Rialtas na hÉireann
Government of Ireland

SLÁINTECARE IMPLEMENTATION STRATEGY

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Sláintecare Implementation Strategy and Next Steps

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Foreword

Being healthy and well is what we cherish most for ourselves, for our family, for our friends and neighbours, and for society more generally. When we are in need of health care, we want to have confidence that we will be well looked after.

There are many good things happening in our health service. Life expectancy is increasing and mortality rates are declining. Survival rates from conditions such as heart disease, stroke and cancer are improving. The majority of patients who participated in the first national patient survey reported their experience as good.

Despite these encouraging trends, it is obvious that there are still far too many people experiencing difficulties in accessing affordable care in some areas of our health service, due to waiting lists and overcrowding.

We also know that our health and social care services, as currently designed, cannot meet the growing demands being placed on them. Ireland's population is increasing and we are living longer than ever before. Our lifestyles are changing, altering our healthcare needs. New developments in technology and practice are opening up new opportunities to transform care delivery. All of these influences raise important and unavoidable questions for how we deliver and experience care.

The work of the all-party Oireachtas Committee on the Future of Healthcare has been instrumental in providing us a platform for achieving consensus on a long-term vision for our health service. It's report, Sláintecare, provides us with a framework within which change can be planned, managed and implemented over the next decade.

We are all united in our vision for the health service. We want health care to be organised and delivered in a joined-up way and designed around the needs of people. We want more care provided at home, or close to home in communities. We want people to be able to access care when they need it in a timely manner, and we never want a situation where someone needs care but can't access it for financial reasons. Implementing change of this scale will not be easy and it won't happen overnight.

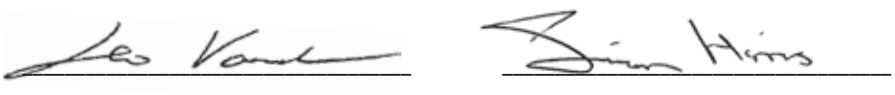
The publication of this Sláintecare Implementation Strategy represents another important milestone in our effort to reform and modernise our health and social care services. The Strategy sets out an ambitious programme of reform commencing with implementation of an initial set of key actions over the next three years. It will see change happen across 10 interlinked areas that will, combined, allow us to begin to realise our vision for the health service.

This year over €15 billion has been committed in health spending, the largest budget in the history of the State. The next decade will see a significant period of investment across our health services. We know that this investment must be coupled with reform in order to work.

Publication of this strategy signals the Government's intention to bring about a transformational reform of the health service. We can't do this alone. The processes that led to the establishment of the all-party Oireachtas Committee and the development of the Sláintecare report have laid the foundation for consensus building and constructive engagement with all stakeholders.

We look forward to continuing in this spirit.

We ask for your support in building a new health service fit for our future needs and we look forward to working with the many stakeholders to deliver it.



An Taoiseach, Leo Varadkar, T.D.

Simon Harris, T.D., Minister for Health

Overview

Sláintecare provides us with an unprecedented opportunity for the realisation of real and sustained improvement in the provision of healthcare to all citizens.

Background

Our goal is to translate the Sláintecare Vision into a living Implementation Process.

Health reform has been at the centre of political and societal discourse in Ireland for many years. Efforts have been made by successive governments to improve and enhance our health services, and advances have been made, with clear examples of success emerging over the years. Overall, however, the reality has fallen short of expectations. There remain fundamental and deep-rooted problems across the health service, and there is an understandable level of scepticism among the public and frontline workers in relation to our collective capacity to effectively tackle these issues. Sláintecare provides us with an unprecedented opportunity for the realisation of real and sustained improvement in the provision of healthcare to all citizens.

In 2016, there was an overwhelming consensus across all political parties that these issues needed to be addressed comprehensively and on a cross-party basis. The Oireachtas Committee on the Future of Healthcare was set up by unanimous decision, and was tasked with developing cross-party political agreement on a long-term vision and policy direction for the health and social care system over the next decade. This move recognised the need for a coherent, long-term strategy that would continue to be implemented irrespective of the make-up of Government.

Implementing the Sláintecare vision will require concrete and well-defined steps to be taken, steps which are prioritised, sequenced, coordinated and funded over time.

The Committee published its report, Sláintecare, in May 2017.[1] The Committee's report sets out a vision for the development of the Irish health service over the next decade that has attracted broad support from across the Oireachtas and across stakeholders more generally.

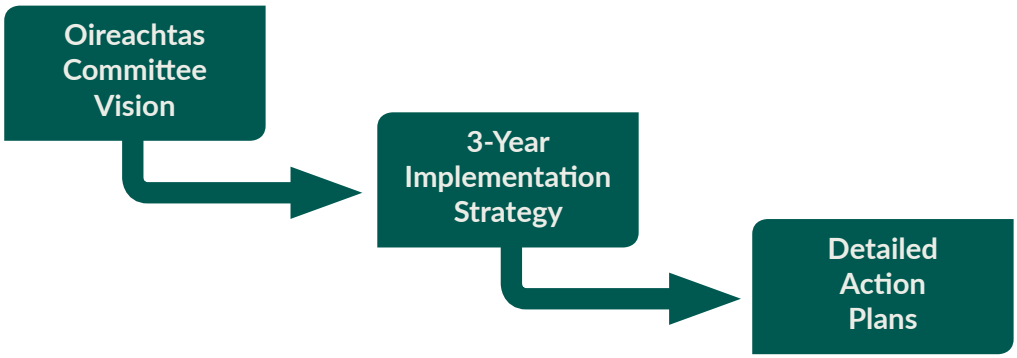
This document represents the first output of the detailed planning process for the implementation of the Sláintecare report. Sláintecare presents a ten-year vision, covering a wide canvas of complex issues across the health sector. Implementing that vision will require concrete and well-defined steps to be taken, steps which are prioritised, sequenced, coordinated and funded over time. At the same time, implementation planning should be seen as a continuous process, which sits alongside effective project management, so that reform in practice can adjust to new trends and real experience.

Accordingly, this implementation strategy sets out the actions to be taken in the first three years of the Sláintecare implementation process. It will be further developed into annual action plans, as reform progresses, and the implementation structures are built, as set out in Figure 1.

This Implementation Strategy is being published in advance of the full establishment of a Sláintecare Programme Office to provide clarity on the overall vision and immediate priority actions to ensure momentum is maintained. However, in recognition of the importance of the Office having a significant input into the development of the Implementation Strategy, the Executive Director of the Sláintecare Programme Office will be tasked with refining the Implementation Strategy into a more detailed Action Plan within three months of taking office. This will include a review of the actions and associated timeframes, the development of detailed milestones and timelines for year one and the assignment of responsibility for each action. Thereafter, the Sláintecare Programme Office will publish rolling plans on an annual basis. Progress reports will be published on a biannual basis.

[1] Sláintecare Report, Houses of the Oireachtas Committee on the Future of Healthcare, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

Figure 1: Roll-out of Sláintecare Implementation



Reform is already underway

The Sláintecare Report acknowledged and endorsed a number of health reforms which are already well underway. A great many of the recommendations contained in the Sláintecare Report are well aligned with existing policy and reforms already being implemented across the health system. Significant programmes of work already exist in some areas, which means that the journey to a reformed system is, in some respects, already advanced. This Implementation Strategy encompasses and builds on those reforms, bringing them together into a unified reform programme. These include the Healthy Ireland Programme, maternity and cancer strategies, a suite of patient safety initiatives and the development of primary care centres, teams and networks.

Early priorities have been urgently progressed

Translating the Sláintecare vision into a new reality has meant moving forward on a number of fronts at once. Soon after the publication of the Sláintecare report, the Government put in motion a series of actions which are essential to implementing the Sláintecare vision. These included the establishment of the Independent Review Group on the Removal of Private Practice from Public Hospitals, publication of legislation to reform the governance of the HSE, and a public consultation on the geographical alignment of Hospital Groups and Community Healthcare Organisations. These are all key steps required to move forward with Sláintecare implementation.

A selection of these key ongoing reforms are set out, under the 4 Strategic Goals on which this Implementation Strategy is built, in Figure 2 (page 6).

Strong governance and accountability are vital

Enhancing governance and accountability in the health service is a central plank of reform. New structures are being put in place to drive the implementation of the Sláintecare Programme, but this must sit alongside stronger governance of the health service as a whole. The establishment of a HSE Board is an important step in this process. The Board will have a number of immediate priorities to ensure that the change programme is built on solid foundations. These will include: providing oversight of actions necessary to ensure improved service delivery, corporate and clinical governance and financial control and accountability within the HSE; developing and implementing an effective performance management and accountability system in the HSE; carrying out a full examination of the structures, responsibilities, capacities, skills and experience of the senior management in the HSE ensuring the HSE's full support for, and implementation of, the Government's programme of health reform as set out in this Sláintecare Implementation Strategy;

and developing a plan for building public trust and confidence in the HSE and the wider health service.

Improving corporate and clinical governance is also an urgent priority. Patient safety legislation is being drafted, which will provide for, among other things, mandatory open disclosure for serious events. Stronger clinical governance will be a central feature of Sláintecare implementation. Clinical governance systems must constitute a critical component of overall governance in order to assure the delivery of safe, quality and patient-centred care. A new overarching governance framework will be introduced and clinical governance will be underpinned by legislation through the introduction of a system of licensing of healthcare providers.

Reform will be challenging but is achievable if we act in a strategic manner

Reforming healthcare is difficult. Health and social care in Ireland, as in every developed society, is a large and complex sector. Health services must continue to be provided while reform is taking place, and while demand for healthcare continues to grow rapidly. There are multiple inter-dependencies between different parts of the health sector which complicate reform, and there are multiple constraints that have to be navigated if reform is to have its intended effects. That is why the Implementation Strategy is designed around 4 key strategic goals and 10 interlocking high level strategic actions, each of which is further broken down into specific actions. These are set out later in the document.

Figure 2: *Ongoing reforms under four strategic goals*

Goal 1: Deliver Improved Governance and Sustain Reform	Goal 2: Provide High Quality Accessible and Safe Care
■ New HSE Board legislation published. ■ Sláintecare Programme Office funded and an Executive Director Appointed. ■ Chair of Sláintecare Advisory Council appointed. ■ Public Consultation on geographic alignment of Hospital Groups and Community Healthcare Organisations completed. ■ Government approval for legislation to provide for mandatory open disclosure for serious events. ■ Annual Patient Experience Survey commenced in 2017.	■ 12 new Primary Care centres opened in 2018 bringing the total in operation to date to 120, with 7 more to come on stream in 2018. ■ €55m in 2018 for National Treatment Purchase Fund to improve access to scheduled care. ■ Cancer and Trauma Strategies published. ■ Creation of a new Healthy Ireland fund. ■ An additional €35m has been provided to develop mental health services in 2018 with €55m additional funding agreed for 2019. ■ Additional funding of €25 million for home care and transitional care beds in 2018. ■ Development of statutory homecare scheme - the public consultation has been completed and the analysis is published. ■ Provision of medical cards to children in receipt of Domiciliary Care Allowance and GP Visit cards to persons in receipt of carers allowance.
Goal 3: Ensure the health service is financially sustainable	**Goal 4: Enable the system to deliver its goals**
■ Over €15 billion provided for health expenditure in 2018, an increase of 5% on previous year. ■ Activity Based Funding for acute hospitals in place since 2016. ■ Establishment of the Independent Review Group on the removal of Private Practice from Public Hospitals due to report later in 2018. ■ Health Service Capacity Review completed, and its findings accepted and funded in full in the National Development Plan. ■ National Development Plan investment of €10.9bn in overall health infrastructure, including new capacity of 2,600 acute beds, 4,500 community care beds and three new elective hospitals in Cork, Dublin and Galway.	■ GP contract negotiations under way. ■ Expansion in GP training places to 194 places in 2018. ■ An additional 942 nurses and midwives were recruited in 2017 (including student nurses). ■ A Framework for Safe Nurse Staffing and Skill Mix in Adult Hospitals was launched in April 2018 which sets out for the first time a methodology for calculating the staffing requirement and skill mix needed in medical and surgical wards in adult hospitals. ■ Development and publication of the National Strategic Framework for Health and Social Care Workforce Planning. ■ eHealth investment provided for in the National Development Plan.

The Case for Change

There is much to celebrate about our health system. Patient outcomes are improving, our life expectancy is above the EU average and patient experiences are generally good. More than 80% of patients reported good or very good experiences of their stay in hospital in 2017.[2] Mortality rates for heart attack have decreased by 42% over the last ten years. Our cancer survival rates for breast and colorectal cancer compare favourably against other OECD countries and rates of MRSA have fallen by 66% since 2006[3]. Significant progress is being made in addressing risk factors such as smoking and excessive alcohol consumption. These positive outcomes have been driven by proactive national strategies and initiatives, (including the Healthy Ireland Framework and the National Cancer Strategy), and innovation and improvement at service level.

Since 2014, extra resources have been made available to invest in health and social care services. Public funding increased by 19% over the period 2013 - 2018 and this has provided extra investment in services such as homecare and mental health, targeted initiatives to reduce waiting times and enabled the provision of free GP care to children under 6.

It is important to acknowledge these successes and to build on them. However, it is widely accepted that our system is far from perfect and is not serving our citizens as it should. As we look to the future, we need to determine how we take what is working well, and scale it up nationwide. We also need to acknowledge the gaps and issues that exist and decide how we are going to resolve them. The pressures that already exist and the anticipated growth in demand are such that incremental improvement will be insufficient.

The pressures that already exist and the anticipated growth in demand are such that incremental improvement will be insufficient.

The Sláintecare report depicts the challenges facing our health service very well. These problems are faced by patients, service users, their families and the healthcare workforce every day. The following interlinked challenges are most prominent.

Our system is not set up to serve the health and social care needs of our population; it is configured for the past, not for the future.

The Irish healthcare system was built to tackle episodic diseases or accidental injuries. It is now outdated and ill-equipped to tackle the health challenges of the present and the future. Our demographic profile has changed, our life expectancy has risen and premature mortality has reduced, but there is greater prevalence of chronic conditions. Some 60% of those aged over 50 report having at least one chronic condition.[4] Many of these conditions require preventative care and ongoing management, services that are generally better provided closer to home, in the community. However, the system remains overly hospital-centric, with hospitals representing the first port of call for many, while community-based care services are fragmented and underdeveloped. We need to fundamentally change the way we go about delivering care to our population.

[2] Health Information and Quality Authority, Health Service Executive, Department of Health, National Patient Experience Survey, Findings of the 2017 inpatient survey https://www.patientexperience.ie/app/uploads/2018/02/NPES-National-Report-2017-WEB.pdf

[3] OECD (2017), *Health at a Glance 2017: OECD Indicators,* OECD Publishing, Paris,https://doi.org/10.1787/health_glance-2017-en. http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm

[4] See: Ipsos MRBI (2017) Healthy Ireland survey 2017 – *Summary of findings*, Department of Health, available at http://health.gov.ie/wp-content/uploads/2017/10/16-048825-Healthy-Ireland-Survey-18-October_for-printing.pdf; the Irish Longitudinal Study on Ageing (TILDA), at https://tilda.tcd.ie/.

Our system cannot meet today's demand, which leads to long waiting lists and waiting times, and basic gaps in provision exist.

Services across all areas of our health system are stretched – with demand far outstripping supply. Hospitals are operating at maximum capacity, with occupancy rates across the country at potentially unsafe levels of 95%–100%.[5] Emergency Department wait times and hospital waiting lists are unacceptably long, and every year the health system struggles to respond to growing demand. Constraints are also evident in community-based care services, with significant wait times for many primary care services and high levels of unmet need for homecare and other social care services. As we are unable to meet today's needs, it is evident that, without reform, the situation will only get worse as the population grows and ages further.

Our system is highly fragmented and does not deliver care that is coordinated and integrated.

The current system operates in silos. There is insufficient formal coordination across, and within, primary, community and social care and acute hospitals. Where coordination does exist, it is down to hardworking individuals on the front line who have built relationships across organisational and institutional lines to work closely with their colleagues. The system has under-invested in the necessary professional staff, data and information, as well as ICT systems that are needed to routinely share information and better manage patients' care needs.

Access to healthcare is unequal; the tiers we have created are both unfair and a fundamental barrier to progress.

Ireland is the only western European health system that does not provide universal access to primary care.[6] In addition, access to public acute hospitals is inequitable. The majority of our population pays out-of-pocket fees to access primary healthcare and 45% of the population purchase inpatient health insurance plans, which can provide faster access to private health services in both public and private hospitals.[7] This inequality of access is embedded in our current system and creates barriers and perverse incentives that stand in the way of doing the right things for patients that need care. Moreover, wider health inequalities persist among some groups of the population.

Our demographic profile is changing and will place substantial pressure on our health and social care services.

Ireland's population is rising and is projected to grow by between 10% and 18% between 2016 and 2031, an increase of between 481,000 and 875,000 people. Although we have one of the youngest populations in Europe, the share of the population aged 65 and over is projected to increase, by 59% over this period, while the number of people aged 85 and over is projected to increase by 97%.[8] This increase is happening sharply and quickly. Older age cohorts are the highest users of most health and social care services.

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[5] Department of Health (2018) *Health service capacity review 2018*: Main Report, p.22, available at https://health.gov.ie/blog/publications/health-service-capacity-review-2018/

[6] Wren, M and Connolly, S. (2017) A European late starter – Lessons from the history of reform in Irish health care, Economic and Social Research Institute, Dublin.

[7] Health Insurance Authority 2018, Market Figures March 2018 available at https://www.hia.ie/sites/default/files/Market%20Figures%20March%202018.pdf

[8] Central Statistics Office. Population and Labour Force Projections for the period 2017-2051 (2018 (M2F2 Scenario))

Recruitment, retention and training of healthcare workers is a major challenge; we are not enabling and supporting our workforce enough to do what they do best – providing world-class care for patients.

While our system is stretched, we also have difficulty attracting and retaining suitably qualified healthcare workers to meet demand. Our workforce is ageing, and the average annual staff turnover rate across our services is 6.5%. Ireland is competing in a global market for a healthcare workforce. The European Commission has estimated a potential shortfall, within the EU, of around one million health workers by 2020. Global developments in technology will also impact on our workforce, with unpredictable consequences, including the potential for new roles and skill development but also the automation and redundancy of other roles.

The health system faces major financial challenges; it is already struggling to match expenditure to income.

The system is already struggling to contain expenditure to available income levels. Over the next ten years, the budget of the health system will be constrained by the rate of growth in real national income. At the same time, expenditure demand is rising, driven by population growth and ageing, changes in disease prevalence and price increases. The Department of Health has projected that demographic pressures would increase costs by between 1.4% and 1.6% annually. There are also non-demographic factors, such as pensions of retired staff and clinical indemnity claims, which are driving costs. Expenditure demand will also be influenced by price increases. The Public Sector Stability Agreement provides for an increase in pay costs over the period 2018–2020, ranging from 6.2% to 7.4% – an annual average increase of 2%–2.5%.[9] Added to this are increases in non-pay costs through price inflation in supplies, including drugs and medical products. At a system level, we have to find better ways of managing demand and delivering savings and productivity improvements.

What happens if we do nothing?

Without a sustained and determined commitment to making the changes necessary to equip our health service to respond to future challenges, in ten years' time we will be faced with:

- increasing premature death and disability as a result of unhealthy lifestyles;
- acute hospitals overwhelmed from dealing with exacerbations of chronic conditions and care crises;
- continued growth in hospital emergency workloads delaying planned admissions, leading to ever increasing waiting lists;
- growing levels of unmet need leading to poor outcomes for patients and ethical dilemmas for staff who cannot deliver appropriate and timely care;
- loss of existing health professionals and new graduates from the Irish public health service;
- increasing reliance on private healthcare among those who can afford it, leading to an even sharper two-tier divide;
- loss of cross-community support for and confidence in public healthcare;
- escalating healthcare costs, both public and private;
- growing ill-health and carer responsibilities, leading to withdrawal of people from the labour force and community participation; and
- Ireland no longer being an attractive place to live, due to an unreliable and inequitable health system that lags far behind that of other countries.

[9] Department of Public Expenditure and Reform, 2018, Public Service Stability Agreement

The Implementation Approach

The Implementation Approach is rooted in the Sláintecare Principles

The strategy and approach is rooted in the overarching Sláintecare vision of a reorientation of the health service towards a high quality integrated system, providing care on the basis of need, and not ability to pay, where the vast majority of care takes place in primary and community care settings.

The eight principles that underpin the Sláintecare report are in Figure 3. They provided the guiding framework for the development of this Implementation Strategy and will continue to act as a reference point throughout the implementation process.

Figure 3: Principles set out in the Sláintecare Report

Front and centre in achieving reform is a focus on implementation. The approach will be centred around strong health service governance, leadership, accountability, a focus on clear outcomes, providing support to the frontline to drive change and sustained stakeholder engagement. In particular, meaningful engagement of the workforce must be a core aim to ensure ownership of this reform process and to achieve the desired outcomes for patients and service users. Finally, at the heart of implementation is engagement of the public, which must continue to be the leading voice and influence in this reform process. The public must be properly empowered to look after their own health and wellbeing and ultimately to hold the health service to account for the delivery of our ambitions.

Four overarching goals have been identified as central to reforming the health system
These goals will be delivered through 10 strategic actions. They are outlined in Figure 4.

Figure 4: *Four Goals and Ten Strategic Actions to implement Sláintecare*

4 Goals		10 Strategic Actions	
Goal 1	Deliver improved governance and sustain reform through a focus on implementation.	Strategic Action 1	Improve governance, performance and accountability across the health service.
		Strategic Action 2	Put in place an effective implementation and governance structure for Sláintecare and establish a Sláintecare transition fund to support key reforms.
Goal 2	Provide high quality, accessible and safe care that meets the needs of the population.	Strategic Action 3	Improve population health-based planning and develop new models of care to deliver more effective and integrated care.
		Strategic Action 4	Expand community-based care to bring care closer to home.
		Strategic Action 5	Develop and modernise the acute care system to address current capacity challenges and increase integration between the hospital sector and community-based care.
		Strategic Action 6	Expand eligibility on a phased basis to move towards universal healthcare and support a shift to community-based care.
Goal 3	Ensure the health system is financially sustainable.	Strategic Action 7	Reform the funding system to support new models of care and drive value to make better use of resources.
		Strategic Action 8	Implement measures to address inequities in access to public acute hospital care based on the independent impact assessment.
Goal 4	Enable the system to deliver its goals.	Strategic Action 9	Build a sustainable, resilient workforce that is supported and enabled to deliver the Sláintecare vision.
		Strategic Action 10	Put in place a modern eHealth infrastructure and improve data, research and evaluation capabilities.

Detailed actions and milestones for each of these strategic actions are set out later in the Implementation Strategy. Our overall approach to delivering on these strategic actions will be two-pronged.

We will commence immediately the processes that will be necessary to undertake the appropriate research, design and planning for those changes that will require fundamental change; it is important that we get these decisions right from the start. In tandem, we will frontload investment and action in those areas that are already underway or that can commence immediately.

Figure 5 provides a summary of the actions that will have a high impact on the quality, accessibility and sustainability of health services for the period 2018 - 2021.

Figure 5: *Summary of High Impact Actions –- What will be delivered by 2021*

Broad Objective	High Impact Action
Governance and Accountability	Introduce a governing board for the HSE.
	Reconfigure the HSE to improve accountability and support integrated care.
	Introduce stronger clinical governance systems, mandatory open disclosure and enhance managerial performance and accountability.
Focused Implementation	Establish a dedicated implementation office to drive reform.
Citizen Engagement	Public engagement launched on Health Outcomes and a nationwide series of events in 2019/2020 to promote health and well being.
Delivering a new Model of Healthcare	Produce a new Citizen Care Masterplan that is population health centred, setting out an overall design for the health service.
	Design new models of care and provide supports to locally implement on a significant scale.
	Accelerate roll out of eHealth systems and infrastructure.
Enhance Community Care	Invest in community-based diagnostics facilities.
	Reform GP contract including new chronic disease management programme for GMS/GP visit card population.
	Enhancement of community mental health services.
	Continue programme of investment in primary care centres.
Expand Eligibility	Review income threshold for GP visit cards.
	Review eligibility framework to develop a roadmap to achieve universal entitlement.
	Introduce a new statutory scheme for homecare services.
Better Access to Acute Hospital Services	Develop an overarching clinical strategy to guide national and regional organisation of acute hospital services.
	Increase bed capacity in public hospitals.
	Select location for new elective hospitals and commence planning processes.
	Invest in the NTPF to reduce waiting times for patients.
	Implement integrated waiting list management system.

We are on the right path

Each of the ten high-level strategic actions are set out in detail in this document. For each strategic action, we set out the vision, the case for change, and the detailed actions to be taken.

This Implementation Strategy, and the structures and actions that underpin it, will contribute to a large-scale change programme . This will be delivered as a key component of a wider drive for public sector reform. It is closely aligned with the Government's commitment to reform of the public service, as outlined in Our Public Service 2020, published in December 2017, and will contribute to the achievement of that policy document's three pillars: delivering for our public; innovating for our future; and developing our people and organisations.[10]

Facing extraordinary challenges, we need an extraordinary response. This will require taking difficult decisions and making clear choices and trade-offs. It will entail working with stakeholders from across the health system (nationally and locally) to make the changes that are necessary to benefit the Irish people, despite some likely resistance. It will require commitment across Government, the political system, the health service and the public.

[10] Department of Public Expenditure and Reform (2017) Our Public Service 2020, available at http://ops2020.gov.ie/resources/Our-Public-Service-2020-PRINT.pdf.

Goal 1

Deliver Improved Governance and Sustain Reform through a focus on Implementation

Large-scale reform will require a coalition across the health system to work together, over the long-term, sustaining momentum and maintaining an enduring focus on the desired outcomes of reform. This must sit alongside stronger governance of the health service as a whole.

Strategic Action 1

Improve governance, performance and accountability across the health service.

The health system requires a new framework of health structures, governance and accountability that supports the delivery of effective and safe health and social care services.

This must start with governance of the health service as a whole. The establishment of the HSE Board will be pivotal in delivering more robust governance and accountability. Secondly the structure of the HSE itself needs to evolve in a phased and ordered manner, to better support and underpin the delivery of new models of care.

The new structures will comprise a strong, lean national centre with responsibility for national planning, strategy and standard setting. This central authority will be complemented in time by regional integrated care organisations that will operate with appropriate operational autonomy within defined geographic areas and with clear reporting structures. Aligning Hospital Groups and Community Healthcare Organisations is an initial step in this direction. A clearer set of accountabilities will be introduced that align authority and responsibility at local, regional and national level.

Thirdly, clinical governance will also need to be a central element of the overall governance framework. The importance of clinical governance will be underpinned by legislation through the introduction of a system of licensing of healthcare providers. Patient safety legislation to encompass guidance on clinical audit and mandatory open disclosure for serious events, will also be put in place.

Health Service Governance and Structures

Current governance arrangements for the HSE via a directorate structure are not appropriate for what is the largest single organisation in the country. The directorate structure was introduced on a temporary basis; inherent limitations regarding the objective oversight it is capable of offering need to be addressed. The Government has agreed to the establishment of an independent Board for the HSE and the necessary legislation is being progressed.

The HSE is by far the largest public body in the State. Without a proper system of devolved governance and accountability, backed up by legislation, there is a risk that proper accountability proves difficult to achieve in practice and the HSE grows to be seen as a monolith that is too big to fail.

Accountability has become concentrated at the top of the organisation in a way that does not always support responsive service delivery and local ownership of decision making. The scale and scope of the HSE's functions mean that the distance from the centre to the frontline is a significant challenge.

The HSE has moved to recognise the need for a better balance between national and regional authority and much progress has been made in developing regional structures of Hospitals Groups and Community Healthcare Organisations since 2013. As these structures mature, the potential

exists to devolve responsibilities to them from the centre. However, the fact that Hospital Groups and Community Healthcare Organisations are not geographically aligned impedes the kind of integrated planning and care delivery that Sláintecare espouses.

> We need to find the right balance between necessary central strategies and standards and local flexibility and responsiveness.

In the coming years, we will evolve our current structures, in a phased and ordered manner, to achieve a new set of health structures that will better support and underpin the delivery of new models of care. The first step will be to align Hospital Groups and Community Healthcare Organisations. In time, the HSE organisation will be evolved to comprise a strong, lean national centre with responsibility for national planning, strategy and standard setting – one that is more equipped to lead and oversee than to directly control and deliver services. This central authority will be complemented in time by regional integrated care organisations, which will operate with appropriate autonomy within defined geographic areas and with clear reporting structures. These organisations will be underpinned by legislation. They will be resourced on the basis of population need and have control over the allocation of funding across services in their region. Their functions and level of autonomy will grow over time.

Regional integrated care organisations will have a statutory basis but they will operate as part of a national health service with overall national policies and standards. They will be funded using population-based resource allocation models and will be accountable for achieving population health outcomes within this funding. They will have a mandate to deliver care in the most effective way possible and will be encouraged to expand the range of services available within communities.

The relationship between the State and the very many voluntary organisations involved in service delivery, including some of our largest health and social care providers, is important. As we seek to achieve greater integration across the care continuum, the need to ensure these relationships function and evolve effectively will increase. An independent review group is currently examining the role of voluntary organisations in the operation of health and personal social services in Ireland so as to inform policy development in this area.

Clinical Governance and Patient Safety

In healthcare organisations, corporate governance and clinical governance are both essential and mutually interdependent for achieving outcomes and long-term success. Starting with the Report of the Commission on Patient Safety and Quality Assurance (1998) and including the recent establishment of the National Patient Safety Office, a significant programme of reform is underway in relation to clinical governance and patient safety. However, our patient safety culture does not yet assure the delivery of high reliability care by a continuously improving, open and accountable health service. Sustained leadership will be required across the health service to bring about the further changes required.

In delivering health services, clinical governance systems must constitute a critical component of overall governance in order to assure the delivery of safe, quality, patient-centred care. A healthcare culture that focuses on quality and patient safety not only delivers an optimal experience and outcome for the citizen; it has been shown in a growing number of studies to also be cost effective.

Clinical governance is the system through which healthcare teams are accountable for the quality, safety and experience of patients. Standalone initiatives are insufficient; rather it is the comprehensive set of patient safety activities that together form the framework for clinical

governance. Key agreed elements are education; continuous professional development; clinical audit; clinical guidelines; clinical effectiveness; risk management; openness and patient engagement and research and development.

Therefore, a governance framework is required that integrates clinical governance with corporate governance and addresses the needs and responsibilities of key partners from patients to clinicians, managers and non-executives. It is a system through which service providers and healthcare teams - clinicians, managers and non-executives are accountable for the quality and safety of patient care. This framework will inform legislation, regulation, contracts and performance management systems.

A consistent approach is required to ensure clinical effectiveness, quality and safety so that as the system begins delivering services in new settings, the highest standards are maintained. Clinical governance requires a national systems approach encompassing the key elements, which can then be meaningfully implemented in full at local clinical level in a standardised manner.

Significant work is underway, led by the National Patient Safety Office, HIQA and the HSE to embed clinical governance and patient safety in healthcare delivery. This work will be underpinned by legislation so that consistent, standard implementation of clinical governance systems occurs and the public can be assured of healthcare excellence across services.

Table 1: *Implementation of Strategic Action 1*

Actions	Sub-Actions	Delivery Date
Strategic Action 1: Improve governance, performance and accountability across the health service.		
1.1 Develop national governance and structures.	1.1.1 Appoint a Chair of the new HSE board	2018
	1.1.2 Legislate for a new governing board to strengthen oversight and performance of the HSE.	2018
	1.1.3 Appoint Board for the HSE	2018
	1.1.4 Define and agree a new organisational and operational structure for the future reconfigured health service, including respective roles of the Department of Health, the HSE and national and regional integrated care organisations.	2019
1.2 Develop regional governance and structures.	1.2.1 Consult and finalise decisions on the geographic alignment of Hospital Groups and Community Healthcare Organisations.	2018
	1.2.2 Introduce modifications to Hospital Groups and Community Health Organisations to ensure geographic alignment and develop processes for collaboration and integrated performance management at a regional level on an interim administrative basis, in advance of regional integrated care organisations.	2019

Actions	Sub-Actions	Delivery Date
1.2 Develop regional governance and structures.	1.2.3 Devolve decision making and autonomy in line with demonstrated functionality and performance at regional level.	2019 and ongoing
1.3 Legislate for revised health structures.	1.3.1 Introduce legislation for revised health structures, incorporating respective roles for the national centre and regional integrated care organisations and the outcome of the Independent Review Group on Voluntary Organisations.	2021
1.4 Develop clinical governance and patient safety policy.	1.4.1 Commence the process of introducing an overarching governance framework that integrates clinical governance with corporate governance, setting out the roles, responsibilities and accountabilities of organisations and individuals within the public health service.	2019
	1.4.2 Progress the Patient Safety Bill to encompass clinical audit, reporting of serious events to the regulator, mandatory open disclosure for serious events and extension of HIQA's remit to the private sector.	2018/2019
	1.4.3 Progress the Patient Safety (Licensing) Bill to include clinical governance and patient safety operating frameworks across hospital, community and other clinical services and implement licensing scheme.	2021
	1.4.4 Implement patient safety operating frameworks across hospital, community and other clinical services.	2021
	1.4.5 Develop and expand systems to capture patient experience.	2019
	1.4.6 Implement a patient safety, complaints and advocacy policy.	2018
	1.4.7 Implement the National Action Plan on Antimicrobial Resistance.	2020

Strategic Action 2

Strategic Action 2: Put in place an effective implementation and governance structure for Sláintecare and establish a Sláintecare transition fund to support key reforms.

Developing an effective implementation structure is the greatest challenge to achieving the vision set out in Sláintecare. While there have been notable reform achievements in the health sector, it is fair to say that policy implementation has often fallen short of policy ambition. This experience, coupled with the scale of the challenge in delivering on the Sláintecare vision, means that thinking through how implementation is to be achieved must be at the forefront of planning.

A new implementation and governance structure will be established to translate the Sláintecare vision into reality. This structure will be underpinned by a new approach to engagement, which will ensure that reforms to the system are informed by and serve patients, services users and the health workforce.

The challenges that the Irish health system face in progressing reforms are not uncommon around the world. Key challenges include: political cycles; complexity and inter-connectedness of service change; management of diverse stakeholders; entrenched interests and ways of doing things; and the gap between actual timelines involved for major reforms and those expected by the public. International experience suggests that successful reform requires a dedicated implementation unit or office, whose function it is to support and enable the public sector to deliver change by being the engine room of implementation. Such an office works with leaders from across the sector to progress and prioritise change, alongside the day-to-day running of the system, and to embed or institutionalise change and reform.

In Ireland, there are examples of successful implementation of new initiatives, such as the National Cancer Control Programme. The articulation of a strong case for change, committed leadership (including clinical leadership), deep engagement and the provision of the necessary resources and capabilities ensured that the plan for cancer services was seen through to implementation. Political, managerial and clinical leaders aligned around a single vision and convinced others of the benefits of change.

With consensus for Sláintecare now in place across the political spectrum, the priority is to focus on turning the vision outlined in Sláintecare into a clear set of implementable changes that can be seen and felt in improved outcomes for the Irish population over the next decade. This large-scale change will require a coalition across the health system to work together over the long-term, sustaining momentum and with a clear focus on the desired outcomes of reform.

Core components for successful implementation

Our implementation approach will be built on the following core components:

Figure 6: Core components for successful implementation

Senior Leadership and Decision-Making

Strong leadership, clear governance and effective buy-in from key actors will be essential to success. Figure 7 depicts the Sláintecare implementation and governance structures. The main features are:

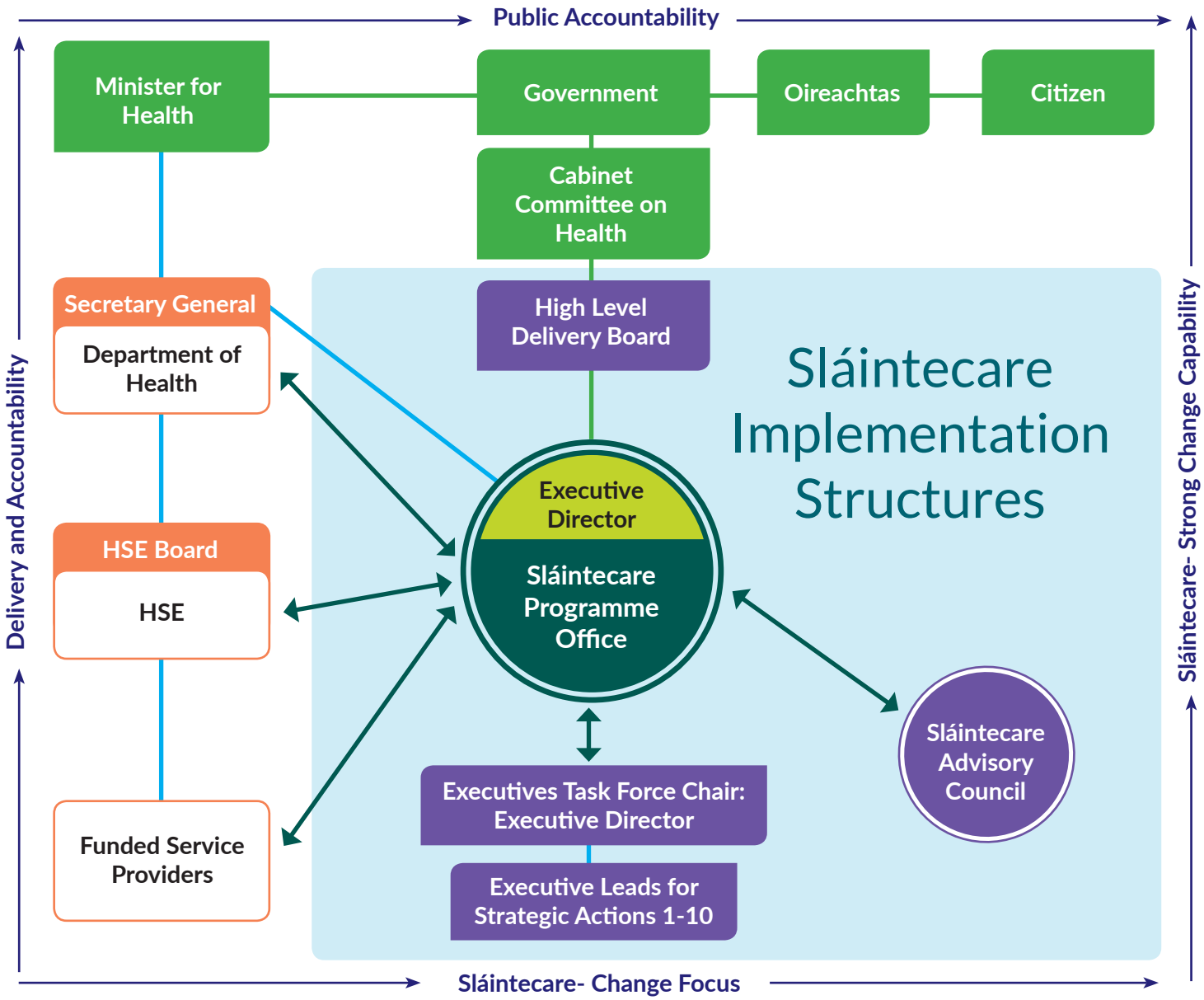
- The Minister for Health will be accountable to the Oireachtas for the delivery of Sláintecare and will report regularly on progress.
- The Cabinet Committee on Health, chaired by the Taoiseach, will give overall strategic direction and will oversee implementation, ensuring leadership at the highest level.
- A High Level Delivery Board will be established, made up of the Secretaries General of the Departments of Health, Taoiseach and Public Expenditure and Reform, the CEO of the HSE and the Sláintecare Executive Director to ensure effective delivery of agreed plans and resourcing of the Sláintecare reform programme.

- A Sláintecare Advisory Council will be established, comprising an independent chair, the Sláintecare Executive Director, clinical and health service leaders, patient/service users, international experts and independent change management experts. The role of the Council will be to periodically advise and support the Sláintecare Programme Office on the change programme.

- A Sláintecare Executives Task Force will be established, and chaired by the Executive Director of the Sláintecare Programme Office, comprising the Executive leads with responsibility for the Strategic Actions. The role of the Executives Task Force will be to ensure a coordinated, integrated and effective approach to the programme.

- Other Working Groups will be set up by the Executive Director as required.

Figure 7: *How Sláintecare will be implemented*



Dedicated reform programme office to act as the engine for transformation

As proposed in the Sláintecare report, a Sláintecare Programme Office is being established in order to support and drive the delivery of the vision outlined in Sláintecare.

The Sláintecare Programme Office, situated in the Department of Health, will be charged with leading, managing and monitoring the reform programme, and will act as a central hub for health reform. Its key functions will be to drive the reform process through implementation planning and direction, programme management and monitoring/evaluation. It will work in partnership with units in the Department and the HSE and other relevant bodies and stakeholders to deliver on the range of actions within the reform programme.

The Sláintecare Programme Office will act as a resource across the system, supporting the work programmes underlying each strategic action, in terms of problem-solving, identifying and helping manage inter-dependencies, helping escalate issues to get decisions where needed, and providing tools and support where helpful (for example, innovation labs, programme management tools and communication support).

It will also have a key role in providing regular reporting on implementation progress to the Minister and to the Cabinet Committee on Health, and in communicating the reform programme priorities and progress to stakeholders and the public.

The Office will be led by an Executive Director with deep experience of large scale change, and will be resourced with an appropriate skill mix, including project management, communications, clinical, and data and evaluation experience.

The Executive Director will:

- Establish the programme of reform as approved by Government and put in place the governance arrangements, processes, structures and resources to implement it;
- Communicate and engage with key individuals and organisations to mobilise support for the changes to be implemented under the reform programme;
- Develop the capacity and capability of the Sláintecare Programme Office to manage this large-scale transformation programme of vital public importance and interest;
- Develop a strategic and programmatic approach to implementation and sequencing of reforms and develop detailed action plans, deliverables, costs and timelines for each area of reform;
- Work in partnership with relevant colleagues within the Programme Office and across the Department and the HSE, including clinical leaders, to ensure effective working arrangements and delivery of the reform programme;
- Rigorously monitor performance, identify obstacles early, and problem solve and overcome challenges and resistance;
- Provide regular reporting on implementation progress to the Secretary General and the Minister, the Cabinet Committee on Health, the Oireachtas and the public;

- Develop strong and effective monitoring and communication processes for ongoing reporting on reform priorities and progress to stakeholders and the public;
- Provide strong leadership and accountability for the successful implementation of the reform programme; and
- Be a member of the High Level Delivery Board, the Sláintecare Advisory Council and chair the Sláintecare Executives Task Force.

Focused work programme with clear start, middle and end

The Sláintecare Implementation Strategy lays out 10 strategic actions. Behind each of these is a work programme involving a series of actions. Each action will be resourced properly and will have accountable leaders and teams to progress the work to delivery.

The Executive Director of the Sláintecare Programme Office will develop a detailed action plan within three months of taking office. This will include a review of the actions and associated timeframes, the development of detailed milestones and timelines for year one and the assignment of responsibility for each action. Thereafter, the Sláintecare Programme Office will publish rolling plans on an annual basis. Progress reports will be published on a biannual basis.

Deep and sustained engagement with stakeholders

At the heart of successful reform will be the ongoing engagement of a coalition of stakeholders across the system. This includes public representatives, provider organisations, representative bodies, educational institutions, staff, patients/service users and the public. New models of engagement will be implemented through the reform process, with a focus on several key actions during the first year.

Actions to engage our workforce

Reforming the system requires constructive engagement between the workforce, representative bodies and other stakeholders across the system, on an ongoing basis. The Sláintecare Programme Office will develop a comprehensive workforce engagement plan, which will build on the commitments to:

- include clinical representation on the Sláintecare Advisory Council;
- involve frontline clinicians in the design and delivery of the full range of strategic actions identified in this Implementation Strategy;
- develop and support a programme of 'change champions' to sustain ownership and momentum across key stakeholder groups;
- invest in capabilities and capacity on the front line to deliver change; and
- launch a comprehensive engagement plan for the workforce including information sessions, newsletters, web content and social media campaigns.

Actions to engage our service users and our public

Patients/services users will be engaged in service design and improving delivery throughout the reform process. In addition, Sláintecare provides an opportunity to influence the way that the wider population views their relationship with the healthcare system. All members of our society will engage with our health services at some point either directly or through family or friends. The voices of current service users and citizens must therefore be at the heart of healthcare reform, and success will be judged in terms of patient experience and outcomes and the overall health of our population. The following commitments are made:

- to include patient/service user representation on the Sláintecare Advisory Council;
- to involve patients and service users in the design and delivery of the full range of actions identified in this Implementation Strategy;
- to champion and expand the use of standardised national patient surveys and other communication channels as part of all transformation work;
- to provide a web platform that enables the public to track ongoing progress towards the implementation of the Sláintecare vision, thereby promoting accountability; and
- to launch a comprehensive public engagement plan including information sessions, newsletters, web content and social media campaigns.

Targeted and protected investment for the reform programme

Experience from national and international change programmes shows that targeted, one-off and protected investment is essential in delivering successful reform. An important component of this will be capital investment, as recommended in the Sláintecare Report. The National Development Plan provides for funding of €10.9bn over the next decade and will provide essential new capacity and redevelopment across the system and can act as a catalyst for reform. Current funding will also be allocated through the estimates process to support the delivery of change with the necessary resources ring-fenced solely for the targeted purpose.

Key actions

Table 2: *Implementation of Strategic Action 2*

Actions	Sub-Actions	Delivery Date
Strategic Action 2: Put in place an effective implementation and governance structure for Sláintecare and establish a Sláintecare transition fund to support key reforms.		
2.1 Establish Sláintecare implementation supports.	2.1.1 Establish a Sláintecare Programme Office and recruit staff, including an Executive Director.	2018
	2.1.2 Put in place dedicated staff and resources in the Department of Health and HSE to advance each strategic action set out in this Implementation Plan.	2018
2.2 Establish Sláintecare governance structures.	2.2.1 Establish a Sláintecare Advisory Council, to include clinical and health service leaders, patient/service users, international health experts and change management experts.	2018
	2.2.2 Establish a High Level Delivery Board and a Sláintecare Executives Task Force.	2018
2.3 Review and update Sláintecare Implementation Strategy.	2.3.1 Publish a detailed action plan within three months of the Executive Director taking office and on rolling basis thereafter.	2018
	2.3.2 Publish progress reports on a biannual basis.	2019 and ongoing
2.4 Develop engagement with stakeholders.	2.4.1 Launch a comprehensive engagement plan for the public and patients/service users.	2018
	2.4.2 Launch a comprehensive engagement plan for the health workforce.	2018
2.5 Establish a transition fund.	2.5.1 Design, establish and resource a multi-annual transition fund with appropriate governance to support the change process.	2018/2019

Goal 2 Provide High Quality, Accessible and Safe Care that Meets the Needs of the Population

The Sláintecare vision for healthcare is one where patients are paramount, access to health and social care is timely and based on need and not ability to pay, care is seamless and integrated and is provided at the most appropriate service level with a strong emphasis on prevention and public health, and health services are planned and delivered on the basis of population need.

In practice, what the Sláintecare vision will look and feel like should differ according to need. For example, if you are a healthy adult with no known health needs, then the concept of an integrated or coordinated approach to care is less important than being able to access care quickly and conveniently when you need it (usually for specific episodes). If your needs are more complex (for example, an elderly individual with multiple long-term conditions or co-morbidities, or someone living with severe and complex mental health needs), then you are likely to require a highly coordinated model of care, with significant support to keep you out of hospital, and living as normal a life as possible at home.

Achieving the Sláintecare vision for healthcare will require significant change, both in terms of designing models of care that can meet the holistic needs of different groups of people, as well as changing the way that care is delivered in all settings – at home, in the community and in hospital. It will also require changes to our eligibility framework.

- **New models of care based on population need:** Models of care will be designed based on evidence and patient safety principles. Design will build on existing work on clinical and integrated care programmes that meet the holistic needs of different groups of the population (for example, older people, mostly healthy adults, children, people with disabilities and people with mental health needs). These models of care will ensure that an evidence-based and integrated approach is taken to meeting needs, across all healthcare settings and providers. A whole-system citizen care masterplan for the health service will be developed to act as a reference point in ensuring consistency across all areas of service planning and model of care development.

- **Community-based care expansion:** An expanded set of services will be available at home and in the community, which will better meet the needs of the population and shift activity into a more accessible and cost-effective setting. There will be very significant workforce implications, with a need to expand community-based resources while also enabling change in terms of how the collective workforce operates to deliver this expanded vision.

- **Acute care development:** There will be substantial changes to how the acute hospital sector operates. Firstly, there will be a short-term focus on addressing waiting times and lists to improve access, as well as the development of strategic plans for the Hospital Groups. In the medium term, the role of acute hospitals will fundamentally change as more care is delivered in the community, with specialists working in the community for some or all of the working week. A national clinical strategy for acute hospitals is needed to ensure consistency of approach countrywide and across Hospital Groups, reflecting this redesign and re-focusing of activity.

- **Eligibility and charging framework:** Eligibility frameworks must support a move towards universal healthcare and improved financial protection and must not act as a barrier to the appropriate shift of activities from hospitals to the community. This will require detailed analysis and a clear roadmap to ensure eligibility for services is expanded in a sustainable and effective manner. In parallel, user charges will be reviewed as part of the annual Budget process.

Strategic Action 3

Improve population health-based planning and develop new models of care to deliver more effective and integrated care.

Our health system requires redesign to enable individuals to navigate the system more easily and access effective and integrated care. This will mean the right care being delivered by the right person, in the right place, at the right time.

This will require the development of a citizen care masterplan for how the overall health system should operate which will inform detailed service planning, resource allocation, workforce planning and policy prioritisation.

Informed by this overall whole-system framework, new models of care will be designed that are structured, coherent and tailored to population need. They will take a system-wide focus and, in doing so, support individuals to access and navigate the system, with more seamless transitions from one care setting to another. Models of care will be designed around groups or cohorts in the population, including frail older people, people with complex needs, those with long-term chronic conditions, those who are mostly healthy, and children.

In order to redesign our overall system, the following actions are needed:

- Develop a citizen care masterplan for the health service based upon population health principles to underpin key strategic objectives and to guide detailed planning;
- Continue cross-government focus on health and wellbeing initiatives under the Healthy Ireland Framework;
- Develop a national framework for models of care to design new models of care, including an approach to identifying population groups or cohorts for priority attention;
- Design, establish and launch an integration fund to test and scale up new models of care on a significant scale, with a focus on community care and integration of care across all settings; and
- Develop a best practice framework for clinical service review.

The case for change

Historically, and as with many countries around the world, health and social care in Ireland has largely developed in an ad-hoc and non-strategic way, often organised around institutions or settings rather than population need.

Sláintecare clearly acknowledges the need to change the way we plan and deliver health and social care services, and it advocates a fundamental shift to a population-based approach to health service planning and delivery.

Significant improvements have been implemented in particular areas in recent years, such as cancer care, and major change programmes are underway in other areas, such as disability, mental health and maternity services. Thirty-three national clinical programmes and four integrated care programmes are developing examples of improved and more integrated care. However the challenge now is to take all these areas of excellence and develop a coherent framework within which care can be designed, planned and delivered.

A model of care defines the way health services are delivered and describes best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.[11]

Vision and ambition

Our vision is that the health system will deliver the types of care that the population needs, while being responsive to the varying needs of different individuals.

Overall health service redesign and model of care development involves translating a set of needs into clear service requirements, which are then developed and resourced in the most appropriate settings, whether that be hospital-based or in the community. Achieving this will involve identifying and profiling population health status and healthcare needs; this can then inform model of care design. Everyone has different healthcare needs at different points in our lives, but many of us share similar needs. The following examples show how such needs can arise and how individuals will benefit when they experience a reformed model of care.

Case Study 1: Mostly healthy individuals

Most people have the good fortune to lead healthy lives, only occasionally needing to access the health system. When they do, it is usually for one-off events such as an accident, a simple infection, or a need for a straightforward, planned procedure. Mostly healthy individuals want access to care to be convenient and are not overly concerned about continuity of care or seeing the same health professional. Their care should therefore be efficient, close to where they live or work, and provided at a time that suits them.

This group may be at risk of future health problems, as a result of unhealthy lifestyle behaviours, so population health promotion and health and wellbeing initiatives will also be important, including screening and health protection services.

Joan attends the practice nurse in her local GP practice for a routine blood test and while there the practice nurse asks her a number of questions, including whether or not she smokes. Joan, who has been trying to give up smoking for some time, tells her that she smokes 20 cigarettes a day. The practice nurse talks with Joan about giving up smoking and the relevant supports that are available to her. Joan is given the telephone number and website of the national QUIT service, where she can

[11] NSW Agency for Clinical Innovation (2013) Understanding the process to develop a model of care – An ACI framework, available at https://www.aci.health.nsw.gov.au/ data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

get more information and make contact with the service by phone, live chat, Facebook or call-back. Later, Joan contacts the service, which helps her to decide on a quit plan that she thinks will work for her. The practical tips to help her prepare to quit are very useful and as she embarks on her journey to give up smoking for good, the regular check-ins help to keep her on track and motivated. The next time Joan visits her GP practice, she is asked about her progress and whether or not she needs any further support.

Case Study 2: Older people with chronic conditions

Older people suffering from chronic conditions rely on the health system a lot. Their goal is to live as full a life as possible, at home. Often, they have more than one chronic condition and therefore need to interact with various health and social care services. If their care is not carefully planned and managed, they risk care crises and avoidable admissions to hospital.

Older people with chronic conditions will, under the proposed future model of care, have a case manager who knows them and whom they can trust. The case manager will help them to navigate the system to get the full continuum of care they need, with as much of it as possible delivered in the community and in their home.

Bridget, who is 80 years old, is brought by ambulance directly to the closest primary care centre after falling at home. Bridget has a number of health problems including Parkinson's disease, osteoporosis, valve disease of the heart and mild depression. She gets around with the help of a stick and needs supervision when going up or down stairs. She has had a number of falls. She lives with her husband Patrick, who is 81 years old, in a two-storey house. They receive home care three times a week.

While in the primary care centre she is given an x-ray to rule out a fracture to her wrist. She also has a full medical assessment including a falls risk assessment. The physiotherapist who sees her provides practical guidance on getting around at home, preventing falls and managing the stairs better.

Bridget is discharged home with arrangements for her to be assessed by the occupational therapist at home and with a two-week increased home care package. Bridget is also given an appointment for the geriatric day hospital the following week where symptom control of her Parkinson's disease will be reviewed in detail and where she will receive ongoing physiotherapy and occupational therapy to further reduce her falls risk and maximise her independence. Bridget's Electronic Health Record is updated so that all relevant health professionals can access the most up-to-date clinical information. The physiotherapist who saw Bridget has been appointed as her case manager within the primary care team.

Case Study 3: Individuals with multiple, complex needs

Individuals with complex health needs may experience difficulties in accessing the services and support they need. Their care is complex and often needs input from a range of professionals and services, not just in the health sector. They need ongoing person-centred support and input from community-based services to enable them to live as full a life as possible and avoid care crises or admissions to hospital or residential care. People with complex needs should have a key worker in the community with direct responsibility for coordinating their care, who will work across sectors to facilitate other needs such as those related to housing, education and employment.

Jack is 32 and has been homeless for the last two years. He has battled with depression and drug addiction for years. One night, when feeling particularly unwell, he passes a mobile health unit and reluctantly decides to drop in. That night, he meets a GP and nurse who seem interested in helping him. They ask him how he is feeling, both physically and mentally, and ask him about the drugs he takes. They also ask him if he has ever been tested for hepatitis C and after they explain the test he decides to have it done. While he is waiting for the result, he meets a key worker who talks to him about his life and difficulties he faces with accommodation and other issues.

The test result comes back positive. Jack's key worker explains the implications and links him in with a number of services, including a needle exchange programme, a liver disease nurse specialist in the community, a counsellor, a regular GP and his local authority's housing service. He is also linked in with a community peer support organisation, which helps as he has the opportunity to talk to someone else with hepatitis C who can answer some of his questions and help him understand what the next steps might be. His key worker keeps in touch with him regularly, and links in with all the different services he requires, co-ordinates his care and helps him to keep it all on track. With the use of an EHR and web-based ICT system, all health and social care team members seen by Jack can access and update his healthcare record, regardless of where they are based. This greatly facilitates coordination and integration of his care.

Re-designing our models of care – Specific actions

What is clear from these case studies is that everyone is different, with individual health care needs. The practical challenge for the health system is to design a set of services that are tailored to the individual yet designed at sufficient scale so that they do not create unnecessary duplication or complexity in the health system, and that they are financially sustainable to deliver.

Delivering the changes required to our models of care will take time and needs to be done in a pragmatic way so that lessons can be learned and applied elsewhere, while also ensuring that approaches are adapted appropriately for local needs, build upon local best practice, and embrace local innovation and entrepreneurship. This will be achieved by the following actions.

1. Develop a citizen care masterplan, based on population health principles

The overall organisation and delivery of our health services has not kept pace with changes in population need and international best practice.

An overall citizen care masterplan will be developed to inform not only detailed service planning, but also resource allocation, workforce planning and policy prioritisation. Without such a masterplan, there is a risk of continuing fragmentation. Recent work such as the Health Service Capacity Review and the Department of Health's research programme with the Economic and Social Research Institute (ESRI), both of which take a whole-system perspective, provide a very useful basis upon which to develop this master planning approach. Progressive national health departments around the world use population health principles to develop and organise their health services. Doing so is not a once-off exercise; rather, it is an ongoing task requiring review, evaluation and updating on a regular basis.

2. Continue cross-governmental support for the implementation of Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025.

A fundamental goal of any country is to support the health of its population. Sláintecare recognises the importance of supporting people to look after and protect their own health and wellbeing. Healthy Ireland is the national strategy for improved health and wellbeing. This strategy is underpinned by a whole-system philosophy involving cross-government and cross-societal responsibility. The health system will continue to play an important leadership role in driving this whole-system shift towards a culture that places greater emphasis and value on prevention and keeping people well. Cross-sectoral implementation of Healthy Ireland will be supported by the evolving Healthy Ireland infrastructure, including the Healthy Ireland Fund and Network and the publication in 2018 of an outcomes framework. Healthy Ireland principles will be embedded in the design of all models of care so that they permeate interactions between the health services and the public.

3. Develop a national framework for models of care design.

A national framework will be developed for designing and implementing models of care to ensure a robust and standardised approach is always taken, underpinned by evidence and in line with patient safety principles. The design work undertaken at national level will guide adherence to minimum model of care standards at local level, but the implementation process will be sufficiently flexible to allow for local adaptation and innovation.

Seven steps to developing and implementing new models of care

- **Population health needs assessment:** The first step in understanding the needs of the population is to assess health need and the distribution of that need in a population, followed by population risk stratification with identification of particularly vulnerable population groups. This must include an understanding of the wider determinants of health.

- **Objectives:** The objectives of the model of care are to improve mortality, morbidity, quality of care, quality of life, and patient experience and to optimise healthcare delivery and utilisation. Specific objectives for the model of care include quality and safety of services provided, good patient experiences with optimal outcomes, appropriate and equitable access to services, financial sustainability and staff satisfaction.

- **Principles:** The model of care, whether at a whole-system level or for individual care groups, population cohorts or disease groups, etc., requires a set of principles as an essential set of considerations for their development.

- **Standards:** Models of care will be developed using robust and transparent methodologies, which can blend evidence for clinical and cost effectiveness with expert and patient views, in order to develop care delivery options with improved patient outcomes and reduced variability while balancing available resources and getting better value for money. This will include decision-making tools such as systematic evidence reviews, health technology assessments and best practice guidelines.

- **Prioritisation:** In deciding which models of care should be developed and implemented first, consideration should be given to potential impacts on health, patients and society, health service delivery, and the feasibility of implementation.

- **Implementation:** Once clear standards have been developed regarding what should be expected for population groups, they need to be translated (nationally or locally) into clear plans and implications for specific providers in terms of activity and resources needed to deliver the required changes to the relevant model of care.

- **Monitoring and evaluation:** Collecting and interpreting information about implementation and other key outcomes is essential in determining whether a model of care is being successfully implemented, meeting stated objectives and delivering agreed outputs and outcomes.

4. Design, establish and launch an integration fund to test and scale up new models of care on a significant scale.
A new integration fund will be established to test and implement new models of care at scale.

The fund will focus on implementing new models of care that will address key challenges within our health and social care services. These may include:

- the need to develop new models of community care to shift delivery of care from the acute to the community setting;

- the need to integrate care across all settings; and

- the need to develop new workforce arrangements to support new models of care.

Funding will be provided for a defined period, to implement new models of care on a significant scale. Successful models of care developed with this funding will then be mainstreamed and scaled up nationwide.

The fund will seek to build on and accelerate existing work being undertaken by the national clinical programmes and the integrated care programmes. It will support and unlock the leadership needed at the frontline to deliver real change. It will be an essential mechanism for taking an evidence-based approach to transforming our health services, and ensuring that success and lessons learned in one area are transferred system wide.

5. Develop a best practice national framework for the conduct of clinical service reviews.
There is a regular requirement to conduct national service reviews in an evidence-based manner and through consultation with service users, the public and stakeholders. Currently, a national review of cardiac services is underway. Just like the development of new models of care, such national reviews would benefit from being conducted in line with an agreed best practice framework. This framework will be developed, specifying that all national service reviews are underpinned by evidence, health intelligence and consultation.

Table 3: *Implementation of Strategic Action 3*

Actions	Sub-Actions	Delivery Date
Strategic Action 3: Improve population health-based planning and develop new models of care to deliver more effective and integrated care.		
3.1 Develop a citizen care masterplan for the health service.	3.1.1 Develop the first iteration of a citizen care masterplan for the health service based on population health principles, to underpin key strategic objectives and guide detailed service planning.	2019
3.2 Support the health and wellbeing of the population.	3.2.1 Publish the Healthy Ireland Outcomes Framework.	2018
	3.2.2 Sustain cross-governmental support for the Implementation of Healthy Ireland- A Framework for improved Health and Wellbeing 2013–2025.	2018 and ongoing
3.3 Develop models of care and establish an integration fund.	3.3.1 Develop a National Framework for Models of Care Design.	2019
	3.3.2 Prioritise and roll out models of care in accordance with overall Government policy and health system priorities.	2019
	3.3.3 Design, establish and launch an integration fund to test and scale up new models of care on a significant scale with a focus on community care and integration of care across all settings.	2019
3.4 National clinical service reviews.	3.4.1 Develop a best practice national framework for the conduct of clinical service reviews, to ensure a consistent and evidence based approach is taken when reviewing particular services.	2019
	3.4.2 Complete the national review of specialist cardiac services.	2019

Strategic Action 4

Expand community-based care to bring care closer to home.

Expanding community and primary care is at the heart of the Sláintecare vision. The relative under-development of primary and community-based care means that achieving a significant shift of care from the acute setting to the community will be particularly challenging and will require difficult choices in the first few years. In the context of the new citizen care masterplan, a new plan for the organisation and operation of community care services will be developed, building on work already underway to develop Community Healthcare Networks and primary care teams. This will entail an expansion of services provided in the community and a significant increase in workforce and infrastructure to enable this expansion.

The following six actions are key here:

- Develop a plan for the organisation and operation of community-based services based on population need and size.
- Expand workforce and infrastructure capacity in the community to deliver the plan for community-based services.
- Expand the range of services available in the community.
- Develop working arrangements for staff and contracted professionals to enable the delivery of expanded services in the community.
- Accelerate implementation of integrated care programmes focused on chronic conditions and older people to provide appropriate and effective care in the community.
- Develop an enabling environment for joined-up community working including ICT, data, clinical governance, patient safety and quality operating frameworks and systems.

The case for change

Internationally, countries have focused health reform around developing robust primary and community care services as a means of providing more appropriate and financially sustainable care to their population. It is broadly recognised that many of today's illnesses and care needs can be better managed in the community, where the focus can be on prevention, self-management, and proactive and coordinated care. This has also been a policy priority for Ireland for many years.

The Primary Care Strategy (2001)[12] set out a vision for primary care services, while the report, Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group (2014)[13], sets out a blueprint for how primary and social care services will be

[12] Department of Health and Children, 2001, Primary Care A New Direction, https://health.gov.ie/blog/publications/primary-care-a-new-direction/

[13] HSE, 2014, Community Healthcare Organisations Report & Recommendations of the Integrated Service Area Review Group, https://www.hse.ie/eng/services/publications/corporate/choreport.html

organised and managed in the community. Community care structures are now established, including nine Community Healthcare Organisations, 96 Community Healthcare Networks and nearly 500 primary care teams. The past decade has also seen concerted efforts to move many social care services, including mental health and disability services, from institutional-type care settings into the community. Despite this progress services remain fragmented and in many cases, access is limited. Data systems and infrastructure are underdeveloped and team working can be weak.

Community settings are ideally suited for the management of many aspects of care for chronic conditions such as heart failure, chronic obstructive pulmonary disease (COPD), diabetes and asthma. These locations can also deliver services such as diagnostics and minor surgery. However, there remains an over-reliance on acute hospitals to provide these services.

Coordination of care can be difficult between the community and the acute hospital sectors. Care plans or pathways are required to provide coordinated care for patients, both across community care providers and between the community and acute sectors, to enable them to provide the appropriate level of management at the lowest level of complexity. Access can be limited by resource constraints and opening hours. Furthermore, current eligibility arrangements restrict access to many community-based services. This compounds the current default tendency among the public to seek care directly in hospitals.

Vision and ambition

The vast majority of healthcare services will be available in the community, in the home or close to home. Services will be integrated with other parts of the health system and responsive to the needs of the population. Referral to an acute hospital will only occur for episodes requiring specific specialist intervention, with discharge back to community- based care as required.

Community-based care will be strengthened to provide a comprehensive service ranging from prevention to diagnostic services, disease management, disability care, mental health care, rehabilitation and palliative care. Care will be available based on clinical need and not ability to pay.

As one example of how this vision might translate to reality, an older person with chronic conditions would have a single, named point of contact in their primary care team and a shared care plan that incorporates both their health and social care needs; this plan could then be reviewed regularly with a nurse in the community. Care planning and delivery would be done via a multi-disciplinary team to ensure specialist input where needed.

Integrating care for older people

If we consider Bridget, her experience will be very different. In the past, Bridget spent a lot of time in hospital, which was not where she wanted to be. Now she is eligible for community- and home-based care support. She has a named point of contact in the primary care team and her conditions are being proactively managed. Instead of being sent to an emergency department, she is brought directly to her local primary care centre where she can get an x-ray. Bridget is able to receive most of the day-to-day medical care and therapy services she needs at home through regular visits from healthcare professionals, or in the primary care centre. When more specialist services are required, she attends a geriatric team in her local hospital.

Specific actions

Six areas have been identified as critical for achieving this vision.

1. **Develop a plan for the organisation and operation of community-based services that is based on population need and size, and that is in line with the overall citizen care masterplan and new models of care.**
   A significant level of redesign of the system will be required. This will require examining new or enhanced service delivery models for current community-based services and introducing appropriate supports for new services to be delivered within the community rather than the acute care setting.

   Much work has already been done in defining the organisation of care for different population sizes within the primary and community care sector, in terms of the role of primary care teams and networks (including services such as pharmacy and dentistry), and the design of Community Healthcare Networks (CHN) and Community Healthcare Organisations (CHOs). This work must now be enhanced and built upon so that all health and social care services are delivered based on population need and size.

   There is consensus that the CHN, where each network will, on average, serve a population of 50,000 provides the optimal structure for population health service planning and resource allocation. This will include addressing care for older people, home care services, disability services and other services delivered in the community.

   Once this work has been completed, both a national and local level approach will be required to identify resourcing requirements (financing, infrastructure and workforce) as well as optimum deployment based on local need (looking at prevalence figures and other relevant demographic information) and existing provider relationships. This work will enable the development and implementation of the community-based models of care.

2. **Expand workforce and infrastructure capacity in the community to deliver the plan for community-based services.**
   The development of primary care infrastructure is already underway. However, given the level of services that is expected to be provided in community settings, additional infrastructure is required, such as additional primary care centres, community care beds (respite, short stay and residential) and improved social care infrastructure. There will also be a new programme of investment in community-based diagnostics facilities.

   Increased workforce capacity, in relation to both employed staff and contracted professionals, will be required in the community. This will include a range of specialist and non-specialist staff in disciplines such as general practice, nursing, midwifery, social work, psychology, physiotherapy, occupational therapy and speech and language therapy, as well as other healthcare and support staff. The effective shift to community-based healthcare is also dependent on the many social care services being delivered in the community setting operating in an integrated and multi-disciplinary way.

3. **Expand the range of services in the community to ensure appropriate provision of, and access to, services in the community.**
In advance of a significant expansion of the community care workforce, there is a clear trade-off between strengthening the current service, expanding and deepening the role played by community-based care in areas like chronic disease management, and expanding free (or largely free) access to services. All three approaches will increase demand on community care services, which are already inadequate. The phasing and prioritisation of service expansion will be critical, as any new services will have to be resourced and staffed.

For this reason, in mapping out three-year actions, priority will be given to the expansion of community care resources and the targeting of these resources in the following areas.

There is a clear trade off between strengthening the current service, expanding and deepening the role played by community-based care in areas like chronic disease management and expanding free (or largely free) access to services.

- **Chronic disease management:** This is an immediate priority as chronic disease management, in overall population health and health system performance terms, can yield the greatest return. We will ensure that the effective management of chronic disease within community settings is prioritised and resourced and that barriers to accessing this service, including eligibility, are tackled early in the implementation process.
- **Community Intervention Teams:** We will further invest in and develop both the scope of practice and scale of implementation of community intervention teams, taking a whole-of- population approach.
- **Community diagnostics:** We will work to continue to implement a phased expansion of timely and universal access to community diagnostics.
- **Community nursing services:** We will introduce a new model of community nursing on a phased basis, to commence with the establishment of demonstrator sites.
- **Palliative care:** We will complete implementation of the Palliative Care Development Framework.

These investments will be made in tandem with a review of the eligibility framework to support the rollout of universal access to services in the community (see Strategic Action 6).

The potential benefits of expanding services in the community are demonstrated in the example below

Care closer to home

Sarah is a 16-year-old student suffering from Crohn's disease who will be sitting her Leaving Certificate this year. Sarah requires an infusion of infliximab every eight weeks and when she turned 16, her care was referred from a paediatric hospital to adult services. But instead of receiving her infusion therapy in the adult hospital, she was referred directly to her local community intervention team (CIT) clinic for her treatment, with clinical governance provided to the CIT clinic by the hospital-based adult gastro-intestinal (GI) service. Sarah's infusion

therapy is provided over a two-hourly appointment in the CIT clinic, and there are no delays. The CIT nurses liaise closely with the GI team in the hospital in relation to any arising clinical issues regarding Sarah's care.

Sarah enjoys numerous benefits arising from this re-orientation of service provision into the community setting. The CIT clinic facilitates extended hours of operation; this enables her to have her appointments every eight weeks scheduled outside of the school day, which is having a positive impact on her attendance rates at school. In addition, Sarah's needle phobia has been reduced significantly since transfer to the quieter, non-acute community CIT clinic setting.

On a general level, the delivery of this service in the community reduces the number of stable patients accessing an infliximab infusion in the hospital setting.

4. **Develop working arrangements for staff and contracted professionals to enable the delivery of expanded services in the community.**
   Since most of the care delivered in the community is dependent on the effective input of healthcare workers, we will need to examine the working and contracting arrangements for staff and contracted professionals to ensure that they align with new community-based models of care. This will include greater inter-disciplinary working, new roles and skills and more flexible working conditions. Staffing arrangements will have to meet the need for increased availability of services beyond the current Monday–Friday, nine-to-five approach. This will require adaptation of existing contracts for health professionals to provide incentives to work in the community in increasing numbers and to adopt new approaches and ways of working. It will also involve working with Hospital Groups to see how best to configure their workforce to operate both within an acute setting and in the community.

   There is an urgent need to update the current GP contract to ensure that GPs are enabled to deliver the type of care required, for the whole population. This means a broad range of services, including chronic disease management and prevention. A much wider population health approach will be introduced on a phased basis, to replace the current approach, which is focused on seeing and treating those who currently have full eligibility for services.

   Initiatives to extend service availability, introduce greater inter-disciplinary working, new roles and skills and more flexible working conditions will be subject to detailed consultation with all relevant groups and stakeholders.

5. **Accelerate implementation of integrated care programmes focused on chronic conditions and older people to provide appropriate and effective care in the community.**
   Many of the changes described in the delivery of community-based care will take several years to achieve and will require significant change to get right. In the short-term, however, a number of gains can be made by addressing some of the issues that result in people inappropriately attending hospital emergency departments or accessing care in hospitals (for which there are long waiting lists) that can be delivered in the community setting. In order to jump start reform, we will accelerate existing, ongoing work around national clinical programmes and integrated care programmes that focus on chronic conditions and older people. This will be supported through the integration fund.

6. **Develop an enabling environment to support joined-up community working, to include enablers such as enhanced ICT systems, better data/information, governance, and an extended workday and workweek.**
   - **Workforce:** The expanded model of community-based care will involve new roles in the community, individuals working at the full scope of their practice, as well as new ways of working across professions that currently operate on a relatively standalone basis.
   - **Technology and management information systems:** Technology can facilitate integration within and across community-based care, hospitals and other specialised care providers. It can also empower patients. Data will play a key role in supporting risk stratification, care planning, governance and accountability and management of complex conditions, as well as coordination across providers and the continuum of care.
   - **Funding models:** Value-based funding models will enable care to be delivered and reimbursed within the most cost-effective part of the system. They will also facilitate access to a choice of services.
   - **Clinical governance, patient safety and quality:** Governance, patient safety and quality frameworks and systems are required in the community to ensure services are of a high quality, that they are safe and that they conform to national standards.

   The system enablers that will underpin the overall reforms and actions that will be taken are described later in this Implementation Strategy.

Table 4: Implementation of Strategic Action 4

Actions	Sub-Actions	Delivery Date
Strategic Action 4: Expand community-based care to bring care closer to home.		
4.1 Develop a plan for the organisation and operation of community-based services in line with the overall citizen care masterplan and new models of care.	4.1.1 Determine how to organise and operate community-based services based on population need and size, in a way that clearly identifies patient pathways for accessing services.	2019
	4.1.2 Develop a methodology for determining the resources and services required in the community based on population need and size and in line with action 4.1.1	2020
4.2 Expand workforce and infrastructure capacity in line with the Health Service Capacity Review and the NDP.	4.2.1 Assess overall workforce required to deliver community-based models of care.	2018 and ongoing
	4.2.2 Establish more primary care centres and develop a new programme of investment in community-based diagnostics facilities.	2018 and ongoing
	4.2.3 Invest in new community care beds.	2018 and ongoing

Actions	Sub-Actions	Delivery Date
4.3 Expand and develop services.	4.3.1 Expand capacity in general practice and community nursing to manage chronic disease in the community (see actions 4.4.1 and 9.2.1).	2018 and ongoing
	4.3.2 Initial expansion, both in terms of the size and scope, of community intervention teams (including the Outpatient Parenteral Antimicrobial Therapy (OPAT) service).	2018
	4.3.3 Implementation of the Palliative Care Development Framework.	2018 and ongoing
4.4 Assess contracts and work practices.	4.4.1 Determine and progress priority objectives for GP contractual reform, with particular focus on enhanced identification and management of chronic disease initially for GMS/GP visit card population.	2018
	4.4.2 Evaluate the GP chronic disease management programme and consider scope for extension to whole population.	2020
	4.4.3 Assess existing health professionals' contracts in the context of enabling a shift to significantly enhanced community-based care, including an examination of scope for extended working hours.	2019
	4.4.4 Develop and begin to rollout new contracts or changes to contracts/work practices.	2020
4.5 Accelerate Integrated Care Programmes.	4.5.1 Implementation of integrated care programmes focused on chronic conditions and older people through the Integration Fund.	2019 and ongoing

Strategic Action 5

Develop and modernise the acute care system to address current capacity challenges and increase integration between the hospital sector and community-based care.

The acute hospital system is currently operating under significant pressure, a situation that will become more challenging as our population ages. The Health Service Capacity Review has highlighted the need for some 2,600 additional hospital beds over the next 15 years – assuming that the major reform of the system, as set out in Sláintecare, takes place.

Expanding capacity, however, is only part of the answer. Developing an integrated system means providing acute services in the community, as well as in hospitals. Existing hospital services need to be planned and managed in a more coherent way to make the best use of available resources and to ensure the delivery of high quality safe care. Hospital Groups need to devise and implement plans to make more strategic use of their existing resources within an overall national clinical strategy. In parallel with an expansion in community based care, our aspiration is to develop a coherent network of acute hospital services by taking the actions outlined below.

Key actions are to:

- address unacceptably long waiting times and emergency department pressures;
- implement a national Integrated Waiting List Management Framework;
- develop hospital services in line with the health service citizen care masterplan;
- introduce additional capacity of the order of 2,600 acute beds in line with the Health Service Capacity Review and National Development Plan, including new elective facilities;
- accelerate the implementation of existing national strategies;
- enhance clinical governance and patient safety standards; and
- drive productivity and efficiency improvements.

The case for change

Ireland has 49 public acute hospitals. Up to 2013, these hospitals operated quite independently of each other, each responding to its own regional and local service challenges. This resulted in a system that involves inefficiencies and duplication, and that is often designed around institutional and administrative concerns, rather than patients. Progress has been made in recent years, including the concept of a network of hospital and clinical services, via seven Hospital Groups.

Key national strategies have been developed for the organisation of integrated care within and across Hospital Groups and with community care services, in areas like maternity care, cancer,

paediatric services, ambulance services and trauma care. Alongside these, national clinical and integrated care programmes are improving care across a range of areas. These developments are evidence-based and informed by population need.

Major improvements have been made in relation to improving clinical outcomes and patient safety. The development of clinical guidelines and audit through the National Clinical Effectiveness Committee is driving evidence- based practice and reducing variation. A suite of patient safety initiatives is underway under the auspices of the National Patient Safety Office.

Despite this progress, hospital services are under extreme strain. Many patients face unacceptably long waiting times for elective care. Patients presenting to emergency departments must wait too long to be seen, or for a bed if they require admission. The quality of care and levels of patient safety remain variable across the system. Hospitals continue to be the default option for many care needs. Too many patients end up in hospitals and stay for longer than necessary due to perverse incentives, lack of capacity and fragmentation in community-based services, as well as lack of development and communication of alternative options. It is widely acknowledged that hospital attendance for a proportion of patients could be avoided through the provision of alternative pathways of care.

Hospitals continue to be the default option for a lot of care needs due to perverse incentives, lack of capacity and under-development and poor communication of alternative care options.

The challenges existing today will only get worse unless radical measures are taken. Short-term, piecemeal solutions can only offer short-term relief. Unless comprehensive changes are undertaken, unacceptable waiting times and risks to quality and patient safety will remain permanent features of Irish health services. Addressing this effectively will require a combination of reforms across health services, both in the hospital system and outside of it.

Vision and ambition

In the future, patients will be able to receive timely access to safe and high quality care, on the basis of medical need. They will only have to go to hospital if absolutely necessary, and will be able to leave hospital care as soon as they are medically ready to do so, at which point their care will transition seamlessly to a community setting. Hospitals will operate within an overarching national clinical strategy and will be well integrated with community care services, working together and practising outreach and in-reach, where appropriate. Patient safety will remain paramount. Care will be patient-centred, with a lead clinician always known and responsible for each patient journey through the hospital. The hospital will be a training environment for relevant disciplines.

Strong systems of clinical governance will be in place, integrated with corporate governance, patient safety and quality operating frameworks and with distributed clinical leadership, responsibility, authority and accountability. All patients will be treated equitably, based upon medical need.

Integrating care for older people

If we revisit the case of Bridget – her interactions with the hospital system will be much fewer and will be different. In the past, Bridget was a regular visitor to the hospital's emergency department. In the future, if hospital care is required, there will be joined up working between her care team and the hospital to plan and manage her transition back home. She will be able to access specialist geriatric services in her local hospital on a regular basis.

Specific actions

In parallel with an expansion in community-based care, our aspiration is to develop a coherent network of acute hospital services by taking the steps outlined below.

1. **Tackle unacceptably long waiting times and emergency department pressures:** These two areas have been among the most difficult and persistent challenges facing our health system over many years, despite much effort to address them. Emergency departments are often the first and last port of call for our most sick and vulnerable and become the visible focal point for the challenges in delivering community and hospital care. In addition, long waiting times for scheduled care reflect current capacity constraints in hospitals. There is no single solution to this issue, though all the issues addressed below comprise essential aspects of its resolution, alongside a successful shift towards providing the vast majority of care appropriately in the community.

   The system needs various short- and medium-term solutions to address hospital pressures. Specific interventions will include: more home care packages and transitional care to support timely discharge; development of decision support tools for GPs; greater access to diagnostics; expansion of community intervention teams and outpatient parenteral antimicrobial therapy (OPAT) services; and phased implementation of programmes such as Frailty at the Front Door and early supported discharge for stroke. Patient flow and process improvement measures are also key. Introduction of the 'Acute Floor Model' will provide a platform for enabling frontline change, with a single point of access through the 'Acute Floor Hub' to unscheduled care, with clinical leaders working in a coordinated multi-disciplinary and patient-centred way such that patients are treated and discharged without delay by the most appropriate senior clinician. This will build on the ongoing work in relation to the Patient Flow Improvement Programme.

2. **Develop hospital services within a new overarching national clinical strategy:** Hospital services must be able to respond to emerging technologies and advances in medical science and must be better organised to deal with emergency and elective cases that cannot be treated in the community. Services will be planned and delivered at a regional or national level, to serve the needs of a given population, and guided by a national clinical strategy for safe, high quality care. Clinicians and patients will be centrally involved in the development of this strategy. The work of the national clinical programmes and existing national strategies will act as core building blocks in the development of this national clinical strategy, which will provide an evidence-based framework for strategic planning by Hospital Groups.

   The relationship between volumes and outcomes is now well understood in cancer care and is also relevant for other highly complex areas such as trauma. This will underpin the organisation of high complexity and low volume care in fewer centres across the country, so that the appropriate level of care and expertise can be provided. Other services will be provided in regional and local hospitals, as clinically appropriate. Hospital Groups, in collaboration with community-based care, will be responsible for developing strategic plans for services in their region, plans that are both clinically and financially sustainable. Centrally, the national clinical strategy will ensure this happens within the parameters of safe care, while allowing room for the type of innovation that is regularly developed at 'ground level'.

3. **Expand capacity in line with the Capacity Review and NDP:** While the expansion of community-based services will mitigate, to some extent, the demand for acute services, the Health Service Capacity Review makes clear that there will still be a net requirement for additional acute hospital

beds of the order of 2,600 beds in the public system. New capacity will be targeted at protected elective capacity, more ambulatory and day treatment and increased diagnostic facilities. A national approach will be taken in the development and construction of separate ambulatory elective facilities, appropriately sited adjacent to major hospitals, in Dublin, Cork and Galway, where volumes are sufficient to merit them. This will enable clinicians in such centres to work across the elective facility and general hospitals. Additional capacity will be developed in each region in line with Hospital Group strategic plans, with a focus on streaming ambulatory, day care and elective workloads and the separate management of emergency activity through inpatient and critical care capacity. Opportunities to expand capacity within existing facilities will be pursued but we will also put in place a multi-annual construction programme to expand capacity.

4. **Implement existing national strategies, National Clinical Programmes and integrated care programmes:** The acute sector will continue to focus on implementation, accelerated where possible, of national strategies and policies, to help ensure that less complex care is provided as regionally and locally as possible, while specialised complex care is appropriately centralised to ensure it is safe and of high quality. Continuation and renewed focus on the national clinical programmes and integrated care programmes will also assist in reducing variation and improving access and quality of care along the care pathway.

5. **Ensure patient safety:** An appropriate and visible patient safety and quality operating framework should be in place for all services. Key actions, including advancement of the Patient Safety (Licensing) Bill, are set out later in this Strategy.

6. **Implement productivity improvements:** Improving productivity must remain a core focus and is one of the only ways that the system can ever be financially viable. This will be driven by the continued development of funding mechanisms such as activity-based funding, delivery of care on a day or ambulatory basis, the ambulance reform programme, and workforce measures. Key actions are set out later in this Strategy.

Table 5: *Implementation of Strategic Action 5*

Actions	Sub-Actions	Delivery Date
Strategic Action 5: Develop and modernise the acute care system to address current capacity challenges and increase integration between the hospital sector and community-based care.		
5.1 Tackle unacceptably long waiting times and emergency department pressures.	5.1.1 Develop multi-annual Inpatient/Day Case Waiting List Action Plan.	2019
	5.1.2 Develop multi-annual Outpatient Waiting List Action Plan.	2019
	5.1.3 Develop multi-annual Unscheduled Care Plan, the first element of which will be the implementation of measures at acute hospital and community level to achieve an initial increase in capacity.	2018

Actions	Sub-Actions	Delivery Date
	5.1.4 Carry out a review of ED, MIU, MAU and similar unit utilisation to support unscheduled care planning for alternative pathways.	2019
	5.1.5 Develop a framework to support integrated waiting lists, including the identification of potential ICT solutions, and reporting and publication mechanisms.	2019
	5.1.6 Develop policy framework for evidence-based waiting list guarantee, incorporating consideration of legislation to support the guarantee.	2019
5.2 Develop hospital services within a national clinical strategy.	5.2.1 Finalise Hospital Group strategic plans to direct future service delivery, in line with strategic guidance and in parallel with other elements of reform and establish annual reporting of progress.	2019
	5.2.2 Develop a national clinical strategy to form the basis of all national and regional planning, using a robust methodology and taking a collaborative approach, involving key stakeholders and patient groups.	2020
	5.2.3 Implementation of the Ambulance Reform Plan in accordance with agreed implementation plan.	2018 and ongoing
5.3 Expand capacity in line with the Capacity Review and the NDP.	5.3.1 Identify opportunities to open additional beds in existing hospitals.	2018-2021
	5.3.2 Develop criteria, selection and approval processes for a small number of major investments in new ambulatory elective hospitals in major population centres.	2019
	5.3.3 Conduct detailed planning at Hospital Group level and provide national approval and funding for the development of additional capacity in the context of Hospital Group strategic plans.	2020
	5.3.4 Conduct detailed planning to support the development of additional diagnostics capacity in the context of Hospital Group strategic plans and community care needs, with national approval and funding.	2020

Actions	Sub-Actions	Delivery Date
5.4 Implementation of existing national strategies and policies.	5.4.1 Implement the National Maternity Strategy in accordance with agreed implementation plan.	2018 and ongoing
	5.4.2 Implement the National Cancer Strategy in accordance with agreed implementation plan.	2018 and ongoing
	5.4.3 Implement the National Neurorehabilitation Strategy in accordance with agreed implementation plan.	2018 and ongoing
	5.4.4 Implement the National Trauma Strategy in accordance with agreed implementation plan.	2018 and ongoing

Strategic Action 6

Expand eligibility on a phased basis to move towards universal healthcare and support a shift to community-based care.

Our vision is that all citizens will have universal access to healthcare, in both the acute and community settings. This will require an expansion in eligibility, particularly for primary care.

Enhancing eligibility is not simply a matter of reducing charges for, or expanding access to, existing services. It also means considering what new or reformed services need to be provided and on what basis. Eligibility expansion also has to take account of capacity constraints within the health system, and the trade-offs between intensification of services to those currently eligible and broadening entitlement and improving financial protection.

Careful analysis and policy development will be required to determine how universal eligibility can be achieved on a phased basis, drawing on evidence to determine how best to achieve maximum health impact at a population level.

The case for change

Current eligibility arrangements are provided for in the 1970 Health Act and subsequent legislation. These arrangements have developed over time and in a somewhat ad-hoc manner. While eligibility for acute services is universal, eligibility arrangements for community-based care are diverse. Some population groups are provided with a range of community-based services based on means-tested eligibility criteria (for example, holding a GP visit card, a medical card and long-term residential care) or on an age-related basis. Other specific care, such as mother and infant care, primary school immunisation and certain screening services, are provided on a whole-population basis. In addition, some services are in practice only available to certain groups (such as Medical Card holders) because of limitations in the volume of services currently provided.

The lack of universal access to primary and community care is unusual in the European context and is likely to act as a significant barrier to achieving a fundamental shift to community-based care. It creates perverse incentives which lead to the acute hospital being a preferred 'first port of call' for many people. It can also create financial barriers to accessing healthcare.

Vision and ambition

The Sláintecare vision is that a broad range of services will be universally available at low or no cost. The report recommends that this is achieved on a gradual basis.

It is important however to acknowledge that the delivery of this vision must be planned carefully and introduced over an appropriate time period. Expanding eligibility will generate a significant increase in demand for GP and other primary and social care services. There is a trade-off here between deepening the remit of primary and community care to support new services, such as chronic disease management, and expanding access to free or low cost services on a universal basis. This must be

navigated in parallel with workforce expansion, service investment, and the redesign of tasks to introduce greater capacity.

The pathway to universal primary and community care therefore demands careful analysis to identify the best way to proceed to achieve maximum health impact at a population level. This pathway must use limited capacity effectively and must expand affordable access in an equitable manner so that the vision of universal community-based care is delivered as soon as is feasible over the next decade. Decisions taken in this regard must be right for both patients and the taxpayer. Prioritisation should reflect wider health service impacts so that current and growing pressures are tackled and clinical and financial viability assured. Eligibility arrangements, access rules and any financial contribution by service users must be aligned with the model of care principles.

The pathway to universal primary and community care demands careful analysis to identify the best way to proceed to achieve maximum health impact at a population level

To that end, it will be necessary to review the current eligibility framework for all services and consider different options that will enable a phased expansion of universal access to a prescribed range of services. These options will take account of the ability of the health system to meet the increase in demand that would be expected, including the resource requirements needed from a workforce and service delivery perspective, as well as the impact on the effective management of the financial resources of the total health service. Co-payment or cost-sharing models will also form a critical piece of the analysis to inform the design of a future eligibility framework that will underpin universal access to services.

In the meantime, Government has extended eligibility to different groups, including providing medical cards to those in receipt of Domiciliary Care Allowances and GP visit cards to those in receipt of Carer's Allowance. In addition, Government has committed to introducing a statutory scheme for homecare to support people to live in their own homes. The design of this scheme is underway and it is intended to be operational within the three years of this Strategy.

Linked to the examination of eligibility arrangements is consideration of the current system of charges that exist for hospital services and for medications. Action has already been taken in Budget 2018 to reduce prescription charges and the monthly threshold for the Drugs Payment Scheme. A review of user charges, including impact and sequencing, will be undertaken in the context of the implementation of Sláintecare; this will inform the annual budget process.

Table 6: Implementation of Strategic Action 6

Actions	Sub-Actions	Delivery Date
Strategic Action 6: Expand eligibility on a phased basis to move towards universal healthcare and support a shift to community-based care.		
6.1 Review user charges.	6.1.1 Review the basis for existing hospital and medication charges, their contribution and their policy relevance and devise a framework of options for future changes to be considered in the context of the annual budgetary process.	2019
6.2 Review current eligibility framework.	6.2.1 Review the current eligibility framework for all services to inform the pathway to achieving the vision of universal healthcare.	2019
	6.2.2 Develop a policy proposal and roadmap for achieving universal eligibility which will consider the following (i) the range of services to be provided in the community on a universal basis (ii) the rationale and methodology for phased eligibility for the services, and (iii) the co-payment or cost-sharing models, financial mechanisms and phasing to ensure that the system is properly aligned to meet the increased demand that is expected. This analysis will then determine the preferred future eligibility framework to deliver universal access to healthcare.	2020
	6.2.3 Introduce legislation to ensure that eligibility to health and social care services has a statutory basis.	In line with rollout above
6.3 Develop homecare services.	6.3.1 Introduce a statutory scheme for homecare.	2021

Goal 3 Ensure the Health Service is Financially Sustainable

The health service is facing major sustainability challenges. Additional capacity and funding must be invested strategically and must support the overall vision for reform, with a consistent focus on productivity and achieving value for money.

Financial sustainability and affordability must be core goals of any health system. Today, the health system is facing major sustainability challenges. Additional capacity and funding must be invested strategically and incentives and funding mechanisms will need to support overall reform ambitions. Increased efforts are also needed to drive productivity improvements across all aspects of the system.

Without thorough reform, the current situation is only going to get worse as demand pressures continue to rise over the coming decades. A rising and ageing population, coupled with increased prevalence of chronic disease, medical inflation and increasing expectations from the public will all place extreme pressures on limited resources.

- **Population and demographic growth:** Ireland has a population that is both ageing rapidly and growing at 0.8% per annum.[14] By 2031, it is projected that the 85+ years population will have increased by 97%, while the 65+ years population will have increased by 59%. These segments of the population require a disproportionate share of healthcare resources and tend to have more complex care needs. For example, in 2016, 39% of those who had a day case procedure were over the age of 65, even though that age group represented only 13% of the population. The Department of Health projected that demographic pressures would increase costs by between 1.4% and 1.6% annually.[15] Both the ESRI report, Projections of Demand for Healthcare in Ireland, 2015–2030 (2017), and the Health Service Capacity Review (2018) have projected considerable increases in demand in nearly all care services in the coming decade.[16,17]
- **Non-demographic growth:** Unhealthy lifestyle choices (such as those related to diet, exercise, smoking and alcohol use) also drive demand for health services due to higher levels of chronic conditions. Some 60% of people aged 50 and over report having at least one chronic condition. Chronic diseases account for a significant proportion of hospital activity, including 40% of hospital admissions and 75% of hospital bed days. Other non-demographic factors such as state claims and pensions of retired staff also increase the pressure.
- **Price increases:** Medical inflation is a known driver of costs in the healthcare system, as recognised in the Sláintecare report. This will continue as new drugs and technologies come on stream. There are also cost increases arising from national or sectoral pay awards and across a number of areas that do not relate to current service levels, such as pensions and clinical indemnity claims.

Three specific areas require action.

- 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.
- Productivity: Set multi-annual targets for productivity improvements, to drive year-on-year improvements and deliver better value for money.
- Private practice in public hospitals: Implement measures to address inequities in access to public acute hospital care based on the recommendations of the ongoing independent impact assessment.

[14] Central Statistics Office (2013) Population and Labour Force Projections 2016-2046

[15] Department of Health, internal analysis 2014

[16] Wren MA, Keegan C, Walsh B, Bergin A, Eighan J, Brick A, et al, Projections of demand for healthcare in Ireland, 2015-2030, First Report from the Hippocrates Model, Dublin, Economic and Social Research Institute 2017.

[17] Department of Health, 2018, Health Service Capacity Review

Strategic Action 7

Reform the funding system to support new models of care and drive value to make better use of resources.

Funding Allocation Models

As with many public health systems around the world, Ireland has the ambition of delivering value for all of the money that is spent on healthcare. This means ensuring that the system can maximise outcomes based on the available resources.

The existing system has grown up around a particular set of incentives, which need to be changed to facilitate a new model of care, as set out in Sláintecare. Funding has traditionally been based on historic budget allocations and there is fragmentation of funding across different healthcare providers. This approach does not adequately take account of changing population needs and desired changes to the way care is delivered.

We want to move towards a comprehensive population-based funding model that incentivises delivery of the right care, in the right place, at the right time.

Improvements to resource allocation within the health sector have already been introduced, primarily through the implementation of activity-based funding (ABF) in the acute sector. ABF has now replaced the inefficient block allocation model for a majority of acute hospital services and this has been an important step towards improving our resource allocation. The Sláintecare report recommends the continuation of ABF as a way of 'building connections rather than boundaries'. We will now build on the foundations already in place; in the interim, this will involve an expansion of ABF to other parts of acute services and the development of a costing programme for community-based services. Efforts are also underway to modernise the allocation of disability funding, which will involve a shift towards personalised budgets.

Over the medium term, however, ambitions will be raised and we will constructively move towards a comprehensive population-based funding model that incentivises delivery of the right care, in the right place, at the right time. This should become a critical pillar of our future health service, and will entail an alignment of funding allocation with population health need, at national and local level, and with new models of care. To do this, it will be necessary to develop accurate data and processes to properly define population need and to design and implement integrated models of care to meet that need.

Productivity

During the financial crisis, significant savings were made in the health service, including through substantial reductions in the pay bill. There were also significant improvements in measured efficiency in the acute sector. The health service budget is now growing again, but the challenge to enhance efficiency is now, if anything, greater.

The Irish Exchequer will invest some €15 billion in the health service in 2018. Despite this substantial level of funding, significant problems of access and equity remain, at a time when the demographic transition is only beginning. There is no alternative, but to find ways to achieve

more with the resources available, through both short- and long-term measures. The first step in developing a health and social care system that is more productive is to ensure that care is delivered in the most appropriate and least complex way. This will be at the heart of the redesign process, as new models of care are implemented and care is moved out of specialist institutions to the degree that it is appropriate. However, even within an overall system that is designed to achieve productive allocation of resources, there can be variation in productivity among and within providers. Within the current budgetary system there is insufficient recognition for those who generate improvement through better use of existing resources and challenge of those who do not do so. A framework of incentives and interventions is needed to address this on an ongoing basis.

Productivity improvement is a continuous process. It should be planned on a multi-annual basis and delivered with urgency year on year. Greater efficiency should be seen as a key mechanism to enable high quality safe care, driven by evidence. As recently summarised by NHS Scotland, strategies for cost avoidance and reduction need to be combined with a drive to release resources associated with traditional ways of organising and delivering services. We must seek to reduce unwarranted variation in service provision, remove waste and eliminate harm.[18]

In the short-term, most efficiency gains will be made at the frontline. Every day, clinicians and practitioners are innovating to improve our system. We must identify local solutions and initiatives and provide support so that they can be scaled up or replicated within the healthcare system.

Other similarly sized countries have achieved substantial improvements. For example, Scotland has reduced forecasted costs by as much as 3% year-on-year, which allows their system to contribute effectively to the management of demand increases. While our starting point is different, we must be ambitious in setting targets. In this regard, the HSE has formed a Productivity and Improvement Unit to drive this process. The Unit will consider potential levers for effective change. These levers, which are similar to those focused on in Scotland, include:

- evidence-based care;
- preventative and early intervention;
- outpatients, community and primary care;
- acute flow and capacity management;
- workforce productivity;
- prescribing, procurement, support/shared services; and
- service redesign, innovation and transformation.

[18] NHS Scotland (2011), *NHS Scotland efficiency and productivity:* Framework 2011–2015.

Table 7: Implementation of Strategic Action 7

Actions	Sub-Actions	Delivery Date
Strategic Action 7: Reform the funding system to support new models of care and drive value to make better use of resources.		
7.1 Develop new funding allocation models.	7.1.1 Expand activity based funding for inpatient and day cases to other acute hospitals.	2018
	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.	2019
	7.1.3 Examine the use of ABF for outpatient services.	2018
	7.1.4 Advance the community-based costing programme to measure unit costs and productivity in community-based services.	2019
	7.1.5 Develop a plan for moving to a system of population-based funding in the medium term.	2019
	7.1.6 Finalise proposals for personalised budgets in disability services.	2018
7.2 Develop multi-annual budgeting.	7.2.1 Develop proposals for multi-annual budgeting in the healthcare system to facilitate planning and strengthen financial management.	2019
7.3 Invest in data and information.	7.3.1 Invest in a multi-annual programme of work with key health stakeholders and academic researchers to develop an activity and cost database for health and social care in Ireland.	2018 and ongoing
7.4 Increase productivity.	7.4.1 Implement a multi-annual three-year productivity plan to run 2019–2021, to include service planning targets.	2019-2021
	7.4.2 Undertake a governance review of the drugs approval and procurement process.	2018

Strategic Action 8

Implement measures to address inequities in access to public acute hospital care based on the independent impact assessment.

The Government's ambition is to ensure full equity in the delivery of public hospital services. The dual system of public and private care in our public hospitals has developed over time and for historical reasons.

The Sláintecare report envisages a complete separation of public and private provision on a phased basis to deliver a single tier public hospital system, with holders of private health insurance being able to purchase care from private healthcare providers only.

The Sláintecare report acknowledges that separation will not be easy, and that it will take time to change current arrangements. It also recognizes the considerable cost involved to the State. For this reason, the undertaking of an impact assessment was recommended and this is now underway. This is considering practical approaches to removing private practice from public hospitals, the impacts that this removal may have, the timeframe which might apply and how this will be phased over time. Particular attention will be paid to the following factors.

- **Workforce and capabilities:** The Sláintecare report specifically notes, 'it is important that any change should not have an adverse impact on the recruitment and retention of consultants and other health professionals in public hospitals'.
- **Legal issues:** The Sláintecare report recommends that existing consultants' contracts be addressed through negotiation and that enhanced public-only contracts be introduced for new recruits.
- **Funding:** The Sláintecare report recommends that current revenue to public hospitals from private insurance companies (€649 million in 2016 and an estimated €621 million in 2017) be replaced by additional public funding over a five-year period.
- **Operational matters and hospital activity:** In particular, arrangements for highly specialist services need to be considered.

Table 8: Implementation of Strategic Action 8

Actions	Sub-Actions	Delivery Date
Strategic Action 8: Implement measures to address inequities in access to public acute hospital care based upon the output of the independent impact assessment.		
8.1 Review impacts of removing private practice from public hospitals.	8.1.1 Strengthen the governance and operational framework for monitoring and management of private practice in public hospitals to ensure contractual compliance.	2018
	8.1.2 Complete impact analysis by the Independent Review Group to examine the removal of private practice from public acute hospitals.	2018
	8.1.3 Consider the recommendations of the Independent Review Group on impact assessment and seek Government decision.	2018

Goal 4 Enable the System to Deliver Its Goals

Reform requires an enabling environment in order to fully achieve the health service we want. Without the development of a series of critical enablers, the Sláintecare vision will remain aspirational.

So far, the focus of this Implementation Strategy has been on describing future healthcare in Ireland: how it will look, how it will be experienced and how it will differ from current provision. The Strategy has also focused on how the funding system and incentives will enable the system to sustain itself and deliver the changes required.

Achieving this kind of change requires an enabling environment, driven by a range of elements. Three critical enablers have been identified as central to the successful implementation of this Strategy.

- **Workforce:**

  The focus here will be on ensuring the workforce has the right capacity and capabilities to deliver change, as well as effective support to make the transition. This will require: the right tools to enable a new approach to strategic workforce planning; targeted recruitment and retention initiatives; a dynamic relationship with educators to support the evolution of care models over time; multi-disciplinary and inter-professional learning and practice to enable and enhance team-based working and greater job satisfaction through optimisation of skillset and competence; and the development of leadership capacity.

Three critical enablers have been identified as central to the successful implementation of this Strategy.

- **eHealth:**

  This will involve the delivery of the tools, ICT systems and capabilities needed for the healthcare system to work differently, in a more joined-up way, on the front line. This will involve acceleration of the rollout of eHealth initiatives to provide the integration capability and patient information systems needed to support new models of care. Electronic Health Records (EHR) will be a central component of this and a particular focus will be placed on growing eHealth capabilities in the community.

- **Data, Research and Evaluation:**

  This will require the more effective use of data and research to ensure a robust evidence base is available to support healthcare professionals in the design, delivery and evaluation of high quality health services. It will also entail a strong programme of evaluation to assess the reform programme and its contribution to the performance of the health system during the 10-year implementation period.

Strategic Action 9

Build a sustainable, resilient workforce that is supported and enabled to deliver the Sláintecare vision.

The health workforce will be a critical enabler of reform. An effective health service must be capable of recruiting, retaining and motivating a high quality workforce, while maintaining the core values of care and compassion which have been hallmarks of Irish healthcare. New ways of working will be required, so that staff are able to operate across the full scope of their professional competence in an integrated manner. Our priorities are to:

- Accelerate implementation of Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning (Department of Health November 2017).
- Develop and expand existing workforce strategies.
- Implement priority pilot projects, focusing initially on expansion of care in the community setting.
- Enhance leadership and accountability to support reform.
- Build clinical and organisational capacity to support changes and implementation of new models of care.

The case for change

The health workforce is critical to ensuring ongoing service delivery across our health system and to delivering on this reform agenda.

Global and regional health workforce demand is expected to increase dramatically in the coming decades as a consequence of population and economic growth, combined with demographic, epidemiological and other factors. These demands are compounded by other factors including:

Recruitment, retention and training: The health and social care sector in Ireland is already experiencing significant challenges in the recruitment, retention and geographical distribution of health professionals across various health sector grades, including nurses, midwives, consultants and non-consultant hospital doctors.[19] While targeted efforts have sought to address current recruitment and retention challenges, much more needs to be done across a wide range of areas to build a sustainable, resilient workforce for the future. Such areas include education and training, learning and development, employee health and wellbeing, career pathways and progression, access to supports and diagnostics, quality of the work environment, and flexibility of working practices.

[19] Public Service Pay Commission (2017) *Report of the Public Service Pay Commission*, available at http://paycommission.gov.ie/wp-content/uploads/PSPC-report-2017-WEB.pdf.

Policy context: A range of policies and programmes are being implemented to support the recruitment, retention and development of key parts of the health workforce, including for example the Strategic Review of Medical Training and Career Structures (known as the MacCraith report[20]) and the draft Policy on Graduate, Specialist and Advanced Nursing and Midwifery Practice.[21] The HSE People Strategy 2015–2018 has also delivered a comprehensive suite of initiatives designed to engage, develop and support the workforce to deliver the best possible care and services to people who depend on them. Sláintecare takes these reforms even further, highlighting the need to shift care from the acute hospital setting into new models of care in the community, which will require significant reorganisation of the workforce. The transformational changes envisaged in the Sláintecare report will place significant additional demands on the workforce.

Workforce planning capacity: Effective short-, medium- and long-term workforce planning will be vital to ensure that the introduction of new models of care are planned and managed effectively from a health workforce perspective. The development of a National Strategic Framework for Health and Social Care Workforce Planning in 2017 marked an important milestone in developing a more robust and systematic workforce planning approach.[22] Implementation and resourcing of this framework will significantly strengthen workforce planning capacity within the system; it will also guide and support the creation of the workforce needed to realise the scale of change required.

Complex industrial relations landscape: As with many public healthcare systems, the industrial relations environment in healthcare in Ireland is complex, involving many staff representative bodies. These bodies are critical to ensuring the engagement and fair treatment of staff and are important stakeholders in achieving change. However, the complexity of this industrial relations landscape can lead to a tendency towards a local or sectional approach to change. Achieving the vision of Sláintecare will require a new model of engagement with the representative bodies. Current approaches by both management and unions are not sufficient to achieve even the most essential elements of the service change required to deliver the Sláintecare vision. It is important that this issue is comprehensively addressed, both through engagement as well as governance and public accountability arrangements.

Vision and ambition

Our vision is for an appropriately skilled, supported, motivated, engaged, responsive, productive and sustainable health workforce. Such a workforce will be the key enabler of quality integrated care and improved health outcomes for the population. Achieving this will involve:

- a more strategic approach to identifying and implementing HR and workforce policy solutions;
- enhanced engagement of stakeholders in future workforce planning and development;

[20] Department of Health, 2017, Strategic Review of Medical Training and Career Structures, available at https://health.gov.ie/future-health/tackling-the-capacity-deficit/strategic-review-of-training-and-career-pathways-for-doctors/

[21] Department of Health, 2017. Draft Policy on Graduate, Specialist and Advanced Nursing and Midwifery Practice, available at https://health.gov.ie/office-of-the-chief-nursing-officer/our-policies/developing-graduate-specialist-and-advanced-nursing-and-midwifery-practice/

[22] Department of Health (2017) Working together for health – *A national strategic framework for health and social care workforce planning*, available at http://health.gov.ie/blog/publications/working-together-for-health-a-national-strategic-framework-for-health-and-social-care-workforce-planning/.

- upskilling and supporting the existing workforce to deliver new ways of working through greater focus on clinical effectiveness and evidence-based practice, leadership and management competencies, multi-disciplinary team working, inter-professional learning and practice, flexibilities across traditional professional roles to adapt to new demands, optimum skill mix and optimum geographical distribution;

Success in attracting and retaining health and social care professionals will be a critical dependency for change.

- sustainable collaboration between health service providers and educators in preparing and developing the health workforce;
- increased career and role flexibility, adaptability, mobility and more efficient training;
- extending the roles of existing health professions and introducing new ones;
- improved recruitment rates and enhanced retention of the current workforce; and
- effective delivery of advances in technologies and ICT capabilities, such as telehealth and mHealth (mobile health) initiatives.

This work will be carried out in a collaborative way, engaging extensively with the most important of stakeholders – our staff and the public. Throughout the change process, we aim to place the service user at the centre of care and to create a great place to work while delivering a high- quality health and social care service.

Specific actions

Delivering the scale of change envisaged will require considerable changes in how we plan, organise and resource our workforce. It will also require the workforce to work differently. Over the next three years, we will concentrate on the following steps.

1. **Design:** This involves early acceleration of key elements of the Department of Health policy document, Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning (2017). In addition, as service reforms, and new models of care and productivity improvements are designed, the workforce implications will need to be considered and aligned with ongoing workforce planning. A key element of planning will be engagement with higher educational institutions and employee representatives, as well as funding bodies to support the new workforce models.

2. **Pilot:** The current workforce will need to be supported to work differently. A short-term and focused integrated workforce plan will be developed to support initial implementation pilots of new care models to include key actions (policy, human resources/industrial relations and organisational development).

3. **Deliver:** An overall delivery plan for the workforce (including policy, HR/IR and organisational development actions) will need to be completely rolled out by mid-2019. This will require investment in measurement and evaluation of outcomes and impact. Delivery will continue on a phased basis across the ten-year period.

4. **Build leadership capacity:** The capacities of health services management and clinical leaders will need to be developed to the required standard to support the change process.

5. **Build organisational capacity:** The scale of actions set out in this Implementation Strategy represents a significant undertaking. It will place considerable demands on existing resources and organisations, including the Sláintecare Programme Office, the Department of Health and the HSE. Existing workforce plans will need to be examined and recast to ensure the level and skills of staff are in place to deliver on commitments. Enhancement of team working skills will be a priority.

Table 9 summarises the key transformational actions required to deliver the above, including acceleration of implementation of the Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning.

Table 9: *Implementation of Strategic Action 9*

Actions	Sub-Actions	Delivery Date
Strategic Action 9: Build a sustainable, resilient workforce that is supported and enabled to deliver the Sláintecare vision.		
9.1 Accelerate implementation of Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning.	9.1.1 Establish structures to implement the Workforce Planning Framework (including the Cross-departmental Group and the joint Department of Health/HSE/ Tusla Workforce Planning Group) and develop communications and engagement strategies with the workforce and other key sectors and stakeholders.	2018
	9.1.2 Resource the HSE to effectively lead on strategic health workforce planning for the health sector.	2018
	9.1.3 Identify and commence implementation of priority workforce planning projects to test, evaluate and refine the proposed approach.	2018
9.2 Implement existing workforce strategies.	9.2.1 Develop and introduce a new model of community nursing and midwifery on a phased basis, commencing with the establishment of a demonstrator site, to support a decisive shift to integrated service delivery.	2018 and ongoing
	9.2.2 Expand and develop the role of advanced nurse practitioners to tackle priority service deficits and delays.	2018 and ongoing

Actions	Sub-Actions	Delivery Date
	9.2.3 Fully implement the first and second phases of the work of the Taskforce on Safe Nurse Staffing and Skill Mix. Commence work on the development of this model to determine the appropriate community nursing workforce.	2018 and ongoing
	9.2.4 Implement the recommendations in the Strategic Review of Medical Training and Career Structures.	2018 and ongoing
9.3 Utilise the Workforce Planning Framework to support reform implementation.	9.3.1 Complete short-term workforce planning and agree priority pilots, focusing initially on primary care and community-based care expansion.	2019
	9.3.2 Develop an integrated, detailed workforce plan to deliver model of care and productivity requirements and: i) identify key actions in relation to human resources, industrial relations, organisational development and education; ii) agree actions with higher education institutions; and iii) agree actions with staff representative bodies and staff.	2019
9.4 Enhance leadership and accountability.	9.4.1 Continue to build and enhance leadership development, capacity and capability through the Health Service Leadership Academy.	2018 and ongoing
	9.4.2 Introduce performance management systems in areas of the public health sector where they are not already in place to ensure that managers are held accountable for resources.	2019
9.5 Build organisational capacity.	9.5.1 Introduce skills development programmes to support local reform implementation, with a particular focus on enhanced team working and integrated care.	2019

Strategic Action 10

Put in place a modern eHealth infrastructure and improve data, research and evaluation capabilities.

10.1 eHealth

ICT has the potential to be the biggest and most effective driver of change and improvement for better patient outcomes across the health system. In the future, a coherent suite of eHealth solutions will underpin and support our overall vision for integrated, patient-centred care, population health planning and more effective and safe delivery of health services. Patients and health professionals will have ready access to clinical records and administrative information, which will enable better decisions to be made. Our priorities are to:

- Implement the national acute Electronic Health Record (EHR), starting with the new National Children's Hospital.
- Design and roll out community-based Electronic Health Records, connecting data across the system and, over time, making data available to patients.
- Design and roll out a range of primary and community-based ICT services that will improve the lives of patients, including ePrescribing, summary care records and commence implementing telehealth solutions to support care in the community.
- Develop new ICT systems and invest in infrastructure to support the health workforce and the delivery of integrated care.
- Implement the national digital maternity system.

Unlike some other countries around the world, Ireland has not yet fully realised the potential that eHealth and technology can deliver in terms of transforming care. We have a significant journey to travel to put in place the infrastructure, capabilities and organisational change that will be required to truly transform patient care.

Prior to 2013, ICT investments focused on back-office functions and hardware infrastructure like finance and patient administration solutions. Since then, good progress has been made following the publication of the national eHealth strategy in 2013.[23] New organisational structures are in place to drive this agenda, including a Chief Information Officer role in the HSE. Of critical importance is the implementation of the Health Identifiers Act 2014, which enables the connecting of information across a fragmented system. New national clinical systems are being rolled out, including radiology and maternity and new-born systems.

Digital health solutions can support more efficient processes, empowering patients in managing their care and accessing their own medical records, as well as facilitating the provision of services in more appropriate care settings closer to the patient's home. For health professionals, the lack of visibility

[23] Department of Health, Health Service Executive, 2013, eHealth Strategy for Ireland, available at https://health.gov.ie/blog/publications/ehealth-strategy-for-ireland/

of a patient's health history is a serious obstacle to planned, coordinated care delivery away from acute settings. The Sláintecare report calls for the 'continued strong support of the eHealth strategy – particularly ensuring the necessary funding for timely rollout of the EHR system and resourcing of the eHealth change processes'.

We are therefore committing to embark upon a large-scale programme of ICT development to provide the patient information systems and appropriate integration capability needed to support the new models of care underpinning Sláintecare. Electronic health records will be a central component of this, without them, integrated care is impossible to achieve.

Electronic health records are essential for the proper development of integrated care.

Investing in eHealth and ICT-based systems will allow for the provision of the required infrastructure to make the right information available about the right patient in the right place and at the appropriate time. It will bring much needed efficiency to the current paper-based processes by modernising the information systems that are relied upon to plan and manage our health services in line with international best practice. After this investment, many of the current manual processes such as ordering prescriptions, accessing centralised waiting lists and managing complex hospital functions will be supported through ICT, similar to many other knowledge-intensive sectors of the economy. This will also empower patients to participate in their own care with access to the requisite data.

The implementation of EHRs will be on a modular basis, enabling change at the local level in increments to avoid a negative, 'big bang' effect. By the end of the ten-year plan, EHRs should be a fully embedded part of our health infrastructure. Patient information will follow the patient, thus providing the data to underpin care in the most appropriate care setting and also empowering patients to participate in the management of their own healthcare. Integration of data will be supported by the rollout of the individual health identifier and by more effective and secure organisation of the databases underpinning health and social care.

The new National Children's Hospital will be the first acute digital hospital in Ireland. A significant milestone in the provision of digital supports has been met with the rollout of the digital maternity hospital in Cork in 2016 and Kerry and the Rotunda in 2017.

Specific actions

This change cannot happen overnight. The immediate priority is to secure approval and advance rollout for the ICT and the EHR for the New Children's Hospital. Over the course of the next three years, we will target and significantly expand eHealth capability in the community to provide the foundation for seamless sharing of information across community and acute care.

Community-based care can be supported by providing a number of immediate systems, including ePrescribing, summary care records and an overarching operational system to share data between the key care professionals such as GPs, nurses and other health professionals. The 'shared care' record will provide the necessary integration between community-based care and the acute hospital sector, allowing for a more seamless approach to sharing patient data for both health and social care, and also underpinning planning and developing service improvements. The application of telehealth type solutions will also underpin new models of care. These and other planned systems will provide the necessary information to improve access and the management of waiting lists. The legal basis to process personal sensitive health data will also be clarified through the implementation of the General Data Protection Regulation.

Table 10: Implementation of Strategic Action 10

Actions	Sub-Actions	Delivery Date
Strategic Action 10: Put in place a modern eHealth infrastructure and improve data, research and evaluation capabilities.		
10.1 Implement Electronic Health Record system.	10.1.1 Implement acute Electronic Health Record system, in the new National Children's Hospital, and prepare to roll out nationwide, creating a digital environment in hospitals and supporting improved patient safety and health outcomes.	2018 and ongoing
	10.1.2 Commence implementation of the Electronic Health Record system for community-based care to connect records across the system and support integrated models of care.	2018 and ongoing
10.2 Implement community care solutions.	10.2.1 Commence implementation of community care solutions to enhance information-sharing, empower patients to access their own information, and support the development of digital health services. This will include implementation of ePrescribing and summary care records.	2018 and ongoing
10.3 Develop new ICT systems to support the health workforce.	10.3.1 Provide a digital workplace to enable health service professionals to operate in a modern digitised environment.	2018 and ongoing
	10.3.2 Develop clinical ICT systems, to provide the required infrastructure to support effective clinical decision making.	2018 and ongoing
	10.3.3 Provide telehealth solutions to support delivery of care in the community closer to patients and their families.	2018 and ongoing
10.4 Develop new ICT infrastructure to support integrated care.	10.4.1 Implement financial/corporate systems to improve accountability and ensure money can follow patient activity.	2018 and ongoing
	10.4.2 Provide cloud infrastructure for the whole health service to support a more secure and safe data environment.	2018 and ongoing
	10.4.3 Provide for improved information architecture, including standards, information and identity to underpin the delivery of integrated care.	2018 and ongoing
10.5 Implement the digital maternity system.	10.5.1 Implement the digital maternity system to support the National Maternity Strategy's aims and goals.	2018 and ongoing

10.2 Data, Research and Evaluation

In the future, a strong approach to data collection, analysis and management will underpin the delivery of our health and social care services.

Our priorities are to:

- Publish a health information policy framework;
- Consolidate and invest in data and R&D infrastructures and capabilities;
- Establish an R&D forum in health and social care; and
- Design an evaluation programme for Sláintecare.

Successful implementation of the Sláintecare vision will require robust knowledge and information drawing on good quality, timely and relevant data sources, and a vibrant research and development and health analytics culture. Health information and research, and the infrastructure and skills required for their generation and exploitation, must become a national priority.

Reform, if it is to be effective and to address expectations, will require solid evidence. However, at present health information is often fragmented and not harnessed sufficiently. The roll out of the Individual Health Identifier and the opportunity to implement the eHealth strategy means it is now the right time to develop a new health information policy for Ireland that can connect the legislative requirements, governance and operational arrangements needed to exploit knowledge and information in a modern health service.

As an immediate priority, a national health information policy framework will be finalised to provide transparency, consistency and clarity as to how health information is to be processed in healthcare and health-related settings.

Health research is a key factor in promoting the health of the population, combating disease, reducing disability and improving the quality of care. It brings learning from international best practice and appropriate evaluation techniques and application. This evidence is essential to the creation of a fairer, more efficient health system and for the delivery of better health outcomes. In an environment that is dynamic and changing, health research in Ireland needs to be positioned to make its greatest contribution for patients, the health system and the economy.

A new broad-based national health research strategy will be developed by the Department of Health, to develop and connect the health research system in Ireland. Critical to these deliberations will be the establishment, by the Department of Health, of a Research and Development Forum, which will include representation from across the health, health research and innovation system.

In parallel to these initiatives, we will continue to consolidate and invest in data and research and development infrastructures and capabilities. In addition, a strong programme of evaluation will be implemented to assess the reform programme and its contribution to the performance of the health system during the 10-year implementation period.

Table 10 continued: *Implementation of Strategic Action 10*

Actions	Sub-Actions	Delivery Date
Strategic Action 10: Put in place a modern eHealth infrastructure and improve data, research and evaluation capabilities.		
10.6 Develop information and research, including evaluation of 10-year Sláintecare reforms.	10.6.1 Publish a health information policy framework.	2019
	10.6.2 Establish an R&D forum in health and social care to input into the development of a new national health research strategy.	2019–2020
	10.6.3 Consolidate and invest in data and R&D infrastructure and capabilities to ensure that evidence is at the core of routine decision making.	2018–2020
	10.6.4 Design an evaluation programme for the overall 10-year Sláintecare reforms.	2019

Appendices

Appendix I: Table of Actions

Actions	Sub-Actions	Delivery Date
Strategic Action 1: Improve governance, performance and accountability across the health service.		
1.1 Develop national governance and structures.	1.1.1 Appoint a Chair of the new HSE Board.	2018
	1.1.2 Legislate for a new governing board to strengthen oversight and performance of the HSE.	2018
	1.1.3 Appoint Board for the HSE.	2018
	1.1.4 Define and agree a new organisational and operational structure for the future reconfigured health service, including respective roles of the Department of Health, the HSE and national and regional integrated care organisations.	2019
1.2 Develop regional governance and structures.	1.2.1 Consult and finalise decisions on the geographic alignment of Hospital Groups and Community Healthcare Organisations.	2018
	1.2.2 Introduce modifications to Hospital Groups and Community Health Organisations to ensure geographic alignment and develop processes for collaboration and integrated performance management at a regional level on an interim administrative basis, in advance of regional integrated care organisations.	2019
	1.2.3 Devolve decision making and autonomy in line with demonstrated functionality and performance at regional level.	2019 and ongoing
1.3 Legislate for revised health structures.	1.3.1 Introduce legislation for revised health structures, incorporating respective roles for the national centre and regional integrated care organisations and the outcome of the Independent Review Group on Voluntary Organisations.	2021
1.4 Develop clinical governance and patient safety policy.	1.4.1 Commence the process of introducing an overarching governance framework that integrates clinical governance with corporate governance, setting out the roles, responsibilities and accountabilities of organisations and individuals within the public health service.	2019
	1.4.2 Progress the Patient Safety Bill to encompass clinical audit, reporting of serious events to the regulator, mandatory open disclosure for serious events and extension of HIQA's remit to the private sector.	2018/19
	1.4.3 Progress the Patient Safety (Licensing) Bill to include clinical governance and patient safety operating frameworks across hospital, community and other clinical services and implement licensing scheme.	2021

Actions	Sub-Actions	Delivery Date
	1.4.4 Implement patient safety operating frameworks across hospital, community and other clinical services.	2021
	1.4.5 Develop and expand systems to capture patient experience.	2019
	1.4.6 Implement a patient safety, complaints and advocacy policy.	2018
	1.4.7 Implement the National Action Plan on Antimicrobial Resistance.	2020
Strategic Action 2: Put in place an effective implementation and governance structure for Sláintecare and establish a Sláintecare transition fund to support key reforms.		
2.1 Establish Sláintecare implementation supports.	2.1.1 Establish a Sláintecare Programme Office and recruit staff, including an Executive Director.	2018
	2.1.2 Put in place dedicated staff and resources in the Department of Health and HSE to advance each strategic action set out in this Implementation Strategy.	2018
2.2 Establish Sláintecare governance structures.	2.2.1 Establish a Sláintecare Advisory Council, to include clinical and health service leaders, patient/service users, international health experts and change management experts.	2018
	2.2.2 Establish a High Level Delivery Board and a Sláintecare Executives Task Force.	2018
2.3 Review and update Sláintecare Implementation Strategy.	2.3.1 Publish a detailed action plan within three months of the Executive Director taking office and on a rolling basis thereafter.	2018
	2.3.2 Publish progress reports on a biannual basis.	2019 and ongoing
2.4 Develop engagement with stakeholders.	2.4.1 Launch a comprehensive engagement plan for the public and patients/service users.	2018
	2.4.2 Launch a comprehensive engagement plan for the health workforce.	2018
2.5 Establish a transition fund.	2.5.1 Design, establish and resource a multi-annual transition fund with appropriate governance to support the change process.	2018/19
Strategic Action 3: Improve population health-based planning and develop new models of care to deliver more effective and integrated care.		
3.1 Develop a citizen care masterplan for the health service.	3.1.1 Develop the first iteration of a citizen care masterplan for the health service based on population health principles, to underpin key strategic objectives and guide detailed service planning.	2019
3.2 Support the health and wellbeing of the population.	3.2.1 Publish the Healthy Ireland Outcomes Framework.	2018
	3.2.2 Sustain cross-governmental support for the implementation of Healthy Ireland- A Framework for improved Health and Wellbeing 2013–2025.	2018 and ongoing

Actions	Sub-Actions	Delivery Date
3.3 Develop models of care and establish an integration fund.	3.3.1 Develop a National Framework for Models of Care Design.	2019
	3.3.2 Prioritise and roll out models of care in accordance with overall Government policy and health system priorities.	2019
	3.3.3 Design, establish and launch an integration fund to test and scale up new models of care on a significant scale with a focus on community care and integration of care across all settings.	2019
3.4 National clinical service reviews.	3.4.1 Develop a best practice national framework for the conduct of clinical service reviews, to ensure a consistent and evidence based approach is taken when reviewing particular services.	2019
	3.4.2 Complete the national review of specialist cardiac services.	2019
Strategic Action 4: Expand community-based care to bring care closer to home.		
4.1 Develop a plan for the organisation and operation of community-based services in line with the overall citizen care masterplan and new models of care.	4.1.1 Determine how to organise and operate community-based services based on population need and size, in a way that clearly identifies patient pathways for accessing services.	2019
	4.1.2 Develop a methodology for determining the resources and services required in the community based on population need and size and in line with action 4.1.1.	2020
4.2 Expand workforce and infrastructure capacity in line with the Health Service Capacity Review and the NDP.	4.2.1 Assess overall workforce required to deliver community-based models of care.	2018 and ongoing
	4.2.2 Establish more primary care centres and develop a new programme of investment in community-based diagnostics facilities.	2018 and ongoing
	4.2.3 Invest in new community care beds.	2018 and ongoing
4.3 Expand and develop services.	4.3.1 Expand capacity in general practice and community nursing to manage chronic disease in the community (see actions 4.4.1 and 9.2.1).	2018 and ongoing
	4.3.2 Initial expansion, both in terms of the size and scope, of community intervention teams (including the Outpatient Parenteral Antimicrobial Therapy (OPAT) service).	2018
	4.3.3 Implementation of the Palliative Care Development Framework.	2018 and ongoing

Actions	Sub-Actions	Delivery Date
4.4 Assess contracts and work practices.	4.4.1 Determine and progress priority objectives for GP contractual reform, with particular focus on enhanced identification and management of chronic disease initially for GMS/GP visit card population.	2018
	4.4.2 Evaluate the GP chronic disease management programme and consider scope for extension to whole population.	2020
	4.4.3 Assess existing health professionals' contracts in the context of enabling a shift to significantly enhanced community-based care, including an examination of scope for extended working hours.	2019
	4.4.4 Develop and begin to roll out new contracts or changes to contracts/work practices.	2020
4.5 Accelerate Integrated Care Programmes.	4.5.1 Implementation of integrated care programmes focused on chronic conditions and older people through the Integration Fund.	2019 and ongoing
Strategic Action 5: Develop and modernise the acute care system to address current capacity challenges and increase integration between the hospital sector and community-based care.		
5.1 Tackle unacceptably long waiting times and emergency department pressures.	5.1.1 Develop multi-annual Inpatient/Day Case Waiting List Action Plan.	2019
	5.1.2 Develop multi-annual Outpatient Waiting List Action Plan.	2019
	5.1.3 Develop multi-annual Unscheduled Care Plan, the first element of which will be the implementation of measures at acute hospital and community level to achieve an initial increase in capacity.	2018
	5.1.4 Carry out a review of ED, MIU, MAU and similar unit utilisation to support unscheduled care planning for alternative pathways.	2019
	5.1.5 Develop a framework to support integrated waiting lists, including the identification of potential ICT solutions, and reporting and publication mechanisms.	2019
	5.1.6 Develop policy framework for evidence-based waiting list guarantee, incorporating consideration of legislation to support the guarantee.	2019

Actions	Sub-Actions	Delivery Date
5.2 Develop hospital services within the national clinical strategy.	5.2.1 Finalise Hospital Group strategic plans to direct future service delivery, in line with strategic guidance and in parallel with other elements of reform and establish annual reporting of progress.	2019
	5.2.2 Develop a national clinical strategy to form the basis of all national and regional planning, using a robust methodology and taking a collaborative approach, involving key stakeholders and patient groups.	2020
	5.2.3 Implementation of the Ambulance Reform Plan in accordance with agreed implementation plan.	2018 and ongoing
5.3 Expand capacity in line with the Capacity Review and the NDP.	5.3.1 Identify opportunities to open additional beds in existing hospitals.	2018-2021
	5.3.2 Develop criteria, selection and approval processes for a small number of major investments in new ambulatory elective hospitals in major population centres.	2019
	5.3.3 Conduct detailed planning at Hospital Group level and provide national approval and funding for the development of additional capacity in the context of Hospital Group strategic plans.	2020
	5.3.4 Conduct detailed planning to support the development of additional diagnostics capacity in the context of Hospital Group strategic plans and community care needs, with national approval and funding.	2020
5.4 Implementation of existing national strategies and policies.	5.4.1 Implement the National Maternity Strategy in accordance with agreed implementation plan.	2018 and ongoing
	5.4.2 Implement the National Cancer Strategy in accordance with agreed implementation plan.	2018 and ongoing
	5.4.3 Implement the National Neurorehabilitation Strategy in accordance with agreed implementation plan.	2018 and ongoing
	5.4.4 Implement the National Trauma Strategy in accordance with agreed implementation plan.	2018 and ongoing
Strategic Action 6: Expand eligibility on a phased basis to move towards universal healthcare and support a shift to community-based care.		
6.1 Review user charges.	6.1.1 Review the basis for existing hospital and medication charges, their contribution and their policy relevance and devise a framework of options for future changes to be considered in the context of the annual budgetary process.	2019
6.2 Review current eligibility framework.	6.2.1 Review the current eligibility framework for all services to inform the pathway to achieving the vision of universal healthcare.	2019

Actions	Sub-Actions	Delivery Date
	6.2.2 Develop a policy proposal and roadmap for achieving universal eligibility which will consider the following (i) the range of services to be provided in the community on a universal basis (ii) the rationale and methodology for phased eligibility for the services, and (iii) the co-payment or cost-sharing models, financial mechanisms and phasing to ensure that the system is properly aligned to meet the increased demand that is expected. This analysis will then determine the preferred future eligibility framework to deliver universal access to healthcare.	2020
	6.2.3 Introduce legislation to ensure that eligibility to health and social care services has a statutory basis.	In line with rollout above.
6.3 Develop homecare services.	6.3.1 Introduce a statutory scheme for homecare.	2021
Strategic Action 7: Reform the funding system to support new models of care and drive value to make better use of resources.		
7.1 Develop new funding allocation models.	7.1.1 Expand activity based funding for inpatient and day cases to other acute hospitals.	2018
	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.	2019
	7.1.3 Examine the use of ABF for outpatient services.	2018
	7.1.4 Advance the community-based costing programme to measure unit costs and productivity in community-based services.	2019
	7.1.5 Develop a plan for moving to a system of population-based funding in the medium term.	2019
	7.1.6 Finalise proposals for personalised budgets in disability services.	2018
7.2 Develop multi-annual budgeting.	7.2.1 Develop proposals for multi-annual budgeting in the healthcare system to facilitate planning and strengthen financial management.	2019
7.3 Invest in data and information.	7.3.1 Invest in a multi-annual programme of work with key health stakeholders and academic researchers to develop an activity and cost database for health and social care in Ireland.	2018 and ongoing
7.4 Increase productivity.	7.4.1 Implement a multi-annual three-year productivity plan to run 2019–2021, to include service planning targets.	2019-2021
	7.4.2 Undertake a governance review of the drugs approval and procurement process.	2018

Actions	Sub-Actions	Delivery Date
Strategic Action 8: Implement measures to address inequities in access to public acute hospital care based upon the output of the independent impact assessment.		
8.1 Review impacts of removing private practice from public hospitals.	8.1.1 Strengthen the governance and operational framework for monitoring and management of private practice in public hospitals to ensure contractual compliance.	2018
	8.1.2 Complete impact analysis by the Independent Review Group to examine the removal of private practice from public acute hospitals.	2018
	8.1.3 Consider the recommendations of the Independent Review Group on impact assessment and seek Government decision.	2018
Strategic Action 9: Build a sustainable, resilient workforce that is supported and enabled to deliver the Sláintecare vision.		
9.1 Accelerate implementation of Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning.	9.1.1 Establish structures to implement the Workforce Planning Framework (including the Cross-departmental Group and the joint Department of Health/HSE/ Tusla Workforce Planning Group) and develop communications and engagement strategies with the workforce and other key sectors and stakeholders.	2018
	9.1.2 Resource the HSE to effectively lead on strategic health workforce planning for the health sector.	2018
	9.1.3 Identify and commence implementation of priority workforce planning projects to test, evaluate and refine the proposed approach.	2018
9.2 Implement existing workforce strategies.	9.2.1 Develop and introduce a new model of community nursing and midwifery on a phased basis, commencing with the establishment of a demonstrator site, to support a decisive shift to integrated service delivery.	2018 and ongoing
	9.2.2 Expand and develop the role of advanced nurse practitioners to tackle priority service deficits and delays.	2018 and ongoing
	9.2.3 Fully implement the first and second phases of the work of the Taskforce on Safe Nurse Staffing and Skill Mix. Commence work on the development of this model to determine the appropriate community nursing workforce.	2018 and ongoing
	9.2.4 Implement the recommendations in the Strategic Review of Medical Training and Career Structures.	2018 and ongoing

Actions	Sub-Actions	Delivery Date
9.3 Utilise the Workforce Planning Framework to support reform implementation.	9.3.1 Complete short-term workforce planning and agree priority pilots, focusing initially on primary care and community-based care expansion.	2019
	9.3.2 Develop an integrated, detailed workforce plan to deliver model of care and productivity requirements and: i) identify key actions in relation to human resources, industrial relations, organisational development and education; ii) agree actions with higher education institutions; and iii) agree actions with staff representative bodies and staff.	2019
9.4 Enhance leadership and accountability.	9.4.1 Continue to build and enhance leadership development, capacity and capability through the Health Service Leadership Academy.	2018 and ongoing
	9.4.2 Introduce performance management systems in areas of the public health sector where they are not already in place to ensure that managers are held accountable for resources.	2019
9.5 Build organisational capacity.	9.5.1 Introduce skills development programmes to support local reform implementation, with a particular focus on enhanced team working and integrated care.	2019
Strategic Action 10: Put in place a modern eHealth infrastructure and improve data, research and evaluation capabilities.		
10.1 Implement Electronic Health Record system.	10.1.1 Implement acute Electronic Health Record system, in the new National Children's Hospital, and prepare to roll out nationwide, creating a digital environment in hospitals and supporting improved patient safety and health outcomes.	2018 and ongoing
	10.1.2 Commence implementation of the Electronic Health Record system for community-based care to connect records across the system and support integrated models of care.	2018 and ongoing
10.2 Implement community care solutions.	10.2.1 Commence implementation of community care solutions to enhance information- sharing, empower patients to access their own information, and support the development of digital health services. This will include implementation of ePrescribing and summary care records.	2018 and ongoing

Actions	Sub-Actions	Delivery Date
10.3 Develop new ICT systems to support the health workforce.	10.3.1 Provide a digital workplace to enable health service professionals to operate in a modern digitised environment.	2018 and ongoing
	10.3.2 Develop clinical ICT systems, to provide the required infrastructure to support effective clinical decision making.	2018 and ongoing
	10.3.3 Provide telehealth solutions to support delivery of care in the community closer to patients and their families.	2018 and ongoing
10.4 Develop new ICT infrastructure to support integrated care.	10.4.1 Implement financial/corporate systems to improve accountability and ensure money can follow patient activity.	2018 and ongoing
	10.4.2 Provide cloud infrastructure for the whole health service to support a more secure and safe data environment.	2018 and ongoing
	10.4.3 Provide for improved information architecture, including standards, information and identity to underpin the delivery of integrated care.	2018 and ongoing
10.5 Implement the digital maternity system.	10.5.1 Implement the digital maternity system to support the National Maternity Strategy's aims and goals.	2018 and ongoing
10.6 Develop information and research, including evaluation of 10-year Sláintecare reforms.	10.6.1 Publish a health information policy framework.	2019
	10.6.2 Establish a R&D forum in health and social care to input into the development of a new national health research strategy.	2019–2020
	10.6.3 Consolidate and invest in data and R&D infrastructure and capabilities to ensure that evidence is at the core of routine decision making.	2018–2020
	10.6.4 Design an evaluation programme for the overall 10-year Sláintecare reforms.	2019

Appendix 2: List of Abbreviations

ABF	Activity-based funding
CHN	Community Healthcare Networks
CHO	Community Healthcare Organisations
COPD	Chronic obstructive pulmonary disease
ED	Emergency Department
EHR	Electronic Health Record
ESRI	Economic and Social Research Institute
GMS	General medical services
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
MAU	Medical Assessment Unit
MIU	Minor Injuries Unit
NDP	National Development Plan
OPAT	Outpatient parenteral antimicrobial therapy
PCT	Primary Care Teams
RCSI	Royal College of Surgeons Ireland

Appendix 3: Glossary

Activity Based Funding (ABF)

ABF means that hospitals are paid for the actual quantity and quality of care they deliver to patients, thereby enabling the hospitals to see clearly the link between money and the work they do. In 2016 the HSE introduced ABF for hospital care for inpatient and day-case services. Targets for hospital activity are set centrally by the HSE and prices are set by the Healthcare Pricing Office.

Acute Floor Model

The 'Acute Floor' concept relates to patients presenting for unscheduled care through integrated acute services within Model 3 or 4 hospitals. It comprises a co-located emergency department, acute medical unit, coronary care unit, acute stroke unit, intensive care unit, high dependency unit, interventional cardiology suite, acute surgical assessment unit and clinical decision unit[26].

Acute Medical Unit (AMU) / Acute Medical Assessment Unit (AMAU) / Medical Assessment Unit (MAU)

An AMU / AMAU / MAU is a facility with beds separate from ED whose primary function is the immediate and early specialist management of acutely unwell adult patients who present to, or from within, a hospital requiring urgent medical care. AMU/AMAUs enable appropriate streaming of patients away from ED to improve clinical care and the patient experience. MAUs have the potential to provide more integrated care for patients with urgent medical need, delivered in a more appropriate setting, by staff with the correct skills mix and expertise.

Community Healthcare Organisations[27] (CHO)

Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group', published in October 2014, sets out how health services, outside of acute hospitals, will be organised and managed. Known as community healthcare services, these services include primary care, social care (services for older people and for persons with a disability), mental health and health & wellbeing.

Community Intervention Team (CIT)

Specialist, nurse led health professional team which provides a rapid and integrated response, in the home, residential setting or in the community, to patients with an acute episode of illness who require enhanced services/ acute intervention for a defined short period of time.

General Practitioner (GP)

Doctors working in primary care in group practices, primary care centres, single practices and health centres, who provide a broad service to their patients on all health issues, and may refer patients to see hospital consultants if more specific investigation or treatment is required.

GP Practice Nurse (PN)

Registered general nurse who is privately employed by a GP to provide a holistic nursing model of care to the population of a general practice. The PN reports clinically to the GP and is responsible for her/his individual scope of practice.

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[26] https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/report-of-the-national-acute-medicine-programme.pdf

[27] https://www.hse.ie/eng/services/publications/corporate/choreport.html

Home Care Package (HCP)

Administrative scheme, operated by the HSE, which aims to help older people who need medium to high caring support to continue to live at home independently as long as possible.

Hospital Groups[28]

The hospitals in Ireland have been organised into seven Hospital Groups since 2013[29]. The services delivered include inpatient scheduled care, unscheduled / emergency care, maternity services, outpatient and diagnostic services. The Group Chief Executive of each Hospital Group reports to the National Director for Acute Services and is accountable for their Hospital Groups planning and performance under the HSE Accountability Framework (2015).

Health Service Executive (HSE)

The HSE provides all of Ireland's public health services in hospitals and communities across the country.

Health Services/Healthcare

In this report, health services and healthcare are taken to mean both health and social care services. References to health accord with the World Health Organization's definition of that term: 'health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[30]

Model of Care

A model of care defines the way health services are delivered and describes best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.[31]

Public Health Nurse (PHN)

Nurses based in local health centre and assigned to cover specific geographical areas, who provide a range of health care services in the community.

Service User

Service user" includes "patient," "resident," "client" and "consumer". Some terms may not be appropriate or preferred when referring to individuals who access healthcare services depending on the care setting or sector. These terms are often used interchangeably in healthcare. For clarity and consistency, the term "service user" - intended to be inclusive of all terms is used throughout this document[32].

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[28] https://www.hse.ie/eng/services/list/3/acutehospitals/hospitalgroups.html

[29] The Establishment of Hospital Groups as a transition to Independent Hospital Trusts

[30] Preamble to the Constitution of the World Health Organization, as adopted by the International Health Conference, New York, 19 June–22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948.

[31] NSW Agency for Clinical Innovation (2013) *Understanding the process to develop a model of care – An ACI framework*, available at https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf.

[32] https://www.hse.ie/eng/about/who/qid/governancequality/board-role-improving-quality-and-safety/glossary.pdf