levels should not be under-estimated.
The cooperation of and support for Hospital Groups/ regional health bodies	Hospital Groups (and future regional health bodies) form the contracting entity for ABF. Their development in this role must be assisted by an overarching policy framework which supports this, as well as defining clear accountabilities for Hospital Groups in progressing ABF. To improve system efficiency, Hospital Groups/ regional health bodies must be given the autonomy to harness the benefits of independence and greater control at local level, changing their cost base and arrangements for the deployment of staff to respond to demand.

Dependency	Description
	Assistance is necessary to assist hospitals deemed to be at a structural or geographic disadvantage.
Enabling providers to manage in the most effective manner	It is a fundamental principle of ABF systems that providers are not hampered by conflicting rulesets as they make decisions to bring their unit costs into line.
The development of a Structured Purchasing Framework	The HPO sets prices for healthcare. The determination of activity volumes is a critical component of ABF – without which it cannot progress. Determining activity volumes must be undertaken separately to price-setting.
The development of a Financial Management Plan to ensure the financial stability and sustainability of the hospital system during the transition period	When ABF was introduced, transition adjustments were put in place to ensure the continued financial stability and sustainability of the hospital system. As foreshadowed in the previous Implementation Plan, these will now be phased out, with concurrent work to incorporate any legitimate structural cost differences not included in the ABF model into the pricing system. The system will continue to need economic regulation mechanisms to safeguard good governance and financial management of health services. This may extend, in exceptional circumstances, to intervention to rescue a healthcare provider delivering a service deemed essential to population health needs.
Continued upgrading of ICT infrastructure and capacity across the Irish health system	Delivering the necessary upgrades to health system ICT infrastructure along with the capacity and expertise necessary to operate it continues to require significant investment at central and local levels, including in relation to better and more timely data collection systems, implementation of the Individual Health Identifier, and expansion of systems to support ABF outside of acute care. This requires consideration of ABF requirements at all levels of ICT planning, and agreement on which parts of the system are responsible for doing this. Ultimately, ABF can drive improvements to the scope and quality of information, which as the international examples referenced throughout this Plan demonstrate, can be used by clinicians and system planners to drive better care.
Ongoing communication and engagement with policymakers, providers, other stakeholders	The continued implementation and longevity of ABF requires that political, health system and other stakeholders work collaboratively to support the development of ABF across the health system, and its integration into standard health system financing. This Implementation Plan includes actions designed to support this but cannot alone ensure success. Leadership on ABF at all levels of the system is crucial to success.

7. MANAGING AND REPORTING ON THIS PLAN

Progress against the Implementation Plan will be coordinated by the HPO and formally reported to the DoH and Hospital Groups/ regional health bodies on an annual basis throughout the life of the Plan.

All parties involved in implementation of the plan will be involved in more frequent, informal reporting through the HSE ABF Implementation Steering Group, with this to include a regular quarterly reporting schedule.

A full review of progress against the Implementation Plan will be carried out at the conclusion of Plan in 2023.

Annual and end-of-plan progress will be measured based on an assessment of:

- the extent to which the ABF Programme has delivered the benefits of ABF described in this Plan
- the extent to which the ABF Programme has delivered on the objectives of this Plan
- implementation of the actions listed in this Plan.

Info@HSEprint.ie Ref: ABF Implementation Report 12/21