Chapter 14

Health Service Executive

14.1 Change Management in the HSE

The HSE, which was established in 2005, sought to create an integrated health service by combining the management and delivery of health services, previously delivered by the Eastern Regional Health Authority, ten regional health boards and a number of other organisations[42], within one authority.

Initially, progress on integration was slow. A Chief Executive Officer was not appointed until August 2005 and a settled management structure and team took time to develop. The former Health Board Chief Executive Officers were retained until the middle of 2005 and continued to manage services within the old geographic areas. While this was a practical necessity, it did nothing to advance service integration.

After a new CEO was appointed, the Board set about establishing a new organisational structure and an associated delivery system. Three service delivery directorates were created

- The National Hospitals Office (NHO) which manages acute hospital services in 50 hospitals nationally.
- The Primary, Community and Continuing Care (PCCC) Directorate which manages primary and community services.
- The Population Health Directorate which is responsible for promoting and protecting the health of the population.

In addition, support services such as finance, human resources and ICT services were organised on a national basis.

Notwithstanding the new national reporting lines established by the HSE, many of the administrative and service delivery structures at local level did not change significantly. Thus, for example, budgeting and financial accounting still continued to operate through the former health board systems, since a unified national accounting system was not in place.

In December 2006, the HSE launched a Transformation Programme (2007-2010) with five priorities

- to develop integrated services across all stages of a patient's care journey
- to configure PCCC services so that they deliver optimal and cost-effective results
- to configure hospital services to deliver optimal and cost-effective results
- to implement a model for the prevention and management of chronic illness
- to implement standards-based performance measurement and management throughout the HSE.

Audit Concern

I set out to examine progress under the programme and the steps being implemented to support the change effort.

The Accounting Officer supplied me with a report on the progress achieved up to mid 2008.

[42] Office for Health Management, Health Board Executive, National Disease Surveillance Centre, GMS (Payments) Board, Health Service Employers Agency, and Comhairle na nOspidéal.

Service Integration

Many health services are fragmented, disjointed and difficult for patients and service users to access and easily find their way through. Consequently, service integration is needed to provide organised services that are seamlessly connected, so that people who need access to more than one service can move easily through the entire care system. At this point, some work has been undertaken on the development of an integrated care journey for patients accessing health and social care services. This work entailed

- an analysis of one complex care journey - the respiratory journey
- a review of national and international best practice
- an examination of a range of reports commissioned on the health service over recent years, including the *Acute Hospital Bed Capacity Review*[43], *Primary Care Strategy*[44] and the configuration of services in the North East[45].

This process has informed a draft service delivery model which was presented to the HSE Management Team in December 2007 and described, at a high level, the changes in arrangements, structures and activities that would be required to provide more integrated services.

The model has been used as a basis for consultation with clinicians and managers within the system to determine how the approach to integration envisaged could best be advanced. Following approval from the Board of the HSE and the Department of Health and Children, an Integrated Service Delivery Change Programme was established in June 2008. The aim of this change programme is to implement a single national approach to care, with strengthened local responsibility for service delivery.

Some of the specific organisational changes envisaged in the programme include

- integration of the service delivery components of the different directorates into a single service directorate which would have operational responsibility for all hospital and community based services
- integration of the organisation's current planning functions
- clinical leadership of services.

At area level, clinical and support structures will be modified to reflect these changes. This will involve the appointment of Area Directors who will have operational responsibility and authority to deliver all hospital and community care services and personal and social services in their specific areas.

Three other integration objectives being addressed are

- Integrated discharge planning - a 24 hour, 7 day process for timely and safe discharge of patients from one service area (usually acute hospitals) to another that ensures that patients receive care in the most appropriate setting.
- Establishment of an information governance framework that will enable the sharing of appropriate patient information between different parts of the service.
- Piloting a national client index which will allow service providers link the available information to the patient/client.

The implementation of the Integrated Service Delivery Change Programme is scheduled to take place over the next 18 months. The Accounting Officer has stated that in the meantime integration of services was

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[43] *Acute Hospital Bed Capacity Review* (HSE) PA Consulting 2007
[44] *Primary Care Strategy* (Department of Health and Children) 2001
[45] *An action plan for services in the North East* (HSE) Teamwork Management Services 2006

beginning to show tangible benefits with the functioning of some Primary Care Teams and community based supports for people discharged from hospital.

Configuration of Primary, Community and Continuing Care Services

There is inappropriate use and over-reliance on acute hospital services which often creates inconvenience for patients and clients and unnecessarily overloads the hospitals. The Health Strategy 2001[46] had set out a new direction for primary care as the central focus of the delivery of health and personal social services in Ireland. It envisaged a team-based approach to service provision, aimed at providing a significant range of client services as close as possible to people's homes, while maintaining high quality and safety standards.

The aim is to address local delivery through multidisciplinary Primary Care Teams (PCTs) and local diagnostic services. Each team will serve a population of approximately 8,000 people. Typically, a team will comprise GPs, practice nurses, public health nurses, occupational therapists, physiotherapists and home help personnel. Depending on local need, other disciplines such as speech and language therapists, psychologists, social workers, community welfare officers and dieticians may also be included.

A wider network of health and social care professionals will be formed who will work with these PCTs. The new teams and networks will facilitate structured approaches to chronic disease management, multidisciplinary working and integration between primary and secondary healthcare and acute hospital services.

Primary and Secondary Healthcare

Primary care is the medical care a patient receives upon first contact with the healthcare system, before referral elsewhere in the system. It is also an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services.

Secondary care is a service provided by medical specialists who generally do not have first contact with patients. Many, but not all of these specialists are hospital based. An objective of the PCT model is to give the GP in the primary care setting direct links to the specialist services that are currently only accessible when the patient enters the acute hospital system.

In regard to the progress to date the Accounting Officer stated that a pilot project involving ten PCTs was initiated in 2003. By the end of December 2007, there were 40 PCTs in development, including the original ten. The target set for 2008 is to have 97 PCTs operational and to progress the development of a further 100 PCTs. The eventual aim is to have a total of 530 PCTs and 134 Health and Social Care Networks.

Staffing the Teams

The development and roll out of PCTs and Health and Social Care Networks requires significant reconfiguration of staff within existing primary, community and continuing care services. So far, approximately 630 allied health professionals have been assigned to PCTs. Almost all of these staff were already working in the community, delivering primary care services but not on a formal team basis. In addition, there are over 240 GPs participating in clinical meetings in the PCTs under development, together with a number of Practice Nurses and other GP practice resources.

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[46] *National Health Strategy - Quality and Fairness* (Department of Health and Children) 2001

In the case of specialist services which have traditionally been provided on a care group basis[47], transition plans are currently being developed to assist with the reconfiguration of care group specialist staff to PCTs and Networks. Work has commenced with the National Care Group for Mental Health Services on the required principles for reconfiguration of staff.

Location of Teams

PCTs to be effective need to be located together in primary care centres that will accommodate multi-disciplinary staff, GPs and contracted service providers.

In regard to their provision the Accounting Officer informed me that some of these centres will be in premises owned or leased by the HSE and a number of these are at an advanced stage of development. It is intended that other facilities will be developed privately. In this respect, the HSE sought submissions in late 2007 from individuals or companies who are developing or are planning to develop health facilities in 131 locations with the aim of facilitating the delivery of primary health care in conjunction with local GPs. It has short-listed the applications received, placing an emphasis on GPs being located in the primary care centres. The HSE is initially progressing the 20 highest priority sites and, at this point, the HSE Board has authorised the leasing of four primary care centres. It is expected that agreement to lease a total of 40 centres will be reached by the end of the year.

As well as progressing the remainder of the submissions, the HSE intends advertising for further submissions from individuals or companies to develop health centres in other locations.

Hospital Services Configuration

The current configuration of acute hospitals services evolved during the former health board period. With the establishment of the HSE there was an opportunity to look strategically at the configuration and development of the country's hospitals. The aim is to provide a full range of services that fit appropriately into the integrated care model and are evidence-based, efficiently run and quality assured. The intention is to encourage and support the move to advanced primary care delivery and chronic illness prevention and care.

This reconfiguration aims to ensure the provision, within each hospital network[48], of comprehensive 24/7 medical and surgical services and planned day-case activity and diagnostics.

- The majority of patients, those who require only a routine level of urgent or planned care, will be treated at home or in a centre as close to home as possible.
- The minority of patients, who require emergency or more complex planned care, will be treated in regional or national centres of excellence, where all the relevant clinical expertise is concentrated so that consultant-led, high quality care is available around the clock.

Due to the nature and scale of the change envisaged it was necessary to undertake a number of independent reviews at the scoping stage of the project lifecycle.

The direction of future hospital services described above has guided the work of these reviews. An Acute Hospital Bed Capacity Review[49] has been completed and its findings are informing the ongoing work on improving hospital services. A number of other hospital service reviews have been completed (South and

[47] Mental Health, Older People, Disabilities, Children Services, Palliative Care and Social Inclusion.
[48] For this purpose, a network means a group of hospitals in a geographic area which between them are capable of providing a full range of services other than national specialist services.
[49] *Acute Hospital Bed Capacity Review* (HSE) PA Consulting 2007.

Mid West) or are nearing completion. A detailed National Review of Adult Critical Care[50] services in Ireland commenced in May and will be completed in early September 2008. This review is considered a critical component of the Transformation Programme. Overall, these reviews will provide guidance on governance arrangements within hospitals and between hospitals.

Specific Hospital Services

Specific service transformation projects in the areas of maternity services and paediatrics are also planned.

In the area of maternity services in the Greater Dublin Area a review has been undertaken and the final report[51] is now being considered by the HSE to determine how its recommendations might best be progressed.

In the area of paediatrics, a decision has been taken to establish a new National Paediatric Hospital. The Development Board for the new Hospital is currently progressing the appointment of a project team, CEO and Clinical Director.

A number of additional paediatric reviews have also been undertaken

- A report on the provision of paediatric neurosurgery[52] services has been completed. This is currently being considered by the HSE.
- A review of the requirement for the development of paediatric critical care facilities and services in the Dublin children's hospitals[53] between now and the completion of the National Paediatric Hospital has been undertaken and is currently being considered by the HSE.
- A new model of care as defined by international best practice for the National Paediatric Hospital is being developed.

Reconfiguration of Hospital Services in the North East

Initially, as part of integrated service implementation the hospital services in the North East were chosen for reconfiguration. Based on a report on the development of services in the area[54], a plan of the detailed changes envisaged was drawn up in 2007. While the longer-term plan for the North East entails the establishment of a single regional hospital, the current Transformation Programme (2007-2010) is focusing on the work required to centralise acute and complex care from five to two acute hospitals within the period of the Programme. A detailed planning exercise for the first phase of the configuration of services in the North East has been completed and a draft interim report was produced and distributed to key stakeholders in April for consideration. This report focused primarily on the planned changes in the Cavan/Monaghan hospital group.

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[50] *Independent Review of Critical Care Services* (HSE) Prospectus (underway).
[51] Work in progress. *Independent Review of Maternity and gynaecological services in the Greater Dublin Area.* (HSE) KPMG 2008.
[52] *Review of Paediatric Neurosurgery Services* (HSE) Howarth Consulting (unpublished).
[53] *Review of the immediate requirement for the development of paediatric critical care facilities and services in the Dublin children's hospitals* (HSE) DNV (unpublished).
[54] *An action plan for services in the North East* (HSE) Teamwork Management Services 2006.

Acute and Complex Care

Acute care is medical or surgical treatment of relatively short duration, usually in a hospital, for patients having an episode of illness or injury. Complex care refers to the specialist care provided to patients with multiple clinically advanced illnesses who may require periods of acute care as well as ongoing managed care, for example a patient with chronic obstructive pulmonary disease and cancer.

The timelines for delivering these changes are tentative, but implementation is anticipated during the period July to December 2008. A number of critical dependencies will need to be managed as part of the overall project management including putting appropriate community support in place, enhancing the ambulance service, developing the infrastructure in Drogheda and resolving human resources/industrial relations issues.

Staged Interim Reports will provide additional planning details for all the remaining service changes. A further planned Interim Report was scheduled for presentation to the North East Regional Partnership Forum by the end of August 2008. In an effort to ensure full clinical engagement in the process, nine Clinical Networks have been established in the North East. Their responsibilities are to shape and validate the changes outlined above. Interim Joint Acute Hospitals and PCCC governance structures for delivering the change programme in the North East are currently under review in order to progress local delivery of the planned service changes.

Population Health and Chronic Illness Prevention

The HSE has completed the first stage of a national population health strategy, which sets out an approach to promoting and protecting health. Work is underway on defining the priorities for implementation, actions to be undertaken and on setting up a process for implementation.

A key aspect of the strategy is chronic illness prevention and management. This is being targeted because chronic illness accounts for two thirds of medical emergencies and 5% of inpatients with chronic illness use 40% of all bed days. As the population gets older, chronic illness becomes a more significant factor when planning health services. During 2008 a chronic illness framework was developed by the HSE which sets out, at a high level, an overall approach to dealing with the challenges of chronic illness including prevention, diagnosis, early intervention and patient self-management. This framework will be aligned with the Department of Health and Children Policy Framework for the Management of Chronic Diseases[55].

Other actions being taken include

- the development of a five-year Action Plan on Obesity
- the commissioning of an Infant Feeding Survey, as part of an action plan on breastfeeding.

One of the other HSE priorities for protecting health is the control and management of healthcare associated infection. This is being addressed through the establishment of a National Steering Committee and a national infection control action plan.

Local infection action plans are also being developed. Some 52 infection control posts have been funded, including consultant microbiologist, antibiotic pharmacists, surveillance scientists and infection control nurses. Eight regional infection control committees have been set up and an infection control e-learning module has been developed for staff. Guidelines are in place for hospital staff, aimed at keeping patients

[55] *Tackling Chronic Disease – A Policy Framework for the Management of Chronic Diseases* (2008).

and their families fully informed about MRSA. A GP education programme on the prescribing of antibiotics and related drugs has also been developed and is being rolled out to GPs.

Performance Management

A performance measurement system has been developed at corporate level and is operational. This, together with a service and business planning process and associated monitoring arrangements is part of the routine business of the organisation.

A HealthStat system which provides detailed performance measurement down to individual clinical level is now operational for hospitals and the project will be extended to the PCCC area. This system will be central to establishing a performance management culture in the HSE.

Managing the Change

Audit Concern

Implementing a fundamental change programme on the scale envisaged necessitates a complex dynamic process for engagement, implementation and feedback. I asked the Accounting Officer about how the change process was being managed particularly in relation to risk management, the sequencing of projects and their piloting, and the arrangements for communication and engagement with stakeholders.

The Accounting Officer informed me that the HSE Management Team acts as the Steering Group for the overall change programme. Individual members of this Team are the sponsors for particular sub-programmes and are supported by Programme Managers who meet together as a group. This group reviews cross-programme issues, takes cross-programme decisions and identifies issues to be raised at the HSE Management Team level.

In regard to overall governance a corporate governance framework has been developed and approved by the Minister for Health and Children and is now moving to the implementation stage. Also, a national quality and risk framework has been developed and is being rolled out across the HSE as part of operational management structures.

An approach to managing change across the HSE has also been developed. This approach[56] is designed to provide staff across the organisation with the information and tools for managing change.

The sequence in which projects are progressed is considered as part of the project planning process and reviewed as projects are implemented. Dependencies between projects are identified at planning stage and managed directly within individual programmes. Factors that are taken into account in determining the order in which change will take place include budgetary constraints, availability of physical infrastructure on which to develop services and organisational capability to implement the change.

The existing management structures have quality and risk management processes in place. Risk assessment by project is also carried out and risk management strategies are developed to assist in the management of their key risks during implementation.

[56] *Improving our Services - HSE Change Framework* (HSE) 2008.

Successful change will involve alterations in the culture of the organisation and evolving new ways for staff to interact in pursuit of enhanced performance. In the area of culture, work on developing a set of organisational values for the HSE has been finalised.

As regards piloting the changes, the first integrated service implementation is being undertaken as part of the North East programme. The lessons learned from this will determine how the HSE implements its subsequent change strategy in the Mid West and South. In addition, wider implementation of the PCT structures will be built on the outcomes and lessons learned from the HSE's experience with the ten initial pilot sites.

Communication and Engagement with Stakeholders

The launch of the Transformation Programme was accompanied by a structured communication process where managers throughout the organisation held briefing sessions for staff where the vision and objectives of the Transformation Programme were communicated. Updates on the Transformation Programme's progress are also given as part of the CEO's monthly communication letter to staff. Management Team updates are also given on a monthly basis.

There was extensive clinical and staff engagement as part of the process of developing the Integrated Service Model. Other programmes have also undertaken specific engagement programmes with staff through the partnership process.

A HSE Leadership Development Programme has commenced and is being delivered to senior managers and clinicians across the HSE during 2008 and 2009. A staff engagement survey, which will provide the baseline for developing and implementing a staff engagement strategy has been planned, commissioned and designed. Implementation of the survey was delayed until the new National Director for Human Resources (HR) was in position and has had the opportunity to assess the proposed activity. In the area of teamwork, a Team Development Programme was developed during 2007 and is being used to support the development of PCTs across the HSE.

Expert Advisory Groups have been convened in the areas of Diabetes, Mental Health, Children and Older Persons. These groups have a strong clinical membership and now inform and advise on service development across the HSE. Other such groups are planned.

In the area of stakeholder involvement, it is recognised that service users have an important part to play in the development and improvement of health services. A framework for the Involvement of Service Users and Communities has been adopted and is currently being introduced throughout the organisation. In addition, a Communications Strategy and implementation plan has been completed and a National Director of Communications is to be appointed.

Constraints and Challenges

One of the principal challenges in implementing the Transformation Programme remains how to effectively integrate services. The Integrated Service Delivery Change Programme to be conducted over the next 18 months is intended to address the organisational constraints to integration.

Budgetary constraints facing the HSE in 2008 are having an impact on the Transformation Programme in terms of what can realistically be achieved within the timeframes. Each Programme is currently assessing its objectives in the light of these constraints. A sub group of the Management Team has been established to oversee this process. This exercise is expected to be completed in the coming months.

The reconfiguration of both hospital services and those delivered by way of primary, community and continuing care requires a significant realignment of staff resources. Achieving this rapidly in an

environment where there are strict employment controls is a challenge. This process is, however, being managed both at programme level and through routine employment monitoring processes.

Supporting the Change

Audit Concern

The HSE's capacity to implement and manage the change depends on the quality of support from key functions within its administrative infrastructure. I asked the Accounting Officer what steps are being taken to ensure that the change will be supported by functions such as finance, personnel and information.

Finance and Procurement

The Accounting Officer informed me that in the area of budgeting it was recognised that the historical, geographically based method of funding services has not always led to an equitable distribution of resources. To address this, the HSE intends to move from the present funding model based around service units to a model based on funding the entire continuum of care across organisational boundaries.

Work has been completed on developing the governing principles for such an approach. These principles will guide the next stage of the model's development by balancing resource allocation requirements that are driven by population needs with those that relate to the other elements such as national specialist services, capacity and infrastructural development, nursing and medical training and education. In the next stage of the project, demographic and other factors such as the needs of specific population groupings (*e.g.* mental health, disabilities *etc.*) will be charted.

The development and roll out of the new model will be undertaken between now and 2010 in parallel with the integrated care structures being put in place. In the meantime, an extension of the current Casemix reimbursement in the acute sector should drive further performance improvement. There will also be a focus on targeting new revenue and capital funds at initiatives designed to shift services to a community setting.

A business case for implementing a national financial and procurement system to replace the multiple legacy systems in operation within predecessor agencies has been completed and is with the supervising Departments for approval. A value for money function has been established within the national finance directorate as an ongoing operational function. This is targeting €300m in savings in 2008. The revised procurement approach should enable the HSE to benefit from economies of scale in procurement. Meanwhile options within the current structures and with current and projected resources are being considered, including a more focused approach to the sourcing and selection of suppliers and product categories.

Human Resources

In the area of human resource development the Accounting Officer informed me that

- A draft HR Strategy has been completed and will be reviewed for sign off by September 2008.
- A new team and individual Performance Planning and Review system was developed and launched in January 2008 and will be rolled out across the HSE during 2008.
- Following on from the review of the PPARS system undertaken by the HSE in 2006, a revised approach to the implementation of critical HR information management systems has been submitted to the Department of Health and Children for approval.

- A recruitment shared services function has been established.
- A project has been established to develop shared services for superannuation, payroll and personnel administration.

He added that if optimal efficiency and effectiveness in human resource management is to be achieved, the continued development of HR shared services is highly dependent on implementing a single HR management system.

Information and Communications Technology (ICT)

The Accounting Officer informed me that a national ICT strategy is currently being prepared. It is expected that the strategy will be presented to the Board of the HSE for approval before the end of 2008. It will guide the development of ICT services and systems for the HSE in a way that will support co-ordinated national developments rather than the multiple disparate systems operated in the former health boards.

A National ICT Steering Group was established in 2007 with an independent chair and external experts to oversee the development and implementation of ICT projects. A formal project management methodology has been adopted and deployed across all ICT projects.

In relation to ICT infrastructure, priority projects have been established (including a single data network, national directory services and data centre consolidation as the basic building blocks for storing, managing and sharing data and information across a single organisation) and it is expected that the related tender processes will be completed by the end of 2008.

The priority projects in terms of clinical systems are a national integrated medical imaging system (NIMIS) and a laboratory information management system (LIMS). As regards the NIMIS project, the procurement documentation is currently being prepared. Consequently, the project is at a relatively early stage. Decisions have yet to be made regarding the sequence of rollout of the new imaging system to hospitals. A process of evaluating the readiness of sites for the new system is underway. Final decisions on the rollout sequence will be made later in 2008. The first sites are expected to reach go-live stage in 2009 with the last sites live by 2011.

The LIMS proposal is currently being assessed by the Department of Finance.

Audit Conclusions

The foregoing review sets out the key elements of the envisaged change and the progress to date.

The main focus of the drive – service integration, while at the same time reshaping primary, community and continuing care and reconfiguring hospital services – involves a set of changes that are both interdependent and significant in scale. Piloting them will be important both for organisational learning and to build confidence that they can yield the desired benefits.

Change management is a multi-year undertaking. The HSE faces a considerable challenge in achieving transformation within and between its main service delivery channels. Much of the work to date could be characterised as review and planning.

While acknowledging that organisational change is dynamic and emergent, if the transformation envisaged is to be successfully achieved by the end of 2010 the HSE will need to ensure that milestones and deadlines are established, monitored and adjusted in the light of emergent factors and ongoing learning.

The changes proposed will necessarily involve adjustments in the routines of staff and contractors and changes in the way in which patients and clients access health and social care. They will also require reallocations of resources. While a considerable amount has been done to explain the consequences of change to staff and to their engagement with the change, significant further efforts may be needed to communicate the potential benefits to other stakeholders, particularly local communities.

14.2 Budget Management

The total original gross Vote for the HSE for 2007 was €13.98 billion, made up of

- €13.07 billion allocated for current services and administration,
- €0.55 billion allocated for capital purposes, and
- €0.36 billion in respect of the cost of the Long-Term Charges Repayments Scheme[57].

In 2007, the HSE's net additional spending on current services and administration exceeded the provision in the original Estimates by €245m. This net additional spending is calculated after taking account of savings generated from the delayed start-up of new services for which provision had been made in the financial allocation of the year[58]. Under the supplementary estimates process, provision was made for an increase in most subheads from which day-to-day expenditure is met, with an offset of savings from a number of other subheads. The largest saving transferred in this way was an amount of approximately €216m from the Long-Term Charges Repayments Scheme subhead. The provision in respect of the Long-Term Charges Repayments Scheme was originally intended to be applied only for that purpose.

Audit Concern

As the net overspend of €245m and the deferral of new services for which €208m had been provided raise concerns as to budget management and control in the HSE, I reviewed the budget process in the course of my 2007 audit. In particular, I set out to examine the HSE's budgetary and reporting mechanisms and the factors which gave rise to the overrun.

The main focus of my review was on hospital services[59]. It comprised an examination of

- the most significant budget overruns
- a sample of correspondence between managers and budget holders
- the files of the Department of Health and Children (the Department) in relation to the setting of the 2007 Estimate.

Interviews were conducted with HSE managers and budget holders at different levels of the organisation.

[57] The purpose of this scheme is to reimburse people who were required to pay charges in respect of public nursing home accommodation at a time when there was no correct legal basis for such charges.
[58] Their postponement contributed an estimated €208m in savings in the year.
[59] The overrun on schemes where there was statutory entitlement to services was €177m which represents under 40% of the gross overrun.

Cost Pressures on Health Services

As with health services worldwide, there are considerable cost pressures on the Irish health system. These derive from

- demography
- changing health and social status of the population
- the level and management of chronic illness
- changing health technology
- changing legislation and increasing user expectation.

Service Planning and Budgeting

Under the Health Act, 2004, the HSE is required to prepare a National Service Plan (NSP) for each financial year.

The NSP attempts to balance the requirements of service delivery and patient care within the determined financial allocation. Once adopted by the Board of the HSE, the NSP must then be submitted to the Minister for Health and Children for approval. While the Act stipulates that this should be done no later than 21 days after the publication of the Estimates, the Minister, using powers set out in the Health Act, extended the time for submission of the NSP 2007 to 17 January 2007 in order to allow the Board time to take account of the additional funding and measures which the Government had announced in the Budget. The 2007 NSP, as finalised, outlined the agreed level of health and personal social services to be provided by the HSE for 2007 within the allocation voted by Dáil Éireann and in accordance with Government policy on employment control within the health service. It was approved on 7 February 2007.

In practice, the HSE's financial allocation is determined by taking the core budget (*i.e.* excluding non-recurring items) for the previous year and making a number of technical adjustments for pay increases, non-pay inflation and the current-year cost of developments commenced in the previous year. The cost of proposed new services in the current year is added to this.

Ultimately, a final Estimate, which forms the basis for the appropriation by Dáil Éireann, is arrived at following negotiations between the Minister for Health and Children, the Minister for Finance and their respective officials and is agreed by Government.

Allocating the Budget

When the NSP has received Ministerial approval, the Finance Directorate of the HSE determines the budget allocations for individual hospitals and local health offices. In practice, the starting point is a roll-forward of the previous year's closing budget (adjusted down by once-off items specific to that year) with additions for known new developments specific to the current year. These baseline allocations are then adjusted for pay awards, increments, non-pay inflation and other current year cost increases.

Monitoring the Budget

If the budget is to be managed to target, it is necessary that the outturn at local level be captured and acted upon. The HSE has a standardised Performance Monitoring Framework in place which is intended to allow all levels of the organisation to monitor the achievement of the objectives in the NSP, taking account of allocated resources and approved employment levels and to take the necessary corrective

action, as appropriate. A monthly performance monitoring report (PMR) is produced which gives a wide range of performance data both at national level and for the various pillars and units of the organisation. This report also contains details of related financial performance, showing performance against budget and a comparison with the previous year.

Although both the financial and non-financial data are contained in a single report (and variances, both in relation to budget and service activities are reported) little or no attempt is made to explain budget variances, to relate them to changes in the level of activity or to indicate what specific plans are in place by local management to bring their units back on budget.

Interpreting the reports is hampered by the treatment of minor capital expenditure in the PMR. This expenditure is reported as current expenditure in the PMR even though in due course it will be met out of the capital budget. It is not clear when examining the budget performance of an individual unit whether, and to what extent, a reported budget overrun is a current overrun or is attributable to minor capital expenditure.

Despite these deficiencies, the PMR, which is reviewed by the Management Team and the Board, contains enough information to flag clearly the units where there are budgetary problems.

The Accounting Officer said that local systems were adequate for managers on the front line and information to effectively manage services was available to them. The HSE consolidates financial results from the accounting systems of 17 predecessor bodies and 39 major voluntary providers of services. It had implemented a Corporate Reporting Solution (CRS) to consolidate all 56 systems each month. However, there was no doubt that there was complexity in providing timely and relevant service-related monthly information for senior managers nationally. The absence of a standardised coding system impacted on the quality of data. The HSE did not have a single integrated budgeting system. A legacy system, used to maintain national budgets, was not linked directly to the ledgers in the financial environment of the HSE. There was an inherent risk that budget setting nationally could be inconsistent with the budgets as reflected in the local ledgers. The HSE had put in place manual interventions to ensure that budgets were reconciled monthly and reflected the national position.

The Accounting Officer acknowledged that there was little connection between activity, headcount and financial data stating that the absence of a national financial system, coupled with the fragmented configuration of the systems inherited from predecessor bodies, presented enormous challenges in the integration of financial and non-financial data. The PMR was designed for Management Team and HSE Board purposes and there were limitations on the volume of detail it could convey in respect of 53 individual hospitals and 32 local health offices. The PMR contained a CEO commentary whose purpose was to highlight and explain the key issues which were arising and the management teams of the National Hospitals Office (NHO) and Primary, Community Continuing Care (PCCC) were structured to manage these issues.

Budget Control at Organisational Level

For 2007, the HSE knew by November 2006 the level of funding available to meet the cost of existing services for the following year. At that point it considered the implications of the funding package available and an assessment prepared for senior management concluded that the funding provided to deliver its existing services was about €341m short of what the HSE had sought and that, as a consequence, it would have to find savings of this amount.

The Accounting Officer confirmed that the HSE recognised that the 2007 estimate fell some €341m short of what was sought, but said that the NSP was framed to deliver services consistent with the budgeted allocation.

Despite its initial assessment of the financial position, the HSE Senior Management Team did not direct any specific action at this point to achieve the savings that were likely to be needed to stay within budget. In rolling out the budget it did warn managers that the budgetary position was tight but, for example, it did not ask for specific plans to achieve quantifiable savings. The Accounting Officer informed me that managers were required to produce business plans to live within budget. He said that in 2007 this automatically involved reduction of costs and, in a number of cases, proposals to limit service. He also stated that the financial position, including management's proposed remedial measures, was communicated to the Department, and onward to the Department of Finance, throughout the year.

He informed me that the HSE Control Group, comprising senior HSE management, reviewed the PMR continuously throughout 2007. The Control Group was aware from February 2007 that HSE expenditure was already over budget and of the likelihood of significant financial difficulties for the HSE Vote if activity and spending continued at the levels then pertaining. As the year progressed, the Control Group grew more concerned about the budgetary position and began to take action to try to stay within target. In April 2007, it decided that financial savings targets should be set for each HSE Directorate and that each Directorate would undertake an impact assessment arising from those targets.

In June 2007, it requested break-even plans to be submitted immediately to facilitate an organisational approach to be taken and to allow the CEO to agree actions going forward.

As the financial situation continued to deteriorate, it prepared a break-even plan in July which was designed to address the €341m shortfall which had first been identified in November 2006. Table 45 sets out the savings that were expected in the course of the break-even plan and the elements of the plan.

Table 45 Savings Expected by the HSE Break-even Plan July 2007

	Total €m
Reallocation of Capital Funds to Current Purposes	142.9
VFM/Cost Containment Initiatives	133.7
Service Curtailments	16.5
Use of Primary Care Reimbursement Service Projected Surplus	48.0
Total	**341.4**

Local management were instructed to begin to implement the actions necessary to achieve the break-even plan targets that included

- reduced staff travel
- reduced overtime
- more consideration to be given to the need to replace absent staff
- delaying new appointments
- delaying capital expenditure.

However, by October 2007, the Control Group noted that the break-even plan was progressing at a slower rate than had been expected. It called for an immediate intensification. These actions did not result in the HSE coming within its budget but the Accounting Officer has indicated that their combined effect was to reduce expenditure by €96m for the year.

The Accounting Officer told me that as well as curtailing existing expenditure, certain developments had to be delayed due to the requirement to achieve financial break-even for the year. This strategy was the subject of correspondence with the Department.

The estimated savings as a result of delaying service developments amounted to €208m. The main areas affected were services for older people (€74m), sundry hospital services (€38m), disability services (€31m), primary care (€22m), mental health services (€22m), other services (€21m).

The Accounting Officer stated that, ultimately, the challenge which is extremely difficult if not impossible for the HSE to fully manage derives from the increasing costs associated with demand-led schemes, which have a statutory basis. As each year progresses the HSE is challenged by the prescribing of new and highly expensive medications especially in the cancer and cardiovascular areas. The number of items prescribed for patients is also increasing at a rapid rate year on year, and this trend will continue as our population over 65 years grows. In addition, the number of medical cards issued can increase substantially above planned levels based on changing national economic circumstances, with each card costing in the order of at least €1,500 per year to the HSE.

Views of the Department on Budget Management

The general views of the Department were outlined in a letter of September 2007. The Accounting Officer pointed out that the Government decides what level of funding should be made available to the HSE each year following consideration by the Minister of Finance of the expenditure proposals submitted by all Ministers across the full range of expenditure areas. In the case of health, the information provided to the Department by the HSE is taken into account, as well as the Minister's priorities in relation to service developments. Once the Vote has been determined, it is a matter for the HSE to develop a national service plan within this budget which reflects these priorities, *i.e.* which sets out how the total resources will be allocated and what will be achieved for the resources. Assuming approval by the Minister for Health and Children, the HSE needs to ensure that its national budget and service plan cascades down through the organisation, e.g. that each hospital and ultimately each service unit has a budget and a set of service objectives which are consistent with the budget.

The Accounting Officer also stated that, given the complexities involved in managing the health services and the obligation on the HSE to provide the most effective services possible within approved resources, some adjustment to service objectives may be required as the year progresses in order to remain within budget. Assuming Ministerial agreement to the overall approach, or to an alternative overall approach including, if the Minister for Finance were to so decide, additional funding, the HSE proceeds to deliver the most effective quantum and quality of services possible within its approved allocation. In due course, after end-year, the HSE reports on how its allocation was actually spent and what was actually achieved, and it should in that context be able to explain and if necessary justify departures from the initial service plan.

Local Budget Management

Ultimately, the quality of the communications between the centre and local managers and their response is crucial in managing to budgetary targets. In the course of the review, local management generally acknowledged that it was their responsibility to devise service plans that fit with the delivery targets set out in the NSP and the budget allocation. However, in doing so, they reported encountering the following difficulties

- Cost pressures were not adequately factored into the allocation method.

- The baseline figure on which the budget allocations were founded were unrealistic in that employee numbers, agreed in the past to provide new and developing services, were often not reflected in this baseline budget.
- The costs associated with developments delayed in the past due to budgetary constraints were not adequately reflected in the allocation process.

Overall, it was apparent that some units managed to keep more or less within budget and others incurred substantial overruns. This suggests that overruns may be due to other factors, including delay in reducing activity.

In addition, while accepting that budgets and employment ceilings are not fully aligned, in the case of any divergence if budgetary control is to function the budget should be the determinant of expenditure decisions, not the employment ceiling.

Comments made by managers in relation to new developments suggest that, in the past, some developments may not have been fully costed. In other instances, initial funding of developments may have been adequate but took no realistic account of service growth. Unplanned service growth means increased, and possibly unsustainable, pressure on a unit's budget in future years.

The Accounting Officer said that underestimation of costs when service developments were being approved was not a deliberate practice. He noted that, in the past, approval could have been given for a consultant but that, in the development of the service, ancillary costs of administrative support, medical team, drugs, laboratory, blood *etc.* often came 12 to 18 months later and that in some instances these costs had not been specifically identified with that development at the time it was costed. However, he assured me that this practice does not now occur within the HSE.

Review of Four Hospitals

In the course of the examination, some of the highest overruns in the hospital services were reviewed. These are shown in Table 46.

Table 46 Hospital Overruns in 2007[a]

Hospitals	Original Allocation €000	Final Allocation[b] €000	Outturn €000	Overrun €000	%
Adelaide & Meath Hospital	203,907	209,649	225,620	15,971	7.6%
Sligo General	104,655	108,570	119,454	10,884	10.0%
Mayo General	72,525	72,384	83,128	10,744	14.8%
Our Lady's Hospital, Crumlin	121,694	128,359	138,311	9,952	7.8%

[a] In allocating budgets to individual units the HSE plans on an accruals basis. Hence, all figures relating to individual units in this paragraph are presented on an accruals basis. The total budget overrun on an accruals basis in relation to current services and administration costs (excluding the costs of the Long-term Charges Repayment Scheme) was €261m, compared to a cash based overrun of €245m on the relevant Vote subheads.
[b] The bulk of the final allocation was notified to hospitals before the end of February 2007.

Taking the four hospitals together, the combined overrun in 2007 represented an average for this group of 9.2% for the year. Overruns of this scale are unlikely to have arisen from previously unforeseen service pressures and associated costs. While the detailed reasons for the overruns varied from hospital to hospital, it is clear from interviews with hospital managers that there are significant underlying behavioural issues arising from the expectations of managers about how the budget would, in practice, be managed by the HSE. These can be summarised as follows

- A belief that the budget as communicated to the hospital is flexible because past experience had shown that further money would become available during the year, that if budgets were exceeded the hospital would not be penalised and that by adhering to the budget the hospital would lose out to other parts of the system which ignored the rules.
- A view that the level of funding was incompatible with the role that the hospital believed it was mandated to discharge.
- A view that maintaining the level of service provided in the previous year had either explicit or implicit approval and that, therefore, money would be made available to fund this.
- A view that any action taken to keep within budget that impacted on patient services would not be accepted by senior management.

Previous experience suggests that the managers had grounds for believing that the initial allocation of funding was not the last word. Table 47 shows the original allocation, final allocation and outturn for 2006 for each of the hospitals already referred to in Table 46.

Table 47 Hospital Overruns in 2006

Hospitals	Original Allocation €000	Final Allocation €000	Outturn €000	Overrun over Original Allocation €000	% Over Original
Adelaide & Meath Hospital	196,278	202,840	202,531	6,253	3.2%
Sligo General	94,925	99,447	110,059	15,134	15.9%
Mayo General	66,861	75,338	75,391	8,530	12.8%
Our Lady's Hospital, Crumlin	113,604	120,970	121,001	7,397	6.5%

The Accounting Officer noted that there was no doubt that prior to the establishment of the HSE additional funding had been made available to the health boards and the Eastern Regional Health Authority (ERHA) during the financial year, and often in December. This acted as a perverse incentive and encouraged a 'wait-and-see' attitude among managers who behaved accordingly. He said the HSE had worked hard to break this culture, by making budgets clear early in the year and by fostering a culture of accountability among managers.

He stated that hospitals had been informed at meetings throughout 2007 that they had been allocated substantially all their budget at the start of the year and that there would be only a small additional element drawn from a national contingency provision which the HSE maintained in line with Department of Finance requirements. He also noted that five hospital networks[60] achieved a balanced outcome in 2007 and three networks had deficits. While some managers may have cited 'expectations' as a reason for poor performance, the managers who delivered break-even were very clear that the culture of 'allocations in December' was over and managed accordingly. However, he said that, in hindsight, it was clear that more intense management was required in two hospital networks during 2007.

[60] A hospital network is a group of hospitals that work together to coordinate and deliver a broad spectrum of services in a geographic area. There are eight hospital networks in the four HSE administrative areas - two networks per area.

Alignment of Budget and Service Plans at Business Unit Level

Each element of the NSP is intended to be supported by a range of business plans at area, local and unit level that translate the national deliverables into local deliverables at all levels of the system. In the course of the review I examined the linkage between local plans, budgets and NSP. Local business plans varied widely from, on the one hand, comprehensive plans which described in detail the services which it was proposed to deliver, to, on the other hand, plans that described proposed activities in very general terms. The plans examined contained little or no financial information. At most, new service developments were costed. There was no information on how, for example, existing deficits would be managed nor was there any information about the financial effects of redeploying resources. In effect, there is considerable scope for creating more transparent linkages between budgets and service plans by setting out in business plans the cost implications of those plans against the budgets available.

Case Study - Our Lady's Children's Hospital, Crumlin

Some local business plans did not appear to be aligned with the NSP and some business units implemented local plans without regard to what the NSP and its associated budget contained.

Our Lady's Children's Hospital, Crumlin submitted a business plan for 2007 to the HSE in October 2006 with a proposed budget of €139m. This represented an increase of almost 15% over its 2006 final budget. The Hospital's view was that over a period of years the Department, the ERHA and the HSE had designated it as the national tertiary Paediatric service provider and up to and including 2006 it had been funded accordingly. Its view was that the proposed increase in budget was needed to meet the full year cost of services developed in 2005 and 2006 and for other services whose implementation had been deferred until 2007. However, it is clear that the budget allocated by the HSE was prepared on a completely different basis.

The Accounting Officer informed me that Section 38 of the Health Act, 2004, defined the legal basis for dealing with voluntary service providers such as Our Lady's Hospital, Crumlin. The Act does not consider the hospital's view of its role but requires the HSE to provide a defined level of funding for a prescribed level of service. The level of service for each provider was set out in the NSP. He also stated that, in relation to voluntary service providers, the HSE had a duty to set a limit within the Vote which was not always consistent with the providers' view of their roles.

He said that virtually every provider of service to the HSE had aspirations for the development of its services, many of which would be shared by the HSE. However, the fixed nature of the HSE's funding environment and its role in funding providers accordingly could not be over-emphasised. The HSE had to operate within its Vote and could not provide a 15% increase in budget to one hospital to develop its services in 2007. Accordingly, a budget increase in line with available funding was given to each hospital.

In regard to the link between business plans and budgets the Accounting Officer pointed out that the HSE had a defined Business Planning Model that applied to all areas of the HSE business in 2007. The financial basis for business plans was the budgetary allocation provided to the manager, translated into cost centres within the general ledger for the relevant service. He said managers were fully aware of the budget on their general ledger and the business plan was designed to reflect the services which could be delivered for this budget.

Actions to Improve Financial Management

The Accounting Officer informed me that a number of initiatives have been taken or are proposed to improve financial management in the HSE

- An improved Corporate Performance Measuring System had been implemented in 2007. This initiative focused attention on the relationship between responsibility, authority and accountability at each level of the organisation.
- A Healthstat system had been introduced in 2008, focusing on key service deliverables for both hospitals and PCCC. This represents a further improvement in the information provided to managers and includes a focus on issues such as control of absenteeism which have direct cost implications.
- In 2008, budgets were notified to managers prior to the 2007 year end. Managers are aware that they received no new money late in 2007. The message that no further money will be available later in the year is increasingly becoming the reality and cultural change is being embedded.
- The new Director of the NHO has implemented an enhanced governance model with specific NHO Executive meetings devoted to performance in respect of finance, activity and headcount.
- The Control Process is now chaired by the Director of Finance rather than the Director of Corporate Planning and Control Processes.
- A Performance Planning and Review system has been implemented for senior managers which involves the development of Key Performance Indicators. One of the most significant indicators upon which senior managers are being measured is delivery on their budgets and financial plans.
- A single integrated national financial and procurement system is planned. An internal project was currently underway which would support the overall business case in terms of cost, design, implementation plan and rollout strategy. He said that the challenge here remained significant. In the meantime, current systems would continue to operate.

Conclusions

After diverting development funding, the budgetary overrun on the HSE's core services for 2007 was €245m. There was considerable delay in addressing the emerging deficit. In a number of instances where significant overruns were occurring, it could have been expected that specific action would have been taken but the review found no evidence that any such action was taken. A dysfunctional effect of delaying action is that across-the-board savings have then to be targeted, affecting units that are operating within budget as well as those that are not.

The HSE, and the health boards before it, had a practice of using development moneys to subsidise the cost of existing services by delaying the introduction of new services. €208m was generated in 2007 from this approach. Such budget balancing practice is only sustainable during an expansionary phase. Where the rate of new developments being commissioned reduces, a budget deficit will result.

Previous practice in dealing with budget overruns has led to an expectation on the part of certain managers that they will be 'bailed out' in due course. This is beginning to be addressed but it demands enhanced monitoring in areas where deficits arose in 2007.

In the case of demand-led schemes where an overrun of €177m occurred there would be merit in providing more detailed information in both internal and external reports capable of distinguishing between variances in component factors including number of recipients, volumes of service and unit prices.

Based on the foregoing the key factors which need to be addressed by the HSE are

- Ensuring that once service choices and priorities have been established and included in a service plan with an associated allocation that the focus at each level of the organisation is on providing the agreed level of service within the agreed resource allocation.
- Active use of the PMR data to investigate trends and trigger early corrective action .
- Ensuring that appropriate local budget management responses are actioned and the "wait and see" culture discouraged.
- Integrated budget management taking account of planned activities, staff resources and financial allocation.

Overall, the incremental nature of the service funding in the HSE and its predecessors leads to a risk that resources may be allocated on the basis of historic rather than current need with the result that resources may not be used to best effect. In the longer term, a new resource allocation model may deal with this. However, in the interim, there could be value in introducing a zero-based budgeting approach, perhaps implemented across services over a cycle, in order to identify any scope for redistribution.