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# Part 4

## Transition

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## Chapter 11

# Planning the Transition

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The challenges associated with undertaking such a large-scale reform of the structures and functions of the health system are considerable. However, the consequences of not moving towards the new model and not tackling the overlaps and structural deficiencies outlined in this report, need to be spelled out:

- To continue in the current direction of development of structures and functions will lead to even greater fragmentation of critical functions with consequences for cost effectiveness, performance and ability to manage healthcare services in Ireland;
- The continuation of blurred accountabilities, unwieldy governance and lack of clarity of roles will lead to a service which is less responsive to customer needs, which has greater difficulty in delivery of national strategies and where the challenge of realising value for money becomes increasingly onerous;
- Sustaining the current structures, or even just modifying them to some degree, is inconsistent with the level of effort required to fundamentally reorganise and reform the acute sector on a national scale and prepare for implementation of the Primary Care Strategy.

There are endless variations on the potential future model for the Irish health system and as many different views as there are interested parties. We believe that the proposed consolidated structure will position the health system to deliver the aims and objectives of *Quality and Fairness*. In our view, the direction and change being recommended is building on the strengths of the existing system and is consistent with many of the progressive decisions that have already been committed to, including:

- The move towards standardised practices in both HR and IT, as demonstrated by the PPARS programme and the implementation of SAP Finance across the health system;
- The introduction of coordinated system-wide initiatives through HeBE;
- The development of the *Action Plan for People Management* which advocates the introduction of new managerial skills, the establishment of a performance management ethos and the further development of partnership mechanisms.

This Chapter, therefore, seeks to outline how the proposed consolidated structure could be implemented and the likely costs associated with implementing it. It identifies some of the key transitional issues that will need to be addressed in advance of and during implementation. This Chapter is structured into four main areas:

- Implementing the proposed consolidated structure;
- Implementation approach;
- Potential financial implications;
- Dependencies for the effectiveness of the new structure.

## 11.1 Implementing the proposed consolidated structure

Implementing the consolidated structure involves delivering change on a large scale and on a sustained basis over a number of years. It is critical that the changes recommended in this Audit are integrated with other current initiatives including medical workforce reforms for the acute sector, the Primary Care Strategy and the recommendations on the reform of financial controls. All these elements need to be coordinated and planned for in an integrated manner.

The complexities associated with delivering organisational change are well documented in both general publications and healthcare literature. However, the scale of this proposed change programme is such that some of those complexities warrant specific attention:

### 11.1.1 Engaging stakeholders

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Any significant transformation needs to secure and maintain the commitment of stakeholders to the proposed change. This is particularly the case when dealing with a complex, system-wide and potentially lengthy transition such as that proposed here. There are a large number of stakeholder groups that will need to be engaged. They include:

- Leaders from within the existing health system;
- Staff and staff representatives from within the existing health system;
- Consumers, professional groups, politicians and the general public.

The concerns of stakeholder groups will need to be identified and a programme of communication and involvement will need to be established and tailored to engage them in the change programme. Outlined below are some early considerations for each of the three groups identified:

- **Engaging leaders — Health Board and Agency CEOs, Senior DoHC officials**

Leaders need to be actively involved from the outset in driving these changes and maintaining stability during the transition. Their role in securing acceptance for and achieving this change must be personally and publicly acknowledged. The opportunity for them in the short term to play a role in creating this new entity and delivering an improved health service must be clearly painted.

A programme of engagement for leaders will need to be undertaken by the Department/Minister ideally in conjunction with the publication of this report. In the longer term the good progress made to date in developing leadership capability within the health system must be maintained and remain a priority throughout the transition in order to ensure that the system continues to build leadership capability for the future.

- **Engaging staff and their representatives**

Organisational transformation research and experience has clearly demonstrated that the engagement of staff and their representatives to support and participate in the implementation of successful organisational change is also critical. For the Irish health system, which already suffers from skills shortage, this is even more crucial if the necessary skills and competencies to deliver health services in the new consolidated health system are to be retained.

As in any significant transition, it is likely that existing staff will have considerable concerns about the security of their jobs, who their future employer is likely to be and their future career prospects in the new model. This lack of certainty, if poorly managed, is likely to result in a drop in performance and morale, a lack of focus and greater difficulties in retaining talented staff during the transition.

A comprehensive staff engagement approach incorporating existing partnership arrangements as well as comprehensive communication initiatives and true involvement of staff in the implementation of the new structure will need to be developed and deployed across the health system.

Deploying an effective engagement during the transition should also serve to establish the basis for creating a health system with a culture of clarity, openness and trust and a deeper awareness of the potential of working in partnership particularly at a local level.

The potential career opportunities in the new model need to be identified as early as possible along with the extent of any plans to locate some of the proposed new organisations in regions as part of the Government's regionalisation strategy. In addition to this it is important that the Department commits to a fair, equitable and transparent selection process for all new roles. The competencies and skills required to create the new agencies, as intended, will need to be defined and potential candidates assessed against them.

- **Engaging consumers, the general public and their representatives**

One of the recommendations of this audit is to increase direct consumer involvement and representation throughout the system. Engaging consumers and the general public, however, is not just a design feature of the future model — it is a necessity for the acceptance and successful implementation of the proposed consolidated structure. International experience has shown that where the general public and consumer representatives support a proposed course of action it can lead to the creation of momentum and demand for change on a scale otherwise unachievable.

The overall agenda set out in *Quality and Fairness* generated a broad degree of public and stakeholder support. The DoHC therefore has an opportunity with the publication of this and other reviews in the coming months to paint a compelling vision for the future of the Irish health system in terms of the reform and modernisation agenda it envisages and to engage the general public in the achievement of this vision.

Development and implementation of a communication and engagement programme for the general public and consumer groups in the proposed programme of structural reform is a must if the recommendation to increase consumer involvement throughout the health system is to be taken seriously.

### 11.1.2 Capability, coordination and resourcing

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Given the scale of the change, the current capability and resource levels of the system to deliver this transformation is a very real challenge to implementation. Without dedicated and skilled resources committed to delivering the proposed structural changes the effort will struggle to gain the necessary momentum and deliver the results required. Due to the inter-related and complex nature of the proposed changes strong coordination and planning skills will be required, as will resilience to ensure momentum is sustained.

A national reform programme will need to be carefully planned and then effectively resourced with both the requisite staff numbers and skill sets if it is to deliver the intended results. The best people will need to be secured and leading practices in programme management, organisation restructuring and change management techniques will need to be applied. Sufficient resources will need to be assigned not only to designing the detail of the new structures and roles but also to managing leadership and staff engagement, communication and the migration from existing structures into the new environment. The skills, competencies and resources required to deliver this change need to be defined at the earliest opportunity and secured without adversely affecting front-line services.

The scale of the change proposed is such that a full-time reform implementation team alone, regardless of size/staff numbers, will not be sufficient. Change sponsors and champions from across impacted areas of the health system will

need to be secured to support and deliver the change effort on a part-time basis. Existing managers and staff from across the health system will need to participate in steering groups, design workshops and pilot schemes and play a role in communicating with peers and colleagues — where appropriate promoting the proposed changes and feeding back concerns and issues to the implementation team. For agencies being mainstreamed local project managers and project team members may also be required.

While delivering the change programme it is critical that the current levels of service are safeguarded and protected. Any deterioration in the existing levels of service over the course of the change programme will only serve to undermine support for the proposed health system modernisation.

### 11.1.3 Managing the transition

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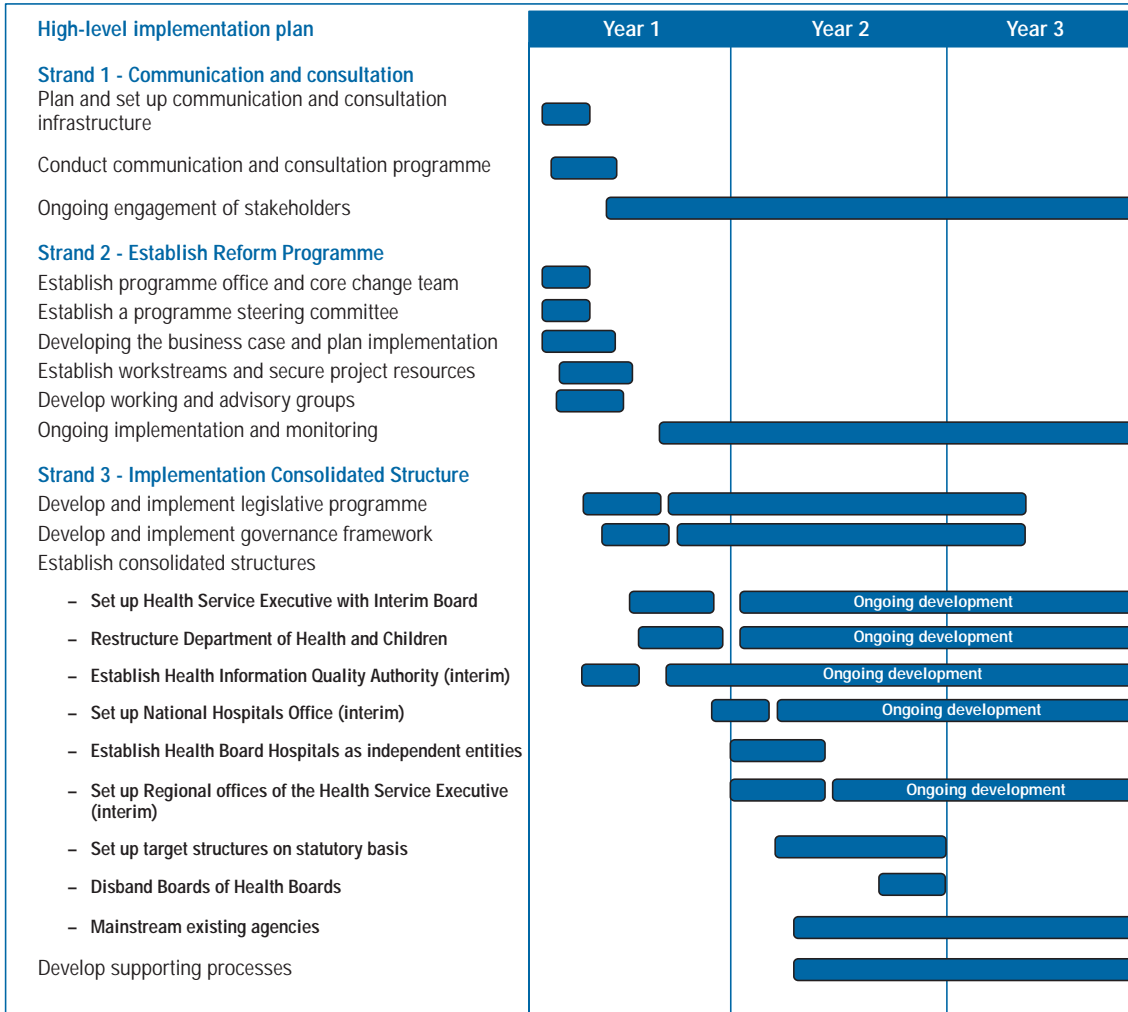
There are considerable implications for many of the health system's 96,000 staff. For some it will mean a change of job with new responsibilities. For others the operational aspects of their role may not change but the structures and processes for securing decisions and funding will be considerably different. For many there will be a change of employer.

There is considerable work involved in planning and managing a successful transition from an existing structure to a new entity. To support these changes the implementation team will be dependent on the support of experts within the system to achieve this transition and play a leading role in the transition effort. The transition of people to the consolidated structure will represent challenges — particularly in a system that despite recent progress and improvements still has a largely underdeveloped HR capability and resources. In our view, the Head of HR for the HSE will need to be appointed at the earliest opportunity and the process of improving HR capability in the consolidated structure commenced as soon as possible.

## 11.2 Implementation approach

The change envisaged will demand adherence to certain criteria common to all major transformations. The sequencing of events in particular will require attention in order to create a momentum for change and to manage the interdependencies inherent within the health system. An initial high-level implementation plan is depicted below and described in some detail in this chapter. This will need validation during the planning stage of the implementation.

Figure 11.1: High-level implementation plan for the proposed consolidated structure



The plan consists of three strands:

- Strand 1 — Communication and consultation
- Strand 2 — Establish a (National) Reform Programme
- Strand 3 — Implement the (proposed) consolidated structure

Each of these is described in more detail below.

### 11.2.1 Strand 1 — Communication and Consultation

The evolution of this Audit assignment to include the need to develop a ‘sense of direction’ for the health system architecture (as described in Chapter 1) has meant that there has been only limited engagement with health system staff, potential leaders of the change and the general public in the development of the proposed consolidated structure. Yet it is fully dependent on the support and involvement of these key groups. Accordingly, we strongly recommend that the first

step in implementing the proposed structure needs to be the planning and implementation of an extensive programme of communication and dialogue with key stakeholders to commence in conjunction with the publication of this report.

The communication programme should be viewed as an opportunity to present and discuss the Department's and the Minister's vision for the future of the health system. The objective should be to explain the rationale for the changes proposed and to elicit views on the best pathways to implementation. The possibility of incorporating the results of other related health initiatives due for publication at the same point in time into one overall vision for the future should be considered. The communication programme should include presentation of the audit findings and the key elements of the proposed consolidated model as well as consultation on the draft implementation plans with stakeholders. Leaders from within the existing health system, such as the health board CEOs, should be engaged in advance of the communication process and should be given an active role in engaging broader stakeholder groups in the proposed future model for the health system. Mechanisms such as agency/team briefings, one-to-one meetings, web and phone based 'Question and Answer' databases are established and work alongside existing partnership and local communication mechanisms to ensure dialogue is maintained and accurate information is available throughout the transformation.

While we are proposing a consultation process focused on implementation, rather than defining the desired services, the extensive consultation process that preceded the publication of *Quality and Fairness* set a standard for inclusiveness which needs to be sustained. The consultation and communication infrastructure will need to be established in advance. Engaging with the well-developed partnership structures in the health service will be critical. The National Consultative Forum will provide one very useful collaborative and non-political vehicle for ongoing consultation around the proposed organisational reforms.

We envisage that a process such as that proposed here will take a number of months to complete. This should be conducted in tandem with the next phase — the establishment of a National Programme for the Reform of the Structure and Functions of the Health System.

### 11.2.2 Strand 2 — Establish a National Reform Programme

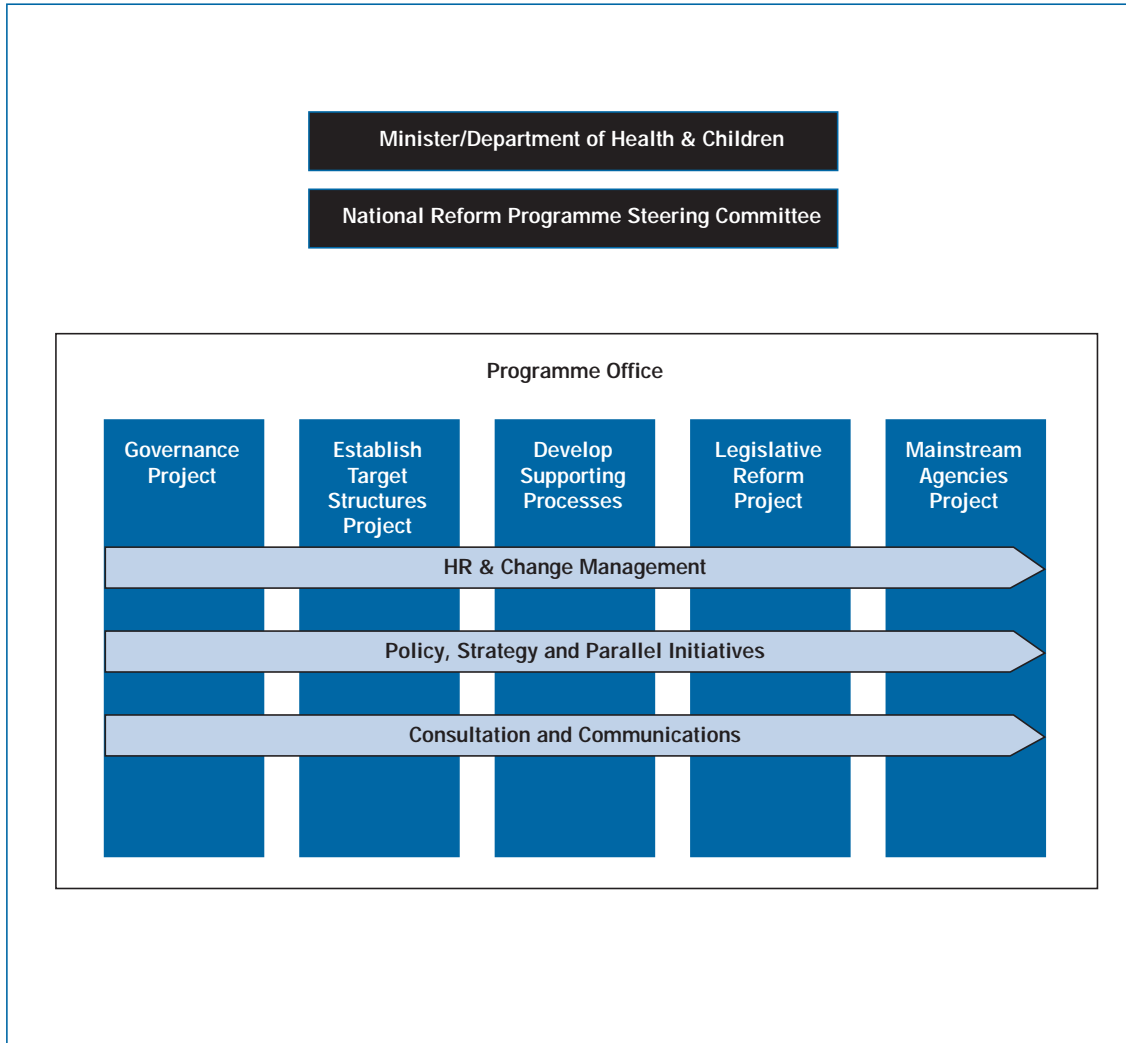
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The Minister will need to establish a National Programme for the Reform of the Structure and Functions of the Health System with the specific aim of implementing the proposed consolidated structure. This will include:

- Establishing a programme office and core change team;
- Establishing a programme steering committee;
- Developing the business cases and detailed implementation plans;
- Defining workstreams and securing workstream resources;
- Setting up working and advisory groups.

The figure below illustrates the major projects and the cross-project support areas:

Figure 11.2: Proposed National Reform Programme



- **Establishing a programme office and core change team**

A programme office will include the following:

- A full-time Programme Director with the skills and experience to drive through and coordinate this scale of change supported by a skilled Programme Coordinator who will coordinate programme planning, reporting, issue management and escalation;
- A full-time Implementation and Change Manager to manage the effective implementation of the change programme and the engagement of stakeholders;
- A Business Analyst with health planning and healthcare cost benefit analysis skills to lead and support the development and tracking of programme and project business cases.

- **Establishing a programme steering committee**

The Programme Director will report to a steering committee established by the Minister for Health and Children. The role of the steering committee will be to set direction for the programme, make decisions, sign off on the design and business cases for future structures and ensure the objectives of the programme are successfully achieved. The steering committee should include individuals (both academics and practitioners) with considerable experience in driving organisational change in the public and private sector.

The major elements of the reform should be led by an interim Board of the HSE. The appointment of a CEO to lead the change must be a priority. Once some of the system wide elements of the proposed consolidated structure (e.g. HIQA, HSE) have been established, it may be appropriate for some workstreams, such as the legislative programme and the governance framework, to separate from the programme and become the responsibility of the DoHC. In this situation the remainder of the programme (mainstreaming the agencies and developing the supporting processes) would then report directly to the HSE.

- **Developing the business cases and detailed implementation plans**

The first task of the core group will be developing a high-level project plan. The core programme team and workstream project managers will need to conduct detailed programme and workstream planning in advance of any implementation. The approach to implementing the changes and managing the engagement of stakeholders will need to be developed. A significant factor will be the ability to coordinate the various activities and provide transparency of process. A business case for the programme, perhaps representing an aggregation of the business cases for the individual workstreams, will need to be developed, submitted for sign off by the steering committee and communicated to stakeholders. Specific deliverables and timeframes for each of the workstreams should be developed and responsibility assigned to team members and working groups.

- **Defining workstreams and securing resources**

At this stage the programme appears to naturally fall into the five workstreams listed below:

- Developing and implementing a governance framework for the health system;
- Establishing target structures;
- Developing supporting processes;
- Identifying and addressing the necessary legislative changes;
- Mainstreaming the existing agencies.

Each of these workstreams will require a project manager as well as dedicated project resources with the necessary expertise. While the exact scale of resources required cannot be determined at this stage without more detailed planning, our experience in organisational reform indicates that the programme is likely to require at least 20 to 25 dedicated team members. Obviously this figure is dependent on a number of different factors including the experience and skill levels of team members as well as the timeframe for the delivery of the programme.

While we recognise that this proposed approach will place a drain on already scarce skills and resources within the health system it is hard to envisage this level and scale of change being successfully driven through the system without a commitment to dedicated resources. The proposed approach does have the benefit of building a longer term capability within the system to drive and deliver organisational change — something identified as critical in *Quality and Fairness*.

- **Setting up working and advisory groups**

The programme team alone will not be capable of delivering the required level of change in the health system. Working groups made up of representatives with relevant knowledge and expertise from across the health system should be developed to work alongside each of these workstreams and in conjunction with full-time project team members. Consideration might be given to how existing change management and organisational development programmes e.g. Office for Health Management and the work of the Health Services National Partnership Forum can be best utilised. Roles for working group members need definition along with an estimate of the time commitment involved during the programme planning stage.

The establishment of the programme to drive the implementation of the proposed consolidated model is a considerable task in itself. We envisage that it could take in the region of two to three months to plan the implementation, work in tandem with the communication and consultation of Phase 1 and in parallel with the appointment of leaders to the key roles in the consolidated structure.

### 11.2.3 Strand 3 — Implement the proposed consolidated structure

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There are a number of distinct but inter-related activities involved in implementing the proposed consolidated structure.

- **Developing and implementing the governance framework**

This workstream will be led by a project manager with considerable expertise in effective governance and delivered by team members working in partnership with a governance working party.

A framework for governance across the system will need to be developed by the project team. All proposed organisations in the new structure will need to be assessed against this framework and the necessary steps taken to ensure agencies work in line with the framework and best practice principles. Those changes involving legislation will need to be fed into the legislative programme. Those changes requiring alterations to any agency's defined accountabilities or terms of reference will need to be incorporated into the mainstreaming workstream for action.

- **Establishing the consolidated structure**

The consolidated structure includes the establishment/restructuring of the following:

- DoHC;
- HSE;
- Health Information and Quality Authority;
- Regional Health Offices;
- National Hospitals Office;
- National Shared Service Centre;
- New acute hospital governance structures.

This workstream will be led by a project manager with considerable expertise in organisational design and restructuring.

The mandate for each new structure will need to be defined by the DoHC and a person appointed to head up each new organisation. The project team should initially design the detail of the target structures — building on the proposals in this report. The design stage would involve clearly defining the next level accountabilities and the responsibilities of the future as well as the key roles and responsibilities within each structure and the competencies and skills required.

This design stage will need to be carried out in consultation with a working group comprising representatives from across the health system. As proposed designs for the target structures are identified they will need to be assessed by the governance project team against the governance framework to ensure that they are aligned with leading practice and submitted to the Programme Steering Committee for sign off.

Once the consolidated structures are signed off by the Programme Steering Committee any necessary legislative changes will need to be incorporated into the DoHC legislative programme and a detailed implementation plan developed for each of the consolidated structure.

## HSE

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The establishment of the HSE will represent the major catalyst for change within the health system. It will drive the DoHC restructuring and the setting up of the sectoral pillars. We therefore recommend the use of an interim board structure to enable the rapid establishment of the HSE.

This will create a momentum for change on three fronts. Firstly, it will send a clear signal for major structural reform. Secondly, it forces the system to engage in the real practicalities of the reform rather than a theoretical debate. Finally, it provides an immediate platform for many of the current functions which are dispersed throughout the system.

To safeguard the quality and integrity of current services, we propose that a two-speed process be adopted in relation to the development of the two service pillars — with more rapid structural change in the acute pillar (e.g. setting up of the National Hospitals Office) and a more paced or evolutionary approach in the primary, community and continuing care pillar. Within the latter, however, it will be important to prioritise the elements of change which precede others. Agreeing the sequencing of this process will form part of the remit of the implementation team.

The major constituencies in the change are health boards and health board-managed hospitals. In the sequencing of the changes it is envisaged that the separation of the health board hospitals would commence after the establishment of the National Hospitals Office.

## The DoHC

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Restructuring the DoHC must be conducted in conjunction with the establishment of the HSE and the mainstreaming of the agencies. The DoHC, through the National Reform Programme, will be accountable for delivering the future health system structure and providing and driving the system towards the proposed model. Ideally therefore it should be restructured quickly and at an early stage in the programme, to demonstrate the commitment of the Department to the consolidated model and to facilitate the mainstreaming of agencies and the functioning of the structures.

However, the restructuring of the Department is dependent, in part, on the existence of new organisations such as the HSE to take over its delivery accountabilities and executive functions. Therefore the restructuring of the Department will need to be phased. Initially it will need to be strengthened to take on the additional accountabilities such as strategic and medium term planning and health measurement and economics while retaining other accountabilities until the new arrangements are in existence. Then it will need to be streamlined following the transfer of accountabilities to the HSE.

## Health Information and Quality Authority

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HIQA will have accountability for setting standards across the system for health and social care. Accordingly, it is recommended that HIQA is established at an early stage in the reform programme, again through the creation of an interim board if necessary.

In order to facilitate this, a clear mandate for the organisation will need to be defined by the DoHC. A leader to head up the organisation should be appointed at an early stage. Legislative change required to facilitate the establishment of HIQA will need to be addressed by the legislative project.

The project team, in conjunction with the CEO of HIQA will need to define accountabilities between HIQA, the HSE and the agencies involved in monitoring and inspection. Based on these accountabilities an organisation structure defining the key roles and resources required can be developed and implemented. HIQA will need to commence its role of establishing a system-wide framework for quality and information standards, monitoring and inspection as quickly as possible.

### **Regional Health Offices**

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The health boards themselves are central to maintaining service levels to customers and as such careful planning of the migration to the envisaged regional structures is required. While it is envisaged that the change from health boards to regional and local structures will be more evolutionary and paced (over two years), the first critical steps on the path to change will be the establishment of the HSE. The driving force for change here will be the replacement of the health board structures with a single board for the HSE.

One way to manage the migration from the existing 10 health boards/area health boards and the Eastern Regional Health Authority is to firstly create the shell of the 4 new RHOs and populate the key roles early. Then the functions and roles of the relevant health boards can be migrated to the new regional offices of the HSE and in time the health boards can be phased out.

### **National Hospitals Office**

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Funding for all hospitals will ultimately be determined by the National Hospitals Office and accountability lines need to be put in place for existing health board acute hospitals. In the short term, service level agreements would be required for services currently provided to these hospitals through the health boards. Over time, a proportion of these services would be provided from the National Shared Services Centre or NHO.

### **National Shared Service Centre**

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It is proposed that a National Shared Service Centre should be designed by the project team in conjunction with a working party. Ideally the objective should be to create a greenfield site while using the skills and experience of shared services already in existence in the EHSS. The design adopted will need to be developed in close consultation with other stakeholders such as the PPARS programme, the SAP Finance initiative and IT as well as the future customers of the service centre. The design for the National Shared Service Centre will need to be signed off by the Programme Steering Committee prior to implementation.

Once designed the National Shared Service Centre should be implemented in line with best practice thinking at the earliest possible opportunity on a phased basis. The HSE will need to appoint a leader to head up the Shared Service Centre and will need to provide him/her with a mandate for the Centre that reflects the proposed consolidated model.

Once the centre has been established the operations of the EHSS can be transitioned across, followed by the activities of the GMS Payments board and relevant HeBE activities. Then, as each new entity is established, the National Shared Service Centre can put in place service level agreements and take over the relevant activities from the health boards and health agencies being disbanded or replaced.

- **Develop supporting processes**

This stream of work will address developing the supporting processes described in Chapter 8. It will focus on the following four areas:

- Develop strong service planning and funding processes;

- Establish strong links between service delivery and evaluation;
- Put in place enablers to support integration;
- Enhance system capability and performance.

A project team will need to scope and plan the activity involved in addressing these four areas and identify key individuals from across the health system who will need to be involved in implementing recommendations. Four sub-project teams may need to be established initially, with responsibility for the development of supporting processes passing over to key roles once the target structures are established.

The development of stronger service planning and funding processes will require some new skills and competencies in the HSE and will require definition of effective work practices and processes. The establishment of strong evaluative capacity will require close cooperation between HIQA and the HSE. A liaison group with representatives from senior levels of each organisation may need to be established and regional and local employees from within the HSE may need to be identified to coordinate the links at the regional and local level.

- **Developing and addressing the legislative programme**

Addressing legislative change is an important enabler of the proposed consolidated structure. In the proposed implementation model a project manager and resources with legislative expertise will be responsible for delivering this workstream. They will need to do this in conjunction with a sponsor from within the Department and a working party made up of individuals from relevant areas of the health system.

Changes to legislation required to support the implementation of the proposed consolidated model will firstly need to be identified and planned in conjunction with the legislative calendar and the other Department work cycles. The legal requirements for the new structure will need to be proposed and the legal and staffing implications of this proposed structure considered. Once planned, the legislative programme and proposed legal structure of the new organisations will need to be signed off by the steering committee in advance of implementation. The legislative project team and the working party will then focus on implementing the proposed legislative changes through the normal legislative process.

- **Mainstreaming existing agencies**

It is recommended that the CEO of each affected agency is assigned responsibility for working with the project team to establish the process, timescale and implications of implementing the proposed recommendations for their agency. The performance measures of some agency CEOs may need to be reviewed to support this responsibility. The timescale for the proposed change should be aligned with the timescale for establishing relevant structures.

It is envisaged that an analysis and planning stage will be conducted by the project team and the CEO and a proposal for implementing the relevant Audit recommendation will be put forward to the Programme Steering Committee. The proposal must define the proposed process, timescale and implications of implementing the recommendation. Where the change represents a merger or involves more than one agency the project team will work in partnership with the CEOs.

## 11.3 Potential financial implications

One of the first areas for attention in the implementation plan will be to conduct a thorough financial appraisal of the reforms proposed with a view to balancing the up-front investment with the longer term benefits. It is extremely difficult to accurately predict the true financial impact of programmes of this scale. This difficulty is likely to be exacerbated by the variability of cost data for certain elements of current expenditure. In preparation of this Audit we sought financial data which might allow for a high-level estimate of costs/benefits in relation to major components of the reform. These

were not readily available, however. Notwithstanding these limitations we have endeavoured to outline the main areas that need to be taken into account in order to develop a robust cost/benefit analysis of the reforms overall. The transition programme as planned provides for the development of business cases for individual components and for the establishment of mechanisms to track both costs and benefits.

Structural reforms of this nature require significant up-front investment to ensure follow through in the changes required. Ongoing experience with reform in the Welsh and Northern Ireland health services is relevant in this regard. A recent study on organisational costs in the health and personal social services sector in Northern Ireland, for example, has highlighted the difficulties in achieving cost savings through structural reform alone. We believe that a coordinated modernisation programme which encapsulates a wider reform agenda covering structures, processes, information, governance and legislative/policy reforms has real potential to deliver longer term financial benefits which should offset the initial investment required.

The costs of healthcare are increasing rapidly year on year. The Irish experience mirrors international trends in this regard. The objective, therefore, should be to ensure that the necessary systems and frameworks are in place to yield maximum value in health terms from the annual investment of public funding in healthcare. A failure to invest the required level in the modernisation programme can only lead to greater cost penalties being carried by the tax paying public at a later stage.

We have identified a number of areas which will warrant attention in developing a thorough cost/benefit analysis:

### 11.3.1 Benefits associated with the reform programme

- **Improved human resource management**

Watson Wyatt research and experience has shown that improvements in management focus, role clarity and team working should contribute to increased productivity from the existing labour base in people-based services, such as healthcare. In our view, a conservative increase of 2.5 % in productivity from the current staff base would not be an unrealistic target to aim for. Based on 2001 total payroll figures this would be worth an extra €140m per annum. While this improvement would take some time to achieve it is an indication of what is possible where these cost factors are actively managed and measured. Enablers to achieve these gains will include management and staff development, performance based management systems and strong HR management.

- **Shared service efficiencies**

Research demonstrates that shared service organisations can be expected to deliver significant savings and productivity improvements across a broad range of functions. Indications of the range of savings across a number of functions are listed below.

<i>Function</i>	<i>Savings/Productivity Gains</i>
General Accounting	55%
Accounts Payables	45%
Human Resource Administration	35%
Purchasing	25%
Receivables	25%

Source: Accenture (2002)

While the ratios provide an indication of the potential associated with a move to a national shared service centre for health, a detailed analysis will be required as part of the business case for the NSSC.

- **Reduction in health board overheads**

The major cost element in the proposed reform relates to the activities of the current health boards and ERHA. For example, DoHC figures for 2001 indicate that the average health board headquarters remuneration costs alone were approximately €8.5m. In moving to the consolidated structure cost improvements are likely to be targeted in this area, as opposed to in the mainstreaming or merging of many of the smaller agencies, where savings may be less significant. These freed-up resources could be utilised to support other elements of the new structure such as the HSE, the NSSC or the NHO, or to meet demand for front-line services. However, it will be necessary to invest in alternative structures and supporting systems to realise the potential savings under this heading.

- **Sales of surplus assets**

Other sources of cost saving should also be considered. If structured appropriately they could be used to fund elements of the transformation programme, e.g. the sale of assets surplus to requirements. It is likely that, on foot of the restructuring, there will be a number of assets, currently in the ownership of public health agencies, which will no longer be required. An immediate task of the HSE would be to identify what assets it has, the property strategy going forward and accordingly what assets should be retained, developed, utilised in other ways or disposed of. Finance could also be raised from the sale and leaseback of properties that do not fit with the HSE's property portfolio strategy.

### 11.3.2 Costs associated with putting in place the new structures

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A number of significant costs associated with the restructuring programme have been identified during the course of our work. While certain restructuring costs have been described below we have not attempted to calculate the exact costs associated with each item. To attempt to do so at this stage with limited access to accurate data would be misleading.

- **Establishment of the HSE**

While there will be additional costs associated with the establishment of the HSE the ongoing costs of its operations should be to some extent balanced by the reduced costs of running a slimmed down DoHC and a lesser number of health agencies. Executive functions being transferred from the Department or elsewhere to HSE will bring existing resources with the transferring function.

With regard to staff we have proposed that the HSE entity be kept lean. Over time, any additional requirements could be met by redeployment from the DoHC or the wider system. The HSE will have to look outside the healthcare system for certain skills that will be fundamental to building the management capability required to lead the healthcare system that we envisage. It is likely these staff will be at a senior level and sourced from the open market.

- **Establishment of the NSSC**

The NSSC will build on the infrastructure already in place in EHSS with input from HeBE and other shared services initiatives currently underway. The scale of its operations will be determined by the areas prioritised for development. With the possible exception of a small number of specialist and senior management posts, it seems reasonable to assume that any additional staffing required can be found within the consolidation of existing health board functions. However, it is likely that a significant investment will be required to enable and support a comprehensive national shared service strategy. This strategy will ultimately determine the investment required.

- **Establishment of new hospital groups**

The overheads associated with establishing health board hospitals (or hospital groups) on a stand-alone basis represent an additional cost. For the moment it is unclear how many such groups there will be, but in any event the on-cost of new hospital governance structures is likely to be relatively modest. A strengthening of management may be required at hospital level in cases where these hospitals currently rely to a large degree on support from health board headquarters.

- **Establishment of HIQA and NHO**

Two of the structures now being proposed, HIQA and NHO, have already been approved for inclusion in *Quality and Fairness* and its overall costing. Accordingly we have not attempted to recalculate the likely benefits or costs associated with their establishment

### 11.3.3 Reform programme

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As described earlier in this chapter, a dedicated and well-resourced transformation team will need to be established to implement the proposed consolidated structure. The cost of the team will be dependent on the cost of the planned changes, the sequencing of them, the pace of implementation and whether the resources can be found within the health system itself or not. It is likely that some of the specialist skills required will need to be sourced from external specialists and drawn down only as required.

Assuming a core team of 25 staff with the requisite skills is assembled to support the transformation programme, a minimum cost of €2.5m per annum over the life of the programme would, in our view, be a realistic estimate in respect of direct costs. Clearly there will be synergies between the overall national reform programme and the roll-out of other large-scale initiatives which should allow for efficiencies, if factored into planning. Particular examples of this would be the anticipated investment in implementing the *Action Plan for People Management*, as referred to earlier in discussing transition arrangements, and the support which will be required for delivering and implementing the major ICT programmes envisaged under the *National Health Information Strategy*.

## 11.4 Additional supports for the effectiveness of the new structure

In Chapter 6 we concluded that structural change on its own is unlikely to address the system deficiencies and that other factors such as governance, service planning and support processes are also critical. In conclusion we thought it appropriate to identify two specific areas for action which are not structural but would greatly support the transition to the consolidated structure. They are:

- Eligibility and entitlement legislation;
- Information Technology investment.

### 11.4.1 Eligibility and entitlement legislation

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The current provisions defining eligibility for services from our health system are highly complex. There is no statutory framework which sets out a citizen's right to access services within a stated timescale or to ensure consistency across the country in the interpretation of legislation or regulations. This is unsatisfactory firstly from the perspective of patients, but also for the carers and managers who have to work within these provisions. We are aware that work is progressing with the DoHC on a package of legislation reforms covering both entitlements and complaints procedures. This is an extremely positive development. The early clarification of the statutory basis for health services would be a powerful force for integration and send a strong signal of the modernising intent behind the overall system reconstruction.

## 11.4.2 Information Technology

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It has been well established that significant development of information technology is required if the health system is to reach the performance standards expected. This will certainly still be the case in the consolidated structure.

The health board CEOs have argued strongly for a major increase in ICT investment from existing levels, suggesting that industry norms indicate a requirement of 2% to 4% of turnover (€160m-€320m) as against the NDP provision of €25m. We would support the view that there would be real gains in process efficiency (move away from paper, use of bar codes, shared financial systems, etc) and equally important gains in transaction efficiency (better managerial and clinical decision-making, benchmarking against other service providers or best practice standards) from a major increase in current levels of investment. The *National Health Information Strategy*, yet to be published, will provide a framework for ICT development but without significant resourcing it will not deliver the required performance improvements. We would anticipate that the ICT Strategy being prepared by HeBE for the health services will set out in more detail an implementation plan for this area.

Investment will be required at a number of levels:

- **HSE/regional and local level IT investment**

This should deliver process and transaction efficiencies particularly in the area of back office/shared service operations. More importantly though it will enable greater access to data and enable more effective planning, decision-making and monitoring of results. In particular access to reliable data across the health system will enable more effective resource management.

- **Service user level investment**

Investment in IT at the patient level is required to enable the efficient movement of necessary clinical data to clinicians regardless of physical location. Integration of the information across the health system should support consistent and shared views of patient data. This must encompass both resource management and patient/client systems to ensure that activity levels are matched to resources. One effective way to facilitate this integration would be the introduction of a unique patient identifier. While this may be a medium term option for reasons associated with data protection issues it would contribute significantly to the integration of the health system from the patient perspective.

Clearly there is a need for a major acceleration in the pace of development of information systems implementation through the health service. Management of budgeting at individual clinical level demands a high level of sophistication and integration of information systems. Much of the benefit to be derived from more streamlined organisation structures and sharper accountability relationships will depend on relevant and up-to-date information being put in the hands of managers and clinicians at all levels in the health system, to enable them to make reliable decisions in a timely manner. Effective devolution of budgetary accountability to clinical managers at the point of contact with patients is neither reasonable nor possible without adequate data.

To gain the full benefits of restructuring it will be essential that the necessary investment is made in strengthening this and other aspects of management systems in the health services.