Evidence Informed
‘Commissioning’ Cycle

Version 1.0 - DRAFT FOR DISCUSSION
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Introduction

Purpose

The priorities for the development of the health and social care system in Ireland have been laid out over recent years in a number of key policy documents (see Appendix 1). The key priorities may be summarised as:

- Keeping people healthy,
- Providing the healthcare people need,
- Delivering high quality services,
- Getting the best value from health system resources,
- Reforming service delivery through the creation of new delivery mechanisms (Hospital Groups, Community Healthcare Organisations and the National Ambulance System) and by changing the way that the corporate centre of the HSE interacts with the service delivery entities.

There has been a growing interest in the application of a ‘Commissioning’ approach as a possible mechanism for reforming service delivery and meeting these priorities. The Directorate and Leadership Team of HSE recognise the need for a change in the manner in which the central functions and governance of the organisation interacts with the delivery system to reflect the establishment of hospital groups, community healthcare organisations and the national ambulance service. Following an internal consultation process, the National Centre Transformation Programme was established to ensure focused leadership on key elements of the change process required to re-define traditional relationships between the corporate centre and the delivery system and to ensure that the role and function of the national centre evolves in tandem with the development of the delivery system.

A number of separate but interdependent workstreams were established within the National Centre Transformation Programme to ensure that the main elements are addressed in a consistent and comprehensive manner. The work follows a standard programmatic approach to define, design and then implement the functions and services that will enable the National Centre to ‘commission’ health services from the service delivery system thus ensuring the appropriate blend of quality, access and resources.

A central element of the role of the National Centre will be the development and implementation of a comprehensive process known as the Evidence Informed ‘Commissioning’ Cycle. The 30-day initiative was established to In order to define the constituent parts of such a cycle so that agreement can be reached prior to the detailed design phase. The purpose of this document is to define an Evidence Informed ‘Commissioning’ Cycle and its components in the Irish context. The document will be used as a platform for discussion and engagement with stakeholders. As such, the document should be regarded as a proposed definition of functions of a National Centre that adopts a ‘Commissioning’ approach.

This document does not refer to enabling functions such as HR, Information Technology, Finance and Communications except where there are specific references in terms of the ‘Commissioning’ cycle. There are other Programmes underway that are tasked with defining and designing those support functions.

Methods

This document has been developed by the National Centre Transformation Programme as one of the deliverables identified in the Programme Plan. The approach taken in the development of this definition document was:

- Desk based research on health systems in other jurisdictions combined with outputs from research visits on ‘Commissioning’ in other jurisdictions
- A series of specific workshops and individual interviews to understand the processes that exist within the HSE today, the current challenges and considerations for the future
Input from a session held with National Directors, HG CEOs, CHO COs and other Health leaders at Castletown House 21 April 2016

Review of existing relevant material produced by the HSE related to these topics

A focussed initiative referred to ‘The 30 day Initiative’ developed the definitions contained within this document. This initiative included a number of key speakers that helped shape the discussion and development of the definitions.

Once this document has been endorsed by the National Centre Programme Steering Group, it will be consulted with more broadly in order to capture and include feedback from the broad range of stakeholders across the system.

Key findings from research

‘Commissioning’

Over the past decade, the role of commissioning, as a key driver of quality, efficiency and outcomes for patients, has become increasingly important to the health systems in many developed countries. At its simplest, commissioning is the process of planning, agreeing and monitoring services. However, securing services is much more complicated than securing goods and the diversity and intricacy of the services delivered by the health care systems is unparalleled.

Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment. Advantages of commissioning have been seen such as shifting clinical accountability closer to the patient, providing strong incentives to collaborate, limiting dominance of a single organisation, strengthening relationships between commissioners and providers.

There is no single ‘Commissioning’ model. However, there is a reasonable degree of commonality to models described in the literature and there is a measure of consensus that ‘Commissioning’ is a strategic, cyclical process involving a series of linked tasks. The tasks include; assessing and identifying the needs of a population, ascertaining desired outcomes for that population, pinpointing service priorities and goals, securing service providers that can deliver those priorities and goals; and releasing funding in return for achieving the identified outcomes on foot of evidence-based evaluations.¹

The literature recognises that building readiness and capacity are key precursors to the effective introduction of ‘Commissioning’. Activities such as providing clarity and coherence on the purpose and model of ‘Commissioning’, building trust and a shared vision, and strong leadership have been reported to build readiness. It is also noted that complex infrastructure is required for ‘Commissioning’ processes.² Expert knowledge and technical skills need to be developed for both ‘Commissioning’ bodies and providers in a wide range of areas such as needs analysis, service user engagement, data and information management and analysis, service design and planning, procurement, contracting, governance, and evaluation. Further complicating the issue, it is acknowledged that the different parts of the health system may demonstrate different levels of readiness and capacity.

The evidence suggests that all ‘Commissioning’ should be guided by a common framework and principles. This document will define a possible framework for an Evidence Informed ‘Commissioning’ Cycle. Articulation of underpinning principles will be left to later phases of the National Centre Transformation Programme, however it might be safe to assume that such principles would reflect the priorities of key policy documents and the Corporate Plan e.g.

- Promotion of health and well-being,
- Provision of fair, equitable and timely access to quality, safe health services that people need,
- Demonstration of value for money,
- Fostering cultures that are honest, compassionate, transparent and accountable.
High performing health systems

Improvements in science, technology and care offer the promise of better healthcare and improved health. Despite this, providing consistently safe, high-quality care remains a challenge for many systems and only some achieve high levels of performance and reliability. Understanding the characteristic behaviours and strategies of high-performing systems offers opportunity for learning. The introduction of a ‘Commissioning’ cycle offers opportunity to embed this learning in practice by promoting these behaviours at each stage of the ‘Commissioning’ cycle. Baker\(^3\) describes the key themes underlying high-performing health care system as:

- Consistent leadership that embraces common goals and aligns activities throughout the organisation.
- Quality and system improvement as a core strategy.
- Organisational capacities and skills to support performance improvement.
- Robust primary care teams at the centre of the delivery system.
- Engaging patients and service users in their care and in the design of care.
- Promoting professional cultures that support teamwork, continuous improvement and patient and service user engagement.
- More effective integration of care that promotes seamless care transitions.
- Information as a platform for guiding improvement.
- Effective learning strategies and methods to test improvements and scale up.
- Providing an enabling environment buffering short-term factors that undermine success.

The Evidence Informed ‘Commissioning’ Cycle

The purpose of the Evidence Informed ‘Commissioning’ Cycle will be to improve the health and wellbeing of the population while getting best value from health system resources.

The proposed ‘Commissioning’ cycle is characterised by an approach where the National Centre \textit{thinks nationally} and the Delivery System \textit{delivers locally}. While Health Care Policy from Government and the Department of Health (see Appendix 1) guides the ‘Commissioning’ Cycle it is supported by the corporate values of Care, Compassion, Trust and Learning and supports achievement of the five corporate goals to:

- Promote health and wellbeing as part of everything we do so that people will be healthier
- Support the provision of fair, equitable and timely access to quality, safe health services that people need
- Aid on fostering a culture that is honest, compassionate, transparent and accountable
- Emphasise the need to engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them
- Support the management of resources in a way that delivers best health outcomes, improves people’s experience of using the service and demonstrates value for money
Figure 1 sets out the different functions required to support a ‘Commissioning’ cycle. Each of these functions is fundamental to effective ‘Commissioning’ that delivers on providing quality care and services to patients and services users. As each of these functions are part of a cycle, they are dependent on each other. For example the outputs from population needs assessment, strategic planning, prioritisation and service design feed into service planning and then contacting.

Key principles of the ‘Commissioning’ cycle are that it is open, transparent and fair and that it involves active engagement with patients, service users, the system as a whole and the public. For this reason, patients and service users are central to the ‘Commissioning’ cycle both in the importance of their active participation in the ‘Commissioning’ process and also in that the care and services provided are fundamentally focussed on providing quality outcomes for patients and services users.

The staff providing care and services within the health system also have a central role to play in the cycle as they provide the leadership, skills and experience required to deliver the best quality care and services to patients and service users. Additionally, they have an important role to play in identifying and advocating for change of health services by participating in all aspects of the ‘Commissioning’ cycle. Staff also need to be supported and developed to meet the capability and capacity requirements for effective ‘Commissioning’. They also need to be valued, supported, managed and developed to empower and enable them to advocate for and deliver quality outcomes for patient and service users. To drive continuous improvements in the quality of care provided to patients and service users the organisation needs to be a learning organisation that embeds a culture and ethos of quality and service improvement in everything it does. This culture needs to be woven into the fabric of the organisation whether its front line services or enabling functions such as finance and HR functions. It is important to
recognise that quality and service improvement while critical in front line services should also be at the heart of all processes and functions in an effective high quality health system.

An effective high performing health system makes healthcare decisions informed by good quality information and evidence. These decisions are at all levels of the health system including making decisions about strategic priorities, service design, service planning, resource allocation and driving quality improvements through monitoring performance and accountability. To inform these decisions and to ensure that care and service provision is based on needs of the population should be assessed. The recommendations of these assessments, combined with government strategy and policy will inform the strategic policies, plans and priorities of the health system and will feed into decisions about resource allocation and service planning.

In the ‘Commissioning’ cycle service design, informed by quality information and evidence, both national and international will include the development of evidence informed models of care, resource allocation and measures to monitor the quality of the care and services provided.

Based on needs assessment, service design and strategic priorities, planning of services will ensure that people receive high quality services in the right place, at the right time and by the right people, and therefore making the best use of available resources. The services will be provided by delivery organisations in compliance with contracts that set out clearly what services should be delivered, the quality outcomes expected and how these outcomes will be measured. The health system will ensure that it is capturing meaningful key performance indicators that measure both processes, for example service volume but also expected quality outcomes. It is also critical that, to continually improve the quality of the care and services being provided, those responsible for the services are accountable for their performance in delivering high quality care and outcomes for patient and service users.

Information and the Evidence Informed ‘Commissioning’ Cycle

It is critically important that ‘Commissioning’ and each of the functions being described as part of the ‘Commissioning’ cycle are underpinned by quality data, information, research and evidence. The availability and use of high quality information and evidence drives and enables evidence based healthcare decision making at all levels of the health system from individual patient and service user decisions about their care to decisions about designing and planning services and responding to issues of quality.

The health system itself generates large volumes of data, information and evidence and this should be captured, analysed, interpreted and used to inform effective decision making. There are many information systems in the Irish healthcare system collecting data and information. These are good sources of good quality information and evidence and it is important for the future that this data and information is collected, analysed and interpreted in line with legislation and agreed standards and guidance so that there is “one version of the truth”.

To be most effective, the right information and evidence needs to be available to decision makers in an accessible format at the point of decision making. This is best achieved by developing and implementing digital information systems that collect the right data from the start.

For ‘Commissioning’ it is important that good quality information and evidence is available and used to ensure that the services and care provided are focused on achieving value based quality outcomes for patient and service users. To achieve this, the information and evidence needs to not only include information on activity and service utilisation, variability in care, demographic information and population needs but also information such as resource availability and cost. It must also be presented in a way that supports the evaluation and promotion of improvements in quality of care. Internationally tools have been developed that allow the analysis and interpretation of the cost or spend on services and the outcomes achieved for example the Spend and Outcomes Tool (SPOT) develop by NHS Right Care. This sort of analysis informs effective decision making in relation to prioritisation, service improvement, planning and resource allocation.
Quality Information is also needed to support the development and monitoring of key performance indicators (KPIs) including quality outcomes. Quality Outcomes should reflect quality outcomes for patients and service users and should feed into continuous quality improvement and learning.

The availability of quality information, evidence and tools will support effective value based ‘Commissioning’ that improves the quality of care for patients and service users.

**Core attributes of the Evidence Informed ‘Commissioning’ Cycle**

**Patients and Service Users Involvement**
Engagement with patients and service users will be strengthened by ensuring that they actively participate (as appropriate) and have a voice throughout all of the functions described in this ‘Commissioning’ cycle.

**Leadership**
Strong leadership, including clinical leadership, will ensure that the culture underpinning the ‘Commissioning’ cycle is one of providing high quality person centred care based on need. Such leadership will provide inspiration and clarity in relation to the vision and strategic objectives of the service and will advocate for patients and service users based on their assessed needs and health priorities. It is vital that this leadership is at all levels and all aspects of the health system. The behaviours of leaders must mirror the organisation values and actively promote the empowerment of front line staff to improve care.

Leaders will help build a culture that is focused on achieving quality outcomes for patients and service users, supported by skilled competent staff within the available resources.

Clinical leaders play a key role in making decisions about the health system as a whole. Through every aspect of the ‘Commissioning’ cycle it is critical that they provide clinical knowledge, insight and evidence, advocate on behalf of their patients and service users and ensure buy-in from their colleagues.

**Governance**
Effective governance must support the continuous improvement of the health system by ensuring services are of the appropriate quality, are safe and effective. It is essential that this governance is inclusive of clinical governance to ensure a focus on the quality and safety of clinical practice and clinical outcomes.

**Focus on Integrating Care**
The ‘Commissioning’ cycle will support and enable further integration of care and services in order to ensure that patient and service user experience is seamless and joined up high quality safe care. This will be done by considering the integration of services from population needs assessments through service design, strategic and service planning and subsequently contracting. The intent is to seek to incentivise different Service Delivery entities that actively integrate services and create seamless patient and service user pathways.

**Quality and Service Improvement**
Ensuring patients and service users experience high quality safe care and services is central to all aspects of the ‘Commissioning’ cycle. All aspects of the ‘Commissioning’ cycle must be performed with quality built in from the start by ensuring each aspect of the Cycle adopts quality processes and delivers quality outputs which are measured and improved where needed. Quality processes and services needs to extend beyond health services to all functions within the National Centre (including Finance, Human Resource, Knowledge and Information Management etc).

**A learning system**
A learning culture will be enabled and fostered throughout the health system, by adopting an approach to continuous improvement where work is evaluated and lessons applied in order to improve. Each function of the ‘Commissioning’ cycle must feed other functions. As an example, the information gathered during population needs assessments must inform strategic planning, prioritisation and service design processes as well as being used as inputs to future population needs assessment activities.

**Support for the Service Delivery entities**
The ‘Commissioning’ cycle seeks to support and enable the Service Delivery entities by ensuring that decisions are based on evidence, allocation of resource is fair and equitable, incentives exist for good
performance and that specifications for services are clear in order to allow Service Delivery entities to focus on local delivery and have the ability to make decisions based on their specific environment.

Capacity and Capability

The ‘Commissioning’ cycle will develop a culture of continuous training and development to ensure that staff can engage with it and are empowered and supported to deliver and advocate for high quality outcomes for patients and service users.

Collaborative Partnership Approach

A critical way of working into the future is fostering a collaborative partnership approach across the health system where broad and varied stakeholders can come together in a supported and systematic way to solve complex problems and participate in all aspects of the ‘Commissioning’ cycle.

Informed by good quality information for decision making

The ‘Commissioning’ cycle will ensure that decision making and prioritisation at all levels and in all aspects of the services, from individual patient and service user decisions to decisions about planning and design, will be informed by good quality information and evidence.

Consistent Frameworks

Frameworks will be developed that avoid duplication and drive consistency of approach to deliverables throughout the end to end Evidence Informed ‘Commissioning’ Cycle. These frameworks will be informed by international and national evidence and experience. For example the WHO framework for strengthening Health Systems.

Staff Engagement

The ‘Commissioning’ cycle will value the unique position of front line workers by systematically listening to their feedback, responding appropriately and initiating service improvements.

It will also support collaborative practice through investment in team working, team leadership and service user engagement to deliver integrated quality care.

Detailed Definitions

The following sections define each component of the Evidence Informed ‘Commissioning’ Cycle. Each section articulates the:

- **Purpose** – why the change is needed, definitions and context in the Irish Healthcare System
- **Role of National Centre** – explained using core attributes of the Evidence Informed ‘Commissioning’ Cycle
Quality and Service Improvement

Purpose

Quality is the organising principle in the ‘Commissioning’ cycle, everything is organised around Quality in a high performing health system, making it everybody’s business and not an afterthought.

Definition of Quality, Quality Assurance and Service Improvement

Quality of healthcare is defined in many ways by different healthcare systems. There are commonalities in all definitions, in that they all seek to place a clear focus on safety, effectiveness, patient/service user experience and a culture of continuous improvement for all who use health services.

In Ireland, quality is defined by the four quality domains set out in the National Standards for Safer Better Healthcare:

1. **Person centred** – care that is respectful and responsive to individual’s needs and values and partners with them in designing and delivering that care
2. **Effective** – care that is delivered according to the best evidence as to what is clinically effective in improving an individual’s health outcomes
3. **Safe** – care that avoids, prevents and minimises harm to patients and learns from when things go wrong
4. **Better health and wellbeing** – care that seeks to identify and take opportunities to support patients in improving their own health and wellbeing

The National Standards provide the basis for all who plan, fund or provide healthcare services to work towards achieving and maintaining high quality, safe and reliable care for all who use them. While there has been many improvements in quality and safety of healthcare services in Ireland, there have also been failings in care and shortfalls in how care is delivered. Therefore, there is a need to maintain a continuous focus on quality and service improvement.

**Quality Assurance** involves monitoring and evaluation of the various aspects of a service to guarantee that the standards for quality are being maintained by the Service Delivery entities. There are three levels of assurance currently in place in the health system for Quality Assurance:

1. Self-assessment
2. Internal audit and healthcare audit
3. External review, such as regulators

**Service Improvement** is the process of identifying and implementing changes to services and processes in order to improve the quality and safety of services. This can be achieved through a combination of Quality Assurance, performance measurement as well as using Quality Improvement (QI) methodologies. Improvements to the system will lead to:

- Better patient outcomes
- Better experience of care
- Continued development and supporting of staff in delivering quality care

Improving services is a continuous journey that takes time. There are many examples of health services internationally that have significantly improved quality outcomes for their patients and service users.
However, these improvements - have to be evolved over time and usually take many years and strong leadership. While the approaches and methods used may have been different, they all started with a vision that was shared by clinicians and management alike.

Context
Across Irish healthcare and other health systems, there is a strong commitment to improving services and delivering high quality care. The Health Service Executive (HSE) has committed to improving quality and safety across all levels of services. This has been well documented in all of its Corporate and service planning priorities. The vision for the HSE is ‘A healthier Ireland with a high quality health service valued by all’. While there has been significant progress in quality and patient safety within the HSE over many years, many of the quality and safety programmes and initiatives have evolved in parallel to each other and often there is little evidence of cohesiveness from a system wide perspective.

In research internationally, there are some common characteristics which are consistent for ‘Commissioning’ across high quality health systems. These are outlined below:

**Being Person Centred:** Central to quality and service improvement is the patient and service user. There is a need to have a clear understanding of patient and service user experience of services and for them to be active partners or leaders of their own care. Measuring patient and service user experience and outcomes is essential to a high performing health system. This information needs to be used alongside other quality related information to support overall quality and service improvement.

**Quality is embedded:** Quality is proactive and systematic and requires a continuous focus at all levels in the health system. Quality needs to be embedded at all levels within the Evidence Based ‘Commissioning’ cycle. The National Centre needs to promote and drive a culture of continuous quality and service improvement and support innovation throughout the system. Quality of care that is clinically led needs to be at the heart of the ‘Commissioning’ cycle. It is essential that quality and service improvement and effective assurance processes are built in to the ‘Commissioning’ cycle and funding needs to be aligned to quality outcomes.

**Leadership for Quality:** It is essential that there is strong and visible leadership for quality at the National Centre and the Service Delivery entities. The vision and values for quality need to be clearly articulated by leadership in order to drive a culture that is honest, compassionate, transparent and accountable.

**Governance for Quality and Safety:** Robust clinical governance systems and processes need to be in place to monitor and manage the quality and safety of commissioned services. Without effective Governance (including Clinical Governance) in place the required quality outcomes will not be achieved. This will require clarity around the leadership roles and responsibilities to take action when the requisite standards for quality and safety are not being met, aligned to the Accountability Framework. All contracts and service level agreements will require Service Delivery entities to ensure that they have robust structures and processes in place to ensure quality and safety of services.

**Outcome based:** Develop clear quality priorities and outcomes for the system as part of the ‘Commissioning’ process accompanied by an implementation plan to be delivered across all the service entities. The agreed outcomes will be measured using a variety of clinical and other indicators and to assess the quality of commissioned services. This information will also assist in quality assurance, informing the service design/re-design and areas requiring improvement.

**Continuously learning:** Learning from serious incidents, complaints and recommendations of major reports should also inform the ‘Commissioning’ cycle. Learning should also be drawn from existing performance data and reports from regulatory bodies and be incorporated into future strategies, service improvement and designs, service plans and specifications.

**Staff engagement and involvement:** It is important to look at the responsibilities of all staff in supporting and ensuring staff are engaged in driving quality and service improvement. All staff levels need to be supported and enabled to deliver on the quality goals of the system. There are three lines of proactive quality management in the health system. These are outlined in Table 1.
Table 1: Proactive Quality Management

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<th>Three lines of Proactive Quality Management</th>
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<tr>
<td><strong>First line</strong></td>
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<td><strong>Frontline</strong></td>
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<td>Frontline professionals, both clinical and</td>
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<td>managerial, who deal directly with patients</td>
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<tr>
<td>and the public and are responsible for</td>
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<td>their own professional conduct and</td>
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<td>competence for the quality of care.</td>
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<td><strong>Third line</strong></td>
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Quality and Service Improvement in the Evidence Informed ‘Commissioning’ Cycle

Figure 4 illustrates that patients and service users receive quality care when there is a focus on both quality services (i.e. what is delivered) and quality processes (i.e. the way they are delivered). The services and processes periodically need to be checked and validated in order to determine whether they meet the quality standards, expectations, measures and targets. This is typically done using quality assurance processes that check and validate both quality services and processes. If they don’t meet the required standards, expectations, targets or a need for improvement is identified, Quality Improvement (QI) methodologies, for example the HSE’s Framework for Improving Quality, system reform, and other service improvement methodologies can be systematically applied to identify, design and implement changes in order to improve either services, processes or both.

The approach shown in Figure 4 must be embedded in the design and processes for each of the functions in the ‘Commissioning’ cycle as well as other functions performed at the National Centre. Each function should be clear about the quality of services (or outputs) it produces and the processes it follows. As an example, Population Needs Assessment should clearly articulate the quality outputs it delivers and the processes taken to deliver it. Those outputs and processes should be periodically checked and validated to ensure they are meeting the quality expectations, and if not identify areas of improvement to be implemented using a suitable improvement methodology.

![Figure 4: Approach to Quality across all functions within the Evidence Informed ‘Commissioning’ Cycle](image-url)
## Role of the Centre in Quality and Service Improvement

The following describes the role of the National Centre as it relates to Quality and Service Improvement.

### Leadership and Governance

While the Service Delivery entities will lead and deliver on their own quality priorities and outcomes, the National Centre will provide clear specification in the ‘Commissioning’ cycle on required priorities and quality outcomes. The Service Delivery entities will be held to account for quality outcomes and any service improvement measurements through the ‘Commissioning’ cycle.

The National Centre will also:

- Set the standards for governance structures and processes relating to Quality and Safety in the ‘Commissioning’ cycle.
- Lead a culture of openness and innovation to ensure that service improvement is a core role of all staff within the health system.
- Champion a culture where patient and service user experience and outcomes become an essential part of Quality.
- Ensure quality processes and services, quality assurance and service improvement is embedded within all functions performed by the National Centre (for example, finance, HR, ICT).

### Collaboration and Partnership

The National Centre will partner and collaborate with the Service Delivery entities in delivering improvements and learning across the system.

The National Centre will act in an oversight role to:

- Understand where service improvement is working well
- Understand and support Service Delivery entities in address problems
- Identify how to collectively support solutions to common service improvement issues

The National Centre and the Service Delivery entities will listen and use feedback and information from service user experiences of care to improve quality of care.

### Information

The National Centre will:

- Take a lead role in enhancing existing approaches to the collection, analysis and interpretation of quality and safety information across the system in order to support service improvement.
- Facilitate sharing of information and intelligence on quality and safety.
- Identify service delivery entity deficient in current quality information systems and identify requirements for effective high quality information systems going forward.
- Specify data and information requirements to support quality, quality assurance and enable service improvement, including patient and service user experience.
The National Centre will:

- Further enhance the support, guidance, tools and expertise to Service Delivery entities to enable them to embed quality and enable them to improve their services where required.

- Assist Service Delivery entities in appraising their quality and service improvement approaches, with a view to assisting them to improve organisational performance, achieve better clinical outcomes and to build on their existing capability as a learning organisation. This is shown in Figure 5 below.

![Diagram](image)

**Figure 5: Local, Service Delivery entity and National level service improvement**

- Support the Service Delivery entities to include service improvement in their own business processes (for example, finance, HR, procurement, information systems etc.), in particular to support clinicians at the front line to achieve their quality initiatives and outcomes.

- Identify opportunities for providing incentives for innovation and service improvement as part of the ‘Commissioning’ process.

- Develop quality and service improvement expertise capable of operating at all levels of the system

- Support a system wide evidence approach to quality that is focussed on ensuring quality is measured properly using correct indicators and outcomes and services are improved where required.

The National Centre will:

- Enhance skills and expertise in quality improvement methodologies in order to support both the National Centre and the Service Delivery entities in quality and service improvement initiatives.

- Build skills and expertise at the National Centre and across the delivery system to ensure evaluation becomes a key activity in identifying and improving services.

- Provide system capacity and capability teams to support embedding quality, assuring quality standards are met and improving services using quality improvement methodologies, coaching, mentoring and training.
### Integrated Care

The National Centre
- Will drive integration of all quality programmes and will ensure integration of all programmes going forward to ensure better quality outcomes and more effective use of existing resources.
- Will drive integration of all service improvement programmes and will ensure integration of all programmes going forward to ensure shared learning and more effective use of existing resources.

### Measuring and Evaluation

The National Centre will
- Work with the delivery system to agree quality outcomes and KPIs and will provide support to the delivery system on measurement for improvement.
- Link quality patient and service user outcomes to population based outcomes in order to inform future strategic planning and areas of prioritisation and investment.
- Ensure effective Quality Assurance processes to monitor and evaluate quality as part of the Performance and Accountability framework and will support services that need assistance to improve their own measurement and evaluation functions, highlighting areas that may require service improvement.
Different to today?

The National Centre will treat Quality as the organising principle at which all other functions must support.

Quality being embedded in all areas of the health system, including strong leadership in the National Centre and Service Delivery entities.

There will be a system wide evidence approach to quality that is more integrated, outcome based, with quality at the core of all we do rather than a set of programmes being delivered across Divisions and services.

Quality will be driven by both the National Centre and the Service Delivery entities, with service delivery entities being measured on their quality and incentivised where successful quality is seen and also enforcing penalties where the lack of quality can be a risk to patient safety.

Service Delivery entities will drive their own service improvement agenda, while also sharing learnings and outcomes with the health system.

Engagement with all staff to ensure a common and consistent approach to support a whole of system approach to quality and service improvement.

Clarity around governance, accountabilities, roles and responsibilities in support of a whole system approach to quality and service improvement.

Quality will be embedded in all areas of the Evidence Informed ‘Commissioning’ Cycle, ensuring that priorities, strategies, service designs, contracts and evaluation all have quality embedded, that this quality can be measured, and allow for service improvement where required.
Population Needs Assessment

Purpose

In Ireland, as in many countries, the increasing demand and cost of health and social care is putting pressure on limited available resources. It is also recognised that for many countries there are significant issues of inequitable access to adequate health and social care, in particular that some population groups who most need care are not able to access it and may not demand it. This can be for a number of reasons, including patients and service users not knowing about services, or understanding that services can help their problem. There are also issues in relation to variation in the availability, quality and use of health and social care by geographical area and point of provision.

Patients and service users may not demand a service, but it is clear that it would be beneficial to their health and wellbeing and the economy as a whole if the service was available. The need for health and social care is widely accepted to mean the population’s ability to benefit from care.

Therefore, when ‘Commissioning’ health services, the ‘need’ of the population should be considered. The three elements to be taken into account when assessing a population’s need are: Demand, Supply and Need (see Figure 6). Supply can be determined by assessment of resources (including cost). Within any healthcare system, the identification and description of these three overlapping areas can be a challenge. A further challenge for ‘Commissioning’ is to ensure that there is better alignment of these three areas – so that supply meets needs.

![Figure 6: The elements of Need, Demand and Supply in Population Needs Assessment](image)

In response to these issues, many countries have introduced a systematic approach to determining the health and social care needs of their population in order to inform decisions about prioritisation, planning and resource allocation. A population needs assessment is seen as a dynamic process undertaken to identify the strengths and needs of a population, including assessing the resources the population has...
access to, which enables the establishment of priorities and facilitates collaborative action planning directed at improving the population’s health and wellbeing.

In Ireland, the implementation of a systematic approach to assessing the health and social care needs of populations will support informed decisions about prioritisation and resource allocation and will enhance the focus on improving and delivering on health and wellbeing outcomes and reducing inequities. Therefore, population needs assessment will be a core input into the ‘Commissioning’ cycle and in particular will inform, and be informed by, service design, strategic planning and service planning.

The assessment of needs is typically the first stage of ‘Commissioning’. This approach has been supported by the development and implementation of policy, and in some countries, legislation. For example, in the UK there is a requirement for Joint Strategic Needs Assessments (JSNAs) to be carried out by local government, local health services and other partners to identify health and wellbeing needs in a given population.

The purpose of population needs assessment is to gather the information needed to understand the type and distribution of services required for a population to gain the maximum benefit. This requires an understanding of the health and wellbeing needs of the population. It is understood that there are many determinants of health and wellbeing and therefore a broad and inclusive approach should be taken to population needs assessment to ensure that it takes into account that other services and sectors can impact on the health and wellbeing of a population. For example, the services provided by county councils, such as parks and recreation facilities, can be taken into account in a population needs assessment focusing on the health and wellbeing of a community or geographical region.

Population needs assessment can be carried out at different levels of the Health system –

- National service or population
- Geographical or Hospital Group or CHO catchment populations
- Local populations – local service

In Ireland, many population health needs assessments have been carried out over the years but there has not been a standard programme approach and many have evolved in response to local need. However, where population needs assessments have been developed they have fed into the planning and development of services e.g. palliative care needs.

Internationally the methodology for population health needs assessment developed by the National Institute for Health and Clinical Excellence (NICE) UK has been and continues to be extensively used or adapted and used. This sets out five steps in the population health needs assessment process.

This methodology includes the assessment of resources, such as physical capital (e.g. Hospitals, Ambulances, Operating Tables), consumables (i.e. Pharmaceuticals, stents etc.), and human resources. For example, a health needs assessment for a community includes assessing resources from all health and social services, including services being provided by voluntary agencies and external third parties. In recent years the focus has increased on the resources assessment element of a needs assessment and it can be specifically referred to in the assessment process. This methodology is outlined in Figure 7.
Figure 7: NICE Steps to Population Needs Assessment

**Step 1: Getting started**
- What population?
- What are you trying to achieve?
- Who needs to be involved?
- What resources are required?
- What are the risks?

**Step 2: Identifying health priorities**
- Population profiling
- Gathering data
- Perceptions of needs
- Identifying and assessing health conditions and determinant factors

**Step 3: Assessing a health priority for action**
- Choosing health conditions and determinant factors with the most significant size and severity impact
- Determining effective and acceptable interventions and actions

**Step 4: Planning for change**
- Clarifying aims of intervention
- Action planning
- Monitoring and evaluation strategy
- Risk-management strategy

**Step 5: Monitoring on/review**
- Learning from project
- Measuring impact
- Choosing the next priority

**Step 1: The first key step is to determine the population for which the needs assessment will be carried out.** This identification should be aligned with national policy and priorities. It is also important that the objective of the population needs assessment is clearly determined and stated and that the resources required to carry out the population needs assessment are identified.

**Step 2: The next step includes identifying the information that is required and available on the population needs and the methods to collect it.**

Needs can be informed by the general burden of disease of the population. It is understood that there is a relationship between burden of disease and demography, as chronic diseases are more common in older persons. This data and information should be collected, analysed and interpreted to build up a picture of the needs, demands and resources available to the population.

In the last decade, as the cost of health care continues to rise but with limits on the resources available, there has been an increased focus on assessing the resources available to meet the needs and demands of populations. There has also been an increased focus on assessing the effectiveness and efficiency of resources and their allocation. Future population needs assessments carried out in Ireland will have a clear focus on assessing the resources available and in making recommendations on how resources could be prioritised and allocated in future service design and planning.

**Step 3: The information collected is analysed and used to inform a prioritisation process for ‘Commissioning’.** For example, which populations with higher prevalence of illness or disease, which have greatest impact as measured by size and severity, should services be commissioned and provided for. These recommendations should be informed by the availability of evidence based interventions that are effective and acceptable to the population and should also be aligned to national policies and strategies.

**Step 4: The next step is the implementation of an action plan for the ‘Commissioning’ and delivery of the selected services.** There should be clear aims and objectives in the action plan for delivery of the services, with targets and timelines (KPIs).

It is also useful to develop a monitoring and evaluation plan to measure the quality, safety and effectiveness of the population needs assessment, but also to measure the impact or added value of the commissioned services or interventions.
**Step 5:** This step, which is important in a learning and quality improvement organisation, relates to the people involved in the population needs assessment reflecting and learning from the process. What went well, what further action is required and what can be learned for the next population needs assessment?

Quality population needs assessment is dependent on quality information and comprehensive engagement with key stakeholders. The type of information required depends on the population needs assessment, but it is important to be able to describe the demography of the population, the prevalence of specific relevant diseases, behaviours that impact on health (e.g. smoking prevalence) and the utilisation of services. Engagement with service users and service providers also informs the process of describing both the demands and the needs of the population.

**Role of the National Centre in Population Needs Assessment**

The following describes the role of the National Centre as it relates to Population Needs Assessment

<table>
<thead>
<tr>
<th>Leadership and Governance</th>
<th>The National Centre will:</th>
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<tbody>
<tr>
<td></td>
<td>- Provide leadership by developing and implementing a shared strategic vision and approach to ‘Commissioning’ that is informed by population needs assessment (including resource assessment) to ensure there is a consistent approach to populations needs across the health system.</td>
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<td></td>
<td>- Provide leadership through example by ensuring its approach to population needs assessment is inclusive, open, transparent, fair, equitable and evidence informed.</td>
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<td></td>
<td>- Ensure that population needs assessment is focused on improving high quality outcomes for patient and service users, including health and wellbeing outcomes such as reducing health inequalities.</td>
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<td>- Ensure that population needs assessment includes a comprehensive resource assessment as appropriate.</td>
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<td></td>
<td>- Ensure the voice of the patient and service user is included in population needs assessment to inform Government and policy makers of critical areas requiring attention based on population need.</td>
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<tr>
<th>Collaboration and Partnership</th>
<th>The National Centre will</th>
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<tr>
<td></td>
<td>- Support and work in collaboration with all sectors of health and social care when population needs assessments are being undertaken. This includes, when appropriate, service providers such as acute hospitals, community care, primary care, social care and with all clinicians such as Consultants, General Practitioners, and allied health practitioners.</td>
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<tr>
<td></td>
<td>- Support and work in partnership with other sectors such as environment, local government: city and county councils, Education and community to ensure a focus on improving the health and wellbeing of the population.</td>
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<tr>
<td></td>
<td>- Actively consult with and collaborate with, when appropriate, with all key stakeholders across the Health System in relation to population needs assessment specifically with the Department of Health, Department of Children and Youth Affairs, other Government Departments and Agencies, the Health Regulators, Academic institutions and universities, NGOs, advocacy groups and voluntary bodies and the private sector.</td>
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<tr>
<td></td>
<td>- Champion and advocate for the involvement of patients and service users in the process of all population needs assessments, for example patients and service users should be active participants in population needs assessments.</td>
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</table>

| Information | The National Centre will provide clear leadership in developing an information, analytics and evidence function to support population needs assessment at all levels of the organisation. |
### Enabling and Supporting Service Delivery

The National Centre will support Service Delivery entities in conducting local population needs assessments by providing a framework, including processes and guidance, in which to undertake the activity and provide subject matter expertise where available.

### Capacity and capability

The National Centre will
- Develop and support health and social services in carrying out population needs assessment by providing population needs assessment capability and capacity and resources. This includes providing support and building the capability and capacity across the organisation, for example by providing a framework, creating supportive networks and developing guidance and tools.
- Access capability and capacity for the health and social services by partnering with academic institutes and bodies for example Universities and third level institutions both within and outside Ireland and with International Health Agencies for example the WHO.
- Model and deliver on cross functional working for example by establishing multidisciplinary teams for national priorities that can work together to deliver on different aspects of the priority such as population needs assessment, service design and planning functions for a identified population group.

### Integrated Care

The National Centre will ensure when supporting and undertaking population needs assessment that there is a focus on an outcome of integrated care and services. This will be supported by ensuring the involvement in the population needs assessment process of stakeholders from across the care sectors, such as service providers from primary care, acute care, community and social care services as well as patient, service users and their carers and families.

### Measuring and Evaluation

The National Centre will ensure that population needs assessments use quality data and information and that as part of the recommendations will clearly set out the requirement for services to measure and evaluate their performance in delivering high quality and effective care. This information is essential in informing the different aspects of the continuous ‘Commissioning’ cycle.

### Different to today?

There will be a consistent approach to population needs across the health system. Local and National needs assessments will use the same methodology and principles to ensure that the same rigor is applied throughout the health system.

Population Needs assessment will inform and drive decisions that are made regarding strategic planning and prioritisation, service design, service planning and subsequently resource allocation and investment decisions.

Capacity and capability will be available in the system for performing population needs assessments in local areas as well as at a national level.
Strategic Planning and Prioritisation

Purpose

Due to the constantly changing environment of healthcare today, it is crucial that healthcare leaders step back and continually assess the organisation's strategic plan and key priorities.

If a healthcare service is unplanned it cannot hope or expect to advance and improve in an expectant manner and spending on health will be reactive rather than proactive. Therefore, money can be wasted on low value care, while other effective services remain underfunded. For these reasons strategic planning is essential and if undertaken robustly will empower decision making that best meet the needs of patients and service users.

Strategic planning is programmable, systematic, rational, holistic and integrates the short, medium and long term needs. This type of planning allows the health system to focus on longer term goals and provides a roadmap on how to achieve these goals. Strategic planning is used to guide decisions, including those regarding capital, technology, staff and other resources. It creates a culture of anticipation and innovation rather than one of reaction and defensiveness. It develops a coherent and clear base for decision making, improves resource allocation, identifies high performing and low performing areas, and provides an opportunity to standardise and otherwise become more efficient. More importantly, strategic planning helps establish the process for delivering high-quality care and shapes the organisations future, and is an ongoing process.

To have an effective strategic planning process it should:

- Have a consistent organisational wide understanding of established processes and procedures for planning
- Have commitment from the top down and not be given just lip service
- Fit with the leadership and management style of the organisation
- Align to the local plans built up through a system wide plan
- Be responsive to patient and service user needs
- Link with research and service information (e.g. population needs and resource assessment).
- Be practicable and doable in the existing system

Strategic plans consist of plans such as corporate plans, longer term strategic plans for services (e.g. Maternity and Infant strategy), and also strategic plans based on population rather than structure.

Prioritisation is complex, politically sensitive and a key challenge for the system and it is critically important that the system has a fair, clear and transparent process to set priorities for planning and ‘Commissioning’ of healthcare services. There should be an explicit, fair and evidence-based approach to priority setting such as Programme Budgeting and Marginal Analysis (PBMA).

The overall purpose of planning in an Evidence Informed ‘Commissioning’ cycle must be the delivery of value and quality for patients and service users.

Value is defined as achieving quality health outcomes for patients and service users relative to their costs. It encompasses quality, productivity, efficiency and effectiveness and how we manage demand, capacity and throughput. Value is important when making the best decisions against the background of constant financial constraints. Understanding and achieving value is difficult to attain, and many organisations find the process very challenging. The only way that healthcare services can effectively improve the healthcare value for patients and service users is to measure outcomes.
Quality is an output of a values based approach and for healthcare in Ireland is defined by four quality domains set out in the Safer Better Healthcare Standards i.e. person centred; effective; safe and better health and wellbeing domains. The healthcare service is committed to improving the quality of care across all levels of services and it is imperative that there is a quality focus embedded in services, from planning through to delivery.

It has been shown that effective planning must be a partnership approach across multiple levels including national, Service Delivery entities and local levels in order to produce a plan that is meaningful and effective, owned by those who have to deliver them and will meet the needs of the population.

Figure 8 below outlines the overall planning that the Health Service will provide. Planning will be a combination of top down planning cognisant of legislation, policy and priorities and bottom up planning arising from the needs identified at local level. This combination of bottom up and top down planning ensures that the needs of the local populations are met in conjunction with the priorities of the health system as a whole, alongside standard processes and procedures that ensures the highest possible quality care to the entire population.

In conjunction with all relevant partnerships such as Government, Department of Health, and the constituent parts of the Service Delivery system, the National Centre will be responsible for producing the Strategic Plans at a national level while supporting Service Delivery entities to produce their own Strategic and Service Plans.

![Figure 8: Overall planning in the Health Service](image-url)
Role of the National Centre in Strategic Planning and Prioritisation

The following describes the role of the National Centre as it relates to Strategic Planning and Prioritisation

### Leadership and Governance

Strategic Planning will be based on and shaped by desired health and quality outcomes; evidence-based needs assessment; integrated models of care that are patient (not system) centred; risk assessment; national policy and strategy; and availability of resources and capability and will focus on the changes required to provide a more sustainable service.

The National Centre will
- Lead strategic planning and prioritisation in a clear and transparent manner and will secure early engagement with Department of Health (DoH) on priorities, policy, requirements and timescales.
- Demonstrate strong leadership and governance by developing a formal process for identifying and prioritising strategic focus areas for investment that is fair, clear and transparent in setting priorities for both planning and ‘Commissioning’ (and decommissioning) of healthcare services.
- Lead on developing a vision for health services on behalf of the population of the country.
- Integrate the various components of the ‘Commissioning’ cycle (e.g. population needs assessment, service design, performance and accountability) in the development of longer term strategies and plans that clearly articulate the priorities of the health system.

### Collaboration and Partnership

The National Centre will
- Lead the engagement with the Department of Health on legislative and policy requirements and with other external stakeholders together with the Service Delivery entities in order to create joined-up strategies.
- Partner with the Service Delivery entities, including external service providers to ensure that these long term strategic plans are achievable within the Service Delivery entities and the health system as a whole.
- Partner with all areas of the health system alongside the Service Delivery entities, such as the Department of Health, other government departments, third party providers, NGOs, patient and service user advocate groups will be partnered in the strategic planning process in order to ensure high quality services are delivered to the patients and service users.
- Engage with front line staff to ensure longer term strategies address challenges faced in the delivery of services.

### Information

The National Centre will
- Build on existing information, knowledge management and analytics capacity such that there is a ‘single version of the truth’ in terms of data and the analysis of same in order to create good quality information that will properly inform strategic planning processes.
- Provide access to relevant information relating to policy and legislation to be considered as a key input to the development of strategic plans and priorities.

### Enabling and Supporting Service Delivery

The National Centre will
- Lead the Planning Function for the health system, building on the structured approach that has been developed and improved over many years.
- Provide support to Service Delivery entities to develop the strategic plans for the health services as a whole. This will involve leading on the overall approach and methodologies in developing strategic plans including providing guidance on policy and legislation to be considered. In the strategic planning processes the National Centre will consider the vulnerabilities of plans, likely impacts on plans, potential risks to the plans and will take a risk based approach in establishing the plans by
Different to today?

Strategic Planning will integrate various components of the ‘Commissioning’ cycle (e.g. population needs assessment, service design, performance and accountability) to develop longer term strategies that clearly articulate the priorities of the health system.

Plans will be based on and shaped by desired health and quality outcomes and will be aligned to service reconfiguration and service redesign.

Need of the population and priorities will be clear in strategic plans and how through the services they will address these.

Formal robust process for the identification of strategic investment areas.

There will be clear lineation from the Strategic plans to the front line plans.

Longer term strategic plans, from which annual, bi-annual or multi-annual plans will evolve.

Integration of service delivery will be at the forefront of strategic planning and priority setting, with population based plans being produced in some cases, agnostic of delivery structures.

Good quality data, information, research and evidence will underpin the strategic planning process.

Patient and service user views and feedback will be represented throughout the strategic planning process.

The prioritisation process will result in more focussed strategic priorities across the health system to support and enable end to end delivery of those priorities within the limited capacity available.
Service Design

Purpose

Currently health and social care services are inadequately equipped to meet the needs of the twenty-first century population. Change is required to meet the needs of our rapidly expanding populations of older and chronically ill people and to contain rising costs. Better Health, Improving Health Care suggests that change should be based upon a set of agreed principles, such as:

- Prevention is a vital part of any strategy for change in health services and therefore must play a pivotal role in enhancing health and well-being of the population. Health services should be provided to people at the most appropriate level including home care and self-management where appropriate.
- The vast majority of health-care needs should be addressed by a comprehensive range of primary care services,
- More integration of care is needed and this should be supported by the assignment to primary care of an explicit coordination and case management role for all but the most complex of cases,
- Patient safety and greater choice and voice for service users in their dealings with the health service should underpin planning and delivery of all services.

Service design (and re-design) is the process by which we aim to meet needs and provide better patient and service user experiences and outcomes while delivering better value and securing stakeholder engagement. A service design process typically consists of four distinct phases of discovery, definition, development and delivery. Outputs from the service design process may include patient journeys, clinical guidelines, preferred medications guidance, gap analyses, operational plans and models of care.

The scope and scale of service design outputs vary according to the size of the project and the subject area. For example, service design focused at the level of the patient or service user may result in the development of a care pathway or clinical guideline. Service design focused at the level of sub-populations or entire populations will result in models of care e.g. a model of care for rehabilitation or a model of care for asthma. A “Model of Care” broadly defines the way health and/or social care services should be delivered. It describes best practice and services or responses within a system (or a part of that system) for a population group as they progress through the stages of a condition, injury or episode of care. It aims to ensure people get the right care, at the right time, by the right team and in the right place.

To date, models of care produced by the Clinical Strategy and Programmes Directorate have been predominantly focused on descriptions of best practice within the hospital setting e.g. Model of Care for Acute Surgery. In the future, models of care will need to sit across a range of services, including primary and secondary and community services and they will have to include best practice descriptions of both health and social care. The aim of service design is to provide a comprehensive description of end-to-end service delivery and so a whole systems perspective will have to be maintained to ensure that service design outputs are joined up and interdependencies between different models of care are recognised. The Integrated Care Programmes currently aim to function in this manner by providing an organising framework for some service delivery outputs.

Patients and service users want to experience a health system that is as seamless and uncomplicated to navigate as possible. If the organising principle for service design and care delivery is integrated care, then patient or service user perspectives will have to be central to design processes and service design teams will have to share a common vision of how our future health services will function. Service design for health and social care, therefore, requires real understanding of the needs of stakeholders and a strategic understanding of how resources can be best used in order for outcomes to be met. Importantly, it requires lateral thinking and an ability to grasp the bigger picture of whole systems thinking. It is vital that each service delivery output not only focusses on delivering real patient or service user benefit but also delivers value in terms of ensuring services are sustainable on a long term basis.
In order for service design to realise the full scale of its contribution to the Evidence Informed ‘Commissioning’ Cycle:

- Service design processes will have to foster stakeholder engagement;
- Service design outputs will have to be in a form that enables them to be used as effective ‘Commissioning’ tools and used to inform other stages of the cycle.

Stakeholder engagement is important for a number of reasons. Engaging with patients, service users and service providers ensures that service design operates from the premise that service providers and communities are viewed as equal participants in the design and delivery of services rather than simply as passive recipients. Co-design fosters an environment that builds on existing stakeholder capabilities, breaks down barriers and develops networks. Finally, stakeholders are more likely to become catalysts for implementation of models of care if they are co-creators in the service design process.

The form that service outputs take is also important for a number of reasons. As previously stated, models of care describe best practice and services. In order for change to be realised, models of care must be implemented. Implementation science provides us with many insights and strategies for incorporating improvements into service settings. Some key themes that arise from the implementation literature that are of relevance to service design are that successful implementation is more likely if:

- The innovation is evidence-based and addresses local need,
- There is a good fit between the innovation and existing structures and values,
- There has been an assessment of capacity to implement and identification of necessary resources required to support implementation.

Models of care therefore need to strike a balance between two opposing forces. They need to be sufficiently comprehensive in their scope that they address financial, workforce and operational implications and risks. However, in terms of description of best practice health or social care process, they should only describe minimum essential service characteristics. This is so that a ‘second redesign’ can occur at the level of the service delivery entity that allows those providing the service to customise what finally gets implemented. Junginger and Sangiorgi\(^9\) encourage designers to move from playing the role of ‘directors’ in the process, to playing the role of ‘enablers’, ‘facilitators’ and ‘connectors’ in a participatory design process that iteratively ‘builds capacities from within.’ This is a key behaviour that will need to be developed within service design at the National Centre.

Models of care will also need to include the design of mechanisms (such as Key Performance Indicators) that can be used to measure, monitor and evaluate outcomes. These mechanisms will feed directly into the Performance and Accountability phase of the cycle. At the end of a service design process, feedback from a monitoring and evaluation phase will also provide important information as to whether needs have been met. If required, a further phase of service redesign may then be planned to better meet needs or to use resources in a different way to achieve outcomes. Additional opportunity to inform the contracting phase of the ‘Commissioning’ cycle arises when value is explicitly considered during the service design process. Understanding the component parts of service delivery, their interactions with other parts of the health system and their associated costs is fundamental to the development and utilisation of new funding models and contracting approaches.

Figure 9 provides an overview of the service design process for health and social care. It details potential inputs and outputs of the process. It is clear that in order to develop comprehensive models of care, service design teams need a wide range of skills. Necessary competencies include health and social care expertise, communication skills, financial, research, economic and data analysis skills, evaluation and project management skills.
Role of the Centre in Service Design

The following describes the role of the National Centre as it relates to Service Design

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<tr>
<th>Leadership and Governance</th>
<th>The National Centre will</th>
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<tr>
<td></td>
<td>Create a common vision for what it is trying to achieve in service design and its role in the evidence-informed ‘Commissioning’ cycle, and a shared approach of how the health system will get there.</td>
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<td></td>
<td>Create an environment which values and actively supports innovation and balances freedom to change with risk of failure.</td>
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<td></td>
<td>Develop a culture of collaboration, information seeking and sharing as well as being results orientated.</td>
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<td></td>
<td>Engage in a process of prioritisation and planning that results in:</td>
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<td></td>
<td>- Transparent, value-based and evidence-informed prioritisation of service design projects,</td>
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<td></td>
<td>- Definition of service design support requirements.</td>
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<tr>
<td></td>
<td>Implement a framework for governance for service design teams that includes consideration of appropriate composition of working group membership and that establishes rules and mechanisms for operation and decision-making (including managing conflicts of interest).</td>
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</table>
### Collaboration and Partnership

The National Centre will
- Engage with Service Delivery entities and other relevant stakeholders to promote collaborative partnerships that support the work of models of care working groups and extends their reach and impact.
- Provide communications support to enhance stakeholder engagement with process of service design, and promotes dissemination and implementation of models of care.

### Information

The National Centre will
- Provide reliable and accessible data and clinical information to inform service design.
- Adopt a pro-active approach to knowledge management and experience based learning to build on the experience of existing service design teams and creates communities of practice with service delivery entities and other stakeholders.

### Enabling and Supporting Service Delivery

The National Centre will develop an organisational capacity to understand the capability of Service Delivery entities to implement service design outputs and develops the capacity to provide support to Service Delivery entities, as appropriate.

### Capacity and capability

The National Centre will develop an organisational capability to conduct service design through improved competencies, provision of tools and technology, development of leadership, and/or other skills.

### Integrated Care

The National Centre will design:
- Models of care that integrate mental health and social determinants of health with physical health.
- Models of care that support care management, case management and coordination.
- Models of care that wherever appropriate, integrate care delivery into the community.

### Measuring and Evaluation

As part of the Service Design process, patient and service user outcome measures will be developed that will be used to both specify and contract services (including funding allocation) and subsequently measure performance.

### Innovation

The National Centre will develop an organisational capacity to pilot and evaluate innovative models of Service Delivery and improvement (including funding and payment models).

### Different to today?

Comprehensive service design will be performed by highly skilled teams that possess clinical, managerial, analytic and financial knowledge. They will have access, use and ability to interpret data to assess a population’s health and conduct health needs assessments.

A consistent approach to service design will support more successful implementation and will ensure that end deliverables do not vary and align to whole system needs.

Service design not only to be focused on the clinical aspects of healthcare delivery but also the social aspects of healthcare in order to meet needs and deliver integrated care.

Service designs in the future will contain a full suite of information that will be used to drive other aspects of the evidence informed Health System such as funding allocation, contracting, performance and accountability.

The outputs of service design will need to be linked to detailed assessment of service delivery entity readiness to implement. Where significant differences in service provider capability, capacity and maturity exist, these will need to be recognised and addressed in implementation plans.
Service Planning

Purpose

Healthcare planning is important for all health services. *Future Health: A Strategic Framework for Reforms of the Health Service 2012-2015* sets out how to address challenges in meeting healthcare requirements by fundamentally reforming Ireland’s health services. The future health framework provides a greater focus on health and well-being as opposed to just the treatment of ill health. It proposes more patient focused service reforms, with a less hospital-focused model of care to be introduced which offers more community-based alternative. These principles need to underpin our planning frameworks for future healthcare services.

Integration of the primary care, acute hospital care, health and wellbeing, social care and mental health care services is critical in healthcare planning. It is being increasingly recognised that many patients and service users will need access to more than one of these services over a lifetime. While achieving connectivity across these categories will be challenging, it has the potential to be very beneficial to patients and service users when they are accessing healthcare.

There are many different types of resource allocation models in operation around the world. Developing a model for healthcare in Ireland requires a careful review of such models from which certain principles can be extracted and applied in Ireland and linked to population needs, strategic planning and priorities and contracting. All capitation models begin with the size, and usually the age distribution of the population in the areas to which resources are being allocated. These measures provide the basis for all further calculation. Different countries use different methods of allocating resources to people for example allocate resource on an individual level or small area level.

The service planning process should include an evidence based resource allocation model. Resource allocation should be cognisant of budget and resource constraints and the availability of good quality information. Resource allocation needs to be based on outputs of population needs, strategic planning and prioritisation and service designs.10

Planning, design and ‘Commissioning’ of services should be fully informed by the realities and challenges of the operational issues within current models of care but not overwhelmed by these and thereby focus on iterative changes required to bring about more sustainable healthcare services.

Currently, a National Service Plan (NSP) is prepared for each financial year in accordance with Section 31 of the Health Act 2004. Future service planning will involve the following characteristics:

- Service planning at a national level
- Service planning at local level
- Multi-annual planning
- Clear resource allocation
- Service plans underpinned by the objective of continuous quality improvement
- Informed by legislation, priorities, evidence-based population needs, strategic plans and service design.
- Overview of all services, including new services and possible services which are decommissioned
- Clear link to budget allocation.
- KPIs for services will be planned at the most appropriate level, and reflected in those plans.
- Act as an input for contracting process and performance and accountability of the health system
Figure 10 demonstrates the link between service planning at a national level and local planning. Each entity (CHO/HG/ NAS/National Centre has individual service plans for how they operate. The national service plan will be representative of local service delivery plans. National service planning ensures that legislation, priorities, evidence-based population needs, strategic plans, priorities and service designs are properly incorporated into local plans as needed, and represent the views of the Health System in delivering a high quality service to all patients and service users.

**Figure 10: Link between national service planning and local planning in the Evidence Informed ‘Commissioning’ Cycle**

**Role of the National Centre in Service Planning**

The following describes the role of the National Centre as it relates to Service Planning

<table>
<thead>
<tr>
<th>Leadership and Governance</th>
<th>The National Centre will</th>
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<tbody>
<tr>
<td></td>
<td>• Provide strong leadership and governance of the service planning cycle.</td>
</tr>
<tr>
<td></td>
<td>• Develop planning guidelines and resource allocation models</td>
</tr>
<tr>
<td></td>
<td>• Ensure that planning of services will be fully informed by evidence-based population needs assessments, to support a more sustainable service.</td>
</tr>
<tr>
<td></td>
<td>• Promote a culture of innovation within the health system. Hold the service delivery entities to account for the delivery of the service plan. Standards will be set by the National Centre for which the service delivery entities are held accountable to and incentives will be provided where good performance and quality is demonstrated.</td>
</tr>
<tr>
<td>Collaboration and Partnership</td>
<td>The National Centre will</td>
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<td>-----------------------------</td>
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</tr>
<tr>
<td></td>
<td>• Lead and partner with the external and internal stakeholders in delivering Service Planning for the health system in totality.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that research, knowledge and evidence based best practice is shared across the health system and informs the planning process.</td>
</tr>
<tr>
<td></td>
<td>• Partner with Service Delivery entities, the Department of Health, other government departments, third party providers, NGOs, patient and service users including advocacy groups in order to ensure high quality services are delivered to the patients and service users.</td>
</tr>
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<table>
<thead>
<tr>
<th>Information</th>
<th>The National Centre will</th>
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<tbody>
<tr>
<td></td>
<td>• Build on existing information, knowledge management and analytics capacity such that there is a ‘single version of the truth’ in terms of data and the analysis of same. Ensure that service planning is based on evidence based information on population groups, specific services or disease epidemiology.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Enabling and Supporting Service Delivery</th>
<th>The National Centre will</th>
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<tr>
<td><strong>Capacity and capability</strong></td>
<td><strong>Integrated Care</strong></td>
</tr>
<tr>
<td><strong>The National Centre will</strong></td>
<td><strong>The National Centre will</strong></td>
</tr>
<tr>
<td>• Lead the Planning Function for the system, building on the structured approach that has been developed and improved over many years.</td>
<td>• ensure service planning supports integrated care as a key priority by taking a population based approach (where ever possible) to support seamless services to patients and service users.</td>
</tr>
<tr>
<td>• Develop ways of working to ensure that local service planning can inform service planning at a national level.</td>
<td>• Ensure there is a focus on outcomes of integrated care and services. This will be supported by ensuring the involvement of stakeholders from across the evidence informed health cycle in the service planning process.</td>
</tr>
<tr>
<td>• Ensure service planning includes inputs from other parts of the evidence-based population needs assessment, service design, prioritisation and allocation of resources and strategic planning are incorporated in the service planning process.</td>
<td></td>
</tr>
<tr>
<td>• Consider the vulnerabilities of the service plan, likely impacts on the plan, potential risks to the plan and will take a risk based approach in establishing the plan by interacting with the Service Delivery entities throughout the process.</td>
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</table>
| Measuring and Evaluation | Service planning will be reflective of the type and volume of health and personal social services provided and consider funding for existing services, gaps in service provision (unmet need) and new developments. The National Centre will:  
- Develop and implement a formal process for the review and development of a more comprehensive set of KPIs including a focus on developing more quality and outcome KPIs covering clinical effectiveness, patient outcomes and patient safety.  
- Ensure that measures and KPIs identified as part of Service Design are incorporated into the planning processes and feed into the contracting and performance and accountability processes.  
- Retire KPI’s that are no longer of key relevance. |

**Different to today?**

The aim is more comprehensive approach to planning rather than focusing on incremental change and new investment. Service planning will seek to:

a) break down existing block funding,

b) include gaps in service provision (unmet need), as well as

c) new investment

Plans across the system will be consistent with a Planning Framework, making plans familiar to all staff at every level. There will also be a far greater focus on the comparison of bottom up and top down plans.

Service Plans will be reflective of strategic plans and priorities within specified timeframes e.g. annual plan, bi-annual plan or multi-annual plan.

Iterative updating of plans during the annual cycle, plans may be updated or changed depending on circumstances of new information and change in demand.

Need of the population and priorities will be clearly outlined in plans including how the services will be delivered to address these.

Good quality data and information will underpin the plans, with measurement and performance a priority including measures that represent patient and service user experience. Research and evidence will also support the service planning process via processes within population needs assessment, strategic planning and service design.

Delivery against plans will form a basis for contracting with Service Delivery entities.

The National Centre will support Service Delivery entities in a more substantive way to build the capacity for service planning across the system.

Patient and service user’s views and feedback will be represented in the service planning process by ensuring active participation in planning processes.
Contracting

Purpose

Contracting is an agreement creating obligations enforceable by law and enables commissioners to transfer the responsibility and risk for the delivery of a particular range of services to a service provider. The law provides remedies if a promise is breached or recognises the performance of a promise as a duty. The basic elements of a contract are mutual assent (agreement by both parties), consideration, capacity, and legality.

In an Evidence Informed ‘Commissioning’ Cycle robust contracting will be used to drive the delivery system to meet the strategic objectives. Contracts with CHO's, HG's and NAS need to be developed to a standard format reflecting the population to be served, the healthcare needs to be met, the specification of services to be delivered along with clearly defined service improvement and quality measures. They will contain the appropriate quality framework, controls in relation to access to services, the evaluation process measuring their delivery, including quality outcomes, outlined within a performance and accountability framework and linked to the funding allocation and payment methodology.

The Service Delivery entities (CHO's, HG’s and NAS) will satisfy their national contracts through internally provided services and a series of sub-contractual relationships with external Service Providers (as noted in Figure 11 below). These sub-contractual relationships will take on a number of new and innovative contractual forms which would best reflect the relative risk and reward for the delivery of these services specifically those in which multiple local providers need to work together to deliver integrated services around the patient and service user need.

The Service Delivery entities will be the contract manager of these sub-contractor relationships using tools and guidance provided by the National Centre.

Contracting is a dynamic process which needs to reflect the capacity and capability of the provider system, the National Centre will therefore provide an oversight role to ensure that the strategic objectives are met.

Contracting needs to be open and transparent, with evidence-based decision-making in the delivery of the component parts, to ensure that the failure of either party to meet their contractual obligations can be effectively managed through the provisions of the contract performance management and escalation process.

Figure 11: Contracting in the Evidence Informed ‘Commissioning’ Cycle
## Role of the National Centre in Contracting

The following describes the role of the National Centre as it relates to Contracting

<table>
<thead>
<tr>
<th>Leadership and Governance</th>
<th>The National Centre will</th>
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<tbody>
<tr>
<td></td>
<td>- Provide strong governance and leadership in the area of contracting through leading and coordinating the development of an effective contracting framework including appropriate collaborative structures for sector engagement, management and compliance assurance requirements, which provides for an integrated approach across the Service Delivery entities. The contracting framework needs to facilitate more flexibility to introduce new pricing models to recognise differences in the delivery of clinical services and the sharing of financial risk.</td>
</tr>
<tr>
<td></td>
<td>- Negotiate and manage individual contracts or ‘performance agreements’ with the Community Health Organisations, Hospital Groups and NAS. These will replace the current performance agreements and provide a more holistic framework for the integrated management of services to support all elements of a value based evidence informed Health System aligned to the ‘Commissioning’ cycle.</td>
</tr>
<tr>
<td></td>
<td>- Provide the framework, guidance and tools for Service Delivery entities to optimise the performance of their sub-contractors.</td>
</tr>
<tr>
<td></td>
<td>- Lead the development of integration in the contracting framework and management which will focus on the delivery of better patient and service user outcomes.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Collaboration and Partnership</th>
<th>The National Centre will</th>
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<tbody>
<tr>
<td></td>
<td>- Manage and support collaboration with relevant stakeholders to ensure the on-going evolution of the contracting models, which are accepted by all parties and meets strategic aims.</td>
</tr>
<tr>
<td></td>
<td>- Provide leadership, direction and facilitation to ensure that the spirit of collaboration and partnership can flourish with a particular focus on national framework agreements which cross care group and division where population needs and services design are the key drivers.</td>
</tr>
<tr>
<td></td>
<td>- Develop the current contracting process to one which is not exclusively focused on non-statutory providers to reflect the fact that the delivery system of Hospital Groups and CHOs will comprise a mix and blend of both statutory and non-statutory providers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information</th>
<th>Good quality information is vital in order to develop rigorous and transparent purchaser provider type relationships and for its successful implementation and sustainability. The National Centre will</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Develop and manage integrated information systems by providing data on service providers and the services provided, to facilitate, analysis and comparison of service providers delivering similar services using the Service Provider Governance (SPG) online tool.</td>
</tr>
<tr>
<td></td>
<td>- Develop and manage the national contract information management IT system, currently the Service Provider Governance (SPG) online tool, to provide operational support for the administration, governance and compliance requirements.</td>
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<tr>
<td></td>
<td>- Will ensure an approach to data be underpinned by the principles of “collect once, use often” and also the principle of “a single version of the truth” in an environment of data rich providers and commissioners.</td>
</tr>
</tbody>
</table>
### Enabling and Supporting Service Delivery

The National Centre will
- Enable and facilitate the development of contract management skills and competencies particularly in the area of governance, compliance and assurance for the Service Delivery entities to effectively manage service providers.
- Continue to develop and deliver automation of the governance and information management requirements where possible.

### Capacity and capability

The National Centre will
- Develop and facilitate training and supports to build the necessary competencies for the delivery of the contracting models including the necessary operational guidance and supporting structures to facilitate the delivery of integrated contracting for the Services and Service Providers.
- Facilitate and enable the development of formal national professional networks within the Service Delivery entities to promote continuous improvement and best practice in contract management and design. This will facilitate the development of the necessary operational management structures for the Service Providers that cross geographical areas and sectors.

### Integrated Care

New contractual forms are a significant driver to the integration of services around patient need with payments made on a population basis rather than segmented by organisation.

The National Centre will
- Set an innovative culture to engender change and experimentation in contractual relationships, such as parallel running an existing diabetes service with a shadow year of capitated outcome based incentivised contract to deliver better outcomes for patients with diabetes and drive integrated care across the Service Delivery entities.

### Measuring and Evaluation

The National Centre will
- Expand existing and develop new key metrics on compliance and quality with the contracting models which provide for a focus on continuing quality improvement and effective management reflecting strategic plans and the dynamic service design.
- Ensure that contracts reflect the performance and accountability framework and agreed national standard Service Delivery metrics, targeted to the particular services provided.
- Lead on the development of funding models which provide for a link to quality outcomes, and quantum of services delivered, and take due account of the unique contribution of the voluntary and charity element of the voluntary service providers.
- Plan and manage the contracting cycle to ensure the standard delivery of contracts which reflect the ‘Commissioning’ cycle and reward quality improvements, better health outcomes and service user experience which is applied to all Service Delivery entities and Service Providers.
Develop the Contracting framework to be

- Fully aligned with the Performance and Accountability framework to provide for standardisation in the management of performance issues including service improvement initiatives across the Service Delivery entities, both internal and external.
- Conversant with the current contracting framework in place for S38 and S39 allowing for effective contract management at local and national level.
- Ensure a phased integration of contracts with the extended health care providers such as GPs, Dentists, Pharmacists and other self-employed health professions allowing for greater integration in Service Delivery and to standardise performance management.
- Responsive and effective to contract change control to ensure accountability is reflective of agreed changes to operational delivery.

The National Centre will

- oversee the management of contracts with Service Providers (where appropriate) that operate in multiple areas across the country optimising the delivery of local performance management and accountability, as well as managing national services through third party providers.
- Manage the delivery of an effective Annual Compliance process for the requirements of all organisations with a particular emphasis on those in receipt of significant funding.

The National Centre will coordinate the governance and compliance requirements in line with the legal and regulatory environment and will work collaboratively with other stakeholders including regulators and other state funders to ensure the models are reflective of current requirements and provides for effective management and compliance requirements.

**Different to today?**

The Contracting process will now incorporate contracts for CHO’s, HG’s and NAS, the intention is to replace the current performance agreements and provide a more holistic framework for the integrated performance management of services to support all elements of a value based evidence informed health system aligned to the ‘Commissioning’ cycle.

Extend the contracting framework to formally contract with internal health service providers with an initial focus being on major hospitals within HG’s.

Focus on reflecting the Performance and Accountability Framework and devolving contract management for service providers to CHO’s and HG’s.

Develop the management of the national and multiple area Service Providers in an integrated manner maximising the delivery of local contracting and performance monitoring while managing the elements of the contracting relationship which require a national perspective.

Strategic alignment of population needs assessment, service design and specification, quality and service improvement, and service planning into the contracting framework.

Expansion of tendering and procurement to support new integrated models of care, service designs and specifications, and the development of framework contracts that cross traditional “care group” silos.
Performance & Accountability

Purpose

*Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015* outlined that appropriate authority, responsibility and accountability for healthcare services must devolve as close to the patient and service user as appropriate in order to empower local decision making. In this context a consistent approach to performance and accountability must occur at each level of the health delivery system cognisant of clearly specified authority and responsibility at each level. Authority and responsibility must be balanced to enable performance and avoid wasted effort, ineffectiveness, unfairness and abuse.

Managing performance, alongside strategic business direction, an organisation can transform how they address issues and improve performance of how the staff performs their roles and ultimately benefit the patient and service users. Performance and Accountability responsibilities need to be clearly known across all roles in the system, through openness and transparency the system as a collective can improve.

Accountability is defined as “an obligation or willingness to accept responsibility or to account for one’s actions”. Accountability can only be achieved however if the appropriate level of responsibility and authority accompanies the scope in which the person is accountable. Burke stated that accountability imposes six demands on public service organisations and their officials/agents. They must

1. Demonstrate that they have used their powers properly
2. Show that they are working to achieve the mission or priorities set for their office or organisation
3. Report on their performance (i.e. the degree of goal achievement)
4. Demonstrate public stewardship (efficiency and effectiveness) regarding the resources used to create the outcomes achieved
5. Ensure the quality of the programs and services produced
6. Show that they service public needs.

The purpose of Performance and Accountability within the Evidence Informed ‘Commissioning’ Cycle is to ensure that the system has clear responsibilities, authority and accountability throughout the system and then ensuring those accountable officers are being held to account for the performance of the systems in which they are responsible.

It is critical that Performance and Accountability is not seen as an activity that is undertaken on a periodic basis by the National Centre. Performance and Accountability must be reinforced throughout the system. The Service Delivery entities have to ensure they are exercising the appropriate performance and accountability throughout their respective systems all the way to front line staff and to ensure they proactively identify issues of underperformance and act upon them promptly to avoid the necessity of escalation within the organisation.

The organisation is committed to providing support to managers and services who are struggling to achieve improvements and ensuring people throughout the system feel empowered to make the right decisions (within their scope of responsibility) to ensure the best outcomes for patients and service users.

Currently, the Performance and Accountability Framework sets out the means by which the health service and its accountable officers are held to account for performance in relation to four key aspects:

- Access to services
- Quality and Safety of those Services
- Operating within Financial resources
with the Workforce employed

These four quadrants make up the current National Balanced Scorecard (National BSC). The Performance and Accountability framework ensures that the health service is reporting its performance against its stated objectives and taking the necessary corrective action as appropriate. It also ensures that implementation of the annual National Service Plan is in accordance with its legal obligations in accounting to the Minister for Health for the provision of services as specified in the plan.

While the National Centre will have a role in monitoring performance and holding to account the Service Delivery entities for the delivery of services against a Balanced Scorecard, the National Centre will also be held to account in the same way for the functions it performs.

Role of the National Centre in Performance and Accountability

The following describes the role of the National Centre as it relates to Performance and Accountability

<table>
<thead>
<tr>
<th>Leadership and Governance</th>
<th>The National Centre will</th>
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<tr>
<td></td>
<td>Provide leadership in performance and accountability by ensuring clear clinical and non-clinical responsibility, authority and accountability is devolved to the appropriate level as close to the patient and service user as appropriate.</td>
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<tr>
<td></td>
<td>Lead a culture of measurement and continuous service improvement that will be present in all areas of the health service, and will incentivise good performance.</td>
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<td></td>
<td>Lead collaboration and learning where good governance is seen and can be shared throughout the health service, and will also have remedial powers when poor governance is present.</td>
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<tr>
<td></td>
<td>Lead an annual review of the Performance and Accountability Framework in collaboration with the Service Delivery entities to ensure it is supporting the system in the way intended.</td>
</tr>
<tr>
<td></td>
<td>Ensure quality and service improvement is embedded within the Performance and Accountability Framework and measured across the system</td>
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<td></td>
<td>Demonstrate leadership by example by ensuring a culture of openness and transparency, accepting that adverse events will occur however working together as a system to examine those adverse events, analyse and learn from them to reduce the risk of similar events occurring in the future.</td>
</tr>
</tbody>
</table>

The Performance and Accountability Framework will continue to be enhanced in order to ensure it is applicable through all levels of the system.

The National Performance Oversight Group (NPOG) will continue to provide governance and will evolve as responsibility, authority and accountability transitions from existing national functions to the Service Delivery entities.

<table>
<thead>
<tr>
<th>Collaboration and Partnership</th>
<th>The National Centre will</th>
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<tr>
<td></td>
<td>Work in collaboration with the Service Delivery entities to ensure continuous improvement to the Performance and Accountability Framework to ensure it remains relevant and represents a balanced measure of performance.</td>
</tr>
<tr>
<td></td>
<td>Support the Service Delivery entities in setting performance goals, KPIs, indicators and other measures that are relevant and achievable to the Service Delivery entities as well as the National Centre alike.</td>
</tr>
</tbody>
</table>

<p>| Information | The National Centre will continue to develop a consolidated approach to data, analysis and information management to produce a collectively owned ‘single version of the truth’ in terms of core dataset that will facilitate information requirements throughout the system. |</p>
<table>
<thead>
<tr>
<th>Enabling and Supporting Service Delivery</th>
<th>The National Centre will</th>
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<tr>
<td></td>
<td>• Support the Service Delivery entities to embed a culture of performance and accountability throughout the system.</td>
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<tr>
<td></td>
<td>• Be responsive to changes in the system (for example: changes to need, service design, creation of new services) by ensuring the Performance and Accountability framework can accommodate those system changes.</td>
</tr>
<tr>
<td></td>
<td>• Provide the Service Delivery entities with an avenue to receive support with escalated issues and identified improvements where required.</td>
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<thead>
<tr>
<th>Capacity and capability</th>
<th>The National Centre will</th>
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<tr>
<td></td>
<td>• Build organisational capacity, skills and expertise in performance and accountability in order to assist Service Delivery entities with the implementation of performance and accountability mechanisms in their own organisations.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that performance expectations consider capacity and other influences (outside of the control of the Service Delivery entity) when measuring overall performance.</td>
</tr>
<tr>
<td></td>
<td>• Provide skills and expertise in the analysis and development of KPIs such that there is a robust set of KPIs representative of health and personal social services across the system.</td>
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<table>
<thead>
<tr>
<th>Integrated Care</th>
<th>The National Centre will</th>
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<tbody>
<tr>
<td></td>
<td>• Ensure the Performance and Accountability Framework has a strong focus on an outcome of integrated care and services. This will be supported by ensuring the involvement of stakeholders from across the system in determining the most appropriate approach in measuring integrated care.</td>
</tr>
<tr>
<td></td>
<td>• Ensure that Performance and Accountability can be assessed where population based services are provided, independent of delivery structures.</td>
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<thead>
<tr>
<th>Measuring and Evaluation</th>
<th>The National Centre will</th>
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<tbody>
<tr>
<td></td>
<td>• Facilitate routine monthly and longer term measurement which will be related to the overall strategy and direction of the health system. This measurement will be specified in partnership with the Service Delivery entities.</td>
</tr>
<tr>
<td></td>
<td>• Ensure realistic and achievable measures for improvements (where services are in escalation) be agreed with clear timeframes for improvement. Monitoring against milestones will be done to allow for evidence of improvement over time.</td>
</tr>
<tr>
<td></td>
<td>• Publish the results of performance of the National Centre and the Service Delivery entities, allowing all stakeholders to see the performance results of the health system.</td>
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</tbody>
</table>

**Different to today?**

The function of Performance and Accountability at the National Centre will ensure and support more robust performance and accountability processes throughout the system.

There will be a system wide approach to measuring performance across all areas of the health system, and managed at the appropriate level.

Accountability will be both upwards and downwards throughout the system, to ensure the National Centre and Service Delivery entities work holistically together to address problems, reduce risk and ensure staff have clear roles and responsibilities which can be measured to improve all aspects of the health delivery system, including operational aspects and improvement aspects.

Service Delivery entities will be held to account for performance within their respective areas of authority and responsibility. The National Centre will support the Service Delivery entities in managing poor performance through the Escalation Framework.
Measurements and Key Performance Indicators will be present throughout the system, these indicators will be relevant and achievable and addressed at the most appropriate level.

Risk assessment, monitoring and reporting will be embedded across the system in order to prevent future mistakes from occurring and provide a 'learning' opportunity from analysis of previous mistakes.

The National Centre will ensure the Escalation Framework is clearly understood across the system and where required, support will be provided by the most appropriate stakeholders.

Action will be taken where areas of improvement are identified and support provided, but improvements fail to be implemented.

In line with the system’s Business Intelligence Programme performance and monitoring will be available in “real-time” due to clear data and information systems, allowing the system to identify poor performance and intervene in a timely and efficient manner.
Immediate Next Steps

The immediate next steps for the Evidence Informed ‘Commissioning’ Cycle are as follows:

- Broadly engage and consult on the content of this document in order to work through key concepts and further develop the requirements of the commissioning cycle and importantly, how they will interrelate.
- Finalise and agree the ‘Commissioning’ cycle.
- Once finalised, commence high level design activities which will look at designing how the functions described in this document will be carried out. This will need to be done in close partnership with a broad range of stakeholders.
- Implementation planning to determine this approach to implement changes and commence moving to an Evidence Informed ‘Commissioning’ Cycle.

In addition to these programmatic next steps, there are a number of specific actions which are planned to be taken in the immediate future. Different aspects within the current environment are at different stages and therefore there are more actions planned in some areas than others. These are outlined in Table 2 below.

**Table 2: Immediate next steps for components of Evidence Informed ‘Commissioning’ Cycle**

| Quality and Service Improvement | Commence development of clear quality priorities and outcomes for the system.  
|                                | Identify service improvement priorities as part of a strategic approach to quality, e.g. improving clinics quality, address waiting lists, reduce HCAI, improve patient and service user experience and satisfaction, improve access, enhance patient safety and provide support to the delivery system to implement required changes to improve services.  
|                                | Test the Framework for Improving Quality in a number of services and publish a guide to support implementation across the service delivery entities.  
|                                | Review current NPOG quality measures with a view to developing a clear set of quality outcomes for the health system with accompanying KPI’s.  
|                                | Analysis of existing quality programmes and initiatives at delivery system and national level to inform the strategic priorities for quality and service improvement in the reform process. Align to existing HSE strategic plans, e.g. People Strategy, Framework for Improving Quality.  
|                                | Support the delivery system in implementing the national safety priorities.  
|                                | Work with key stakeholders in the National Centre and in the delivery system to systematically address strategic and current quality improvement plans that address staff engagement.  
|                                | Support the Service Delivery entities to enhance person centred culture by providing structured programmes to the delivery system.  
|                                | Define Quality Priorities and Outcomes for the system, and a comprehensive suite of Quality KPI’s. |
| Population Needs Assessment    | Start considering an approach to build capability and capacity to support population needs assessment processes across the system. |
| Strategic Planning and Prioritisation | Support the development of skills and expertise to empower effective strategic planning, prioritisation and integrated care.  
|                                | Start capacity and capability building (in both the National Centre and Service Delivery entities) with a dual focus on models of health and social care provision.  
|                                | Building collaborative relationships between service design teams in the National Centre and Service Delivery entities.  
|                                | Testing how ‘fit for purpose’ existing Models of Care are for use in the Evidence Informed ‘Commissioning’ Cycle and applying the learning to ongoing work. |
| Service Design                |
| Service Planning | Continue to build on the National Service Planning process for 2017 which focuses on a reduced number of strategic themes.  
|                  | Develop skills and expertise in service planning across the system  
|                  | Continue to build collaborative ways of working with the Service Delivery entities |
| Contracting      | Engage with Service Delivery Entities and other relevant stakeholders to promote collaborative partnerships and professional networks and develop skills and competencies required to manage contracts in CHO’s and HG’s structure. |
|                  | Develop a formal method and process to review KPIs. |
Appendix 1 – Health Care Policy

A number of policy documents have been produced which sets out how to address these challenges by fundamentally reforming Ireland’s Health Service. These are outlined below:

**Future Health: A Strategic Framework for Reforms of the Health Service 2012-2015**

The future health framework provides a greater focus on health and well-being as opposed to just the treatment of ill health. It proposes more patient focused service reforms, with a less hospital-focused model of care to be introduced which offers more community-based alternatives. A fundamental principle underpinning the reform of the health delivery system is that appropriate responsibility, authority and accountability for healthcare services must devolve as close to the patient and service user. Key to this devolution is the developing CHO’S, HG, NAS structures along with other Service Delivery entities and functions. In this context the role and function of the National Centre must evolve in tandem with these changes.

**The Department of Health Statement of Strategy 2015 – 2017**

The Department’s Strategy highlighted 4 main priorities and also the steps that have been taken to date since Future Health was launched.

**Keeping people healthy**

Encompasses increasing healthy behaviours, focusing on prevention and early detection, reducing health inequalities and improving health status of vulnerable groups e.g. children, older people, those with disabilities, mental illness etc.

**Provide the healthcare people need**

Ensure that people can access care when they need it – improve access to emergency care, shorter waiting times, deliver services as close to home as possible and enable prompt and fair access.

**Deliver high quality services**

High quality services to ensure patient safety.

Care must be delivered in the right setting with high quality clinical treatment delivered consistently on an integrated basis.

**Get the best value from health system resources**

Get the best value from our resources through corporate and clinical governance, sound resource and financial management, skilled and motivated staff.

**Healthy Ireland**

‘Healthy Ireland’ proposed a partnership approach (whole-of-government and society), to deliver the actions set out in the framework with specific goals, principals and actions for all delivery partners.

The four goals of Healthy Ireland are outlined below

- **Goal 1**: Address risk factors and promote protective factors at every stage of life (e.g. weight, mental well-being).
- **Goal 2**: Interventions to target particular health risks and focus on addressing the wider social determinants (e.g. health status).
- **Goal 3**: Being prepared to prevent, respond and rapidly recover from public health threats (e.g. infectious disease).
- **Goal 4**: Need for society wide engagement with health and wellbeing promotions.
**eHealth strategy for Ireland (2014 – 2020)**

eHealth involves the integration of all information and knowledge sources involved in the delivery of healthcare via information technology based systems. This includes patients and their records, caregivers and their systems, monitoring devices and sensors, management and administrative functions. It is a fully integrated digital ‘supply chain’ and involves high levels of automation and information sharing.

**Table 3: eHealth Priority Projects**

<table>
<thead>
<tr>
<th><strong>eHealth Priority Projects</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National Healthcare Identified Infrastructure</td>
<td></td>
</tr>
<tr>
<td>ePrescribing Systems – automation of medication prescribing process, including online repeat prescription ordering.</td>
<td></td>
</tr>
<tr>
<td>Online referrals and schedules</td>
<td></td>
</tr>
<tr>
<td>Telehealthcare – particularly relating to the management of chronic diseases. Devices (blood pressure monitors, glucometers) deployed to homes – data transmitted to monitoring base.</td>
<td></td>
</tr>
<tr>
<td>Development of Patient Summary Records</td>
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</tr>
<tr>
<td>Online Access to Health Information - allow online access to healthcare systems including scheduling, prescription ordering, referrals and telehealth monitoring from the home environment</td>
<td></td>
</tr>
<tr>
<td>National Patient Portal</td>
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</tr>
</tbody>
</table>

**Direction of Travel**

The purpose for this document came from the Directorate and Leadership Team of HSE recognising the need for a change in the manner in which the central functions and governance of the organisation interacts with the operational system. This led to a project to examine key elements of the change process which encompassed a number of workshops attended by the Leadership Team. Broad agreement on a number of core principles emerged from this process which in turn led to the establishment of a sub-group to develop a “Strawman” for the Transformation of the Centre.

The “Strawman” was considered by the Leadership Reform Steering Group in August 2015 which endorsed this document as an outline Direction of Travel for the Centre Transformation Programme. It is recognised that the Centre Programme is not working in a vacuum – other key reform programmes are underway, including CHO, HG, ICP, PCRS, HR, ICT, and Finance. There will be interdependencies between these programmes of work and the work of the Centre Programme. The direction of travel outlined 7 core requirements for the NCTP. These are outlined in Table 4.

**Table 4: Core Requirements for the National Centre Transformation Programme**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Core Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changing the Operating Model</strong></td>
<td>1</td>
<td>Reforming the relationship between developing service delivery organisations (HG, CHO, Ambulance, and other delivery units) and the Centre including appropriate governance and management structures.</td>
</tr>
<tr>
<td><strong>Role of the Centre</strong></td>
<td>2</td>
<td>Population Needs &amp; Resource Assessment.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Service Design &amp; Service Improvement.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Framework for Quality.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Planning, Service Specification, Contracting, Performance and Accountability Frameworks and Processes.</td>
</tr>
<tr>
<td><strong>Supporting the new Model</strong></td>
<td>6</td>
<td>Enabling services within the Centre.</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Organisational Development, Communication and Change Management at the Centre</td>
</tr>
</tbody>
</table>
The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts (The Higgins Report) (2013)\textsuperscript{19}

This report proposed the formation of Irish acute hospitals into six viable and sustainable groups and outlines how the establishment of these groups will; help the introduction of UHI, permit greater autonomy for providers of hospital care and allow hospitals to be more responsive to the needs of their locality. The report emphasises the transitional nature of the hospital grouping arrangements. The grouping of hospitals is a stepping stone toward the total reorganisation of acute hospital services in Ireland, it is envisaged that these will be grouped into a smaller number of hospital trusts that are capable of providing the relevant services to its population.

Report on Community Healthcare Organisations (Healy Report) (2013) \textsuperscript{20}

The Report on Community Healthcare Organisations (CHO) provides a framework for the governance and organisation of all of Ireland’s Community Healthcare services. When placed alongside the 2013 report on the Establishment of Hospital Groups, there is a new structure for the operational delivery system that interacts with the public every day.

The changes will allow the Health Service to focus on service delivery and decision making at local level to: provide better, direct accountability therefore giving more decision making back to local areas; and deliver services in the community through an integrated management structure.

Services will be improved in local areas by providing:

- Better access;
- Services that are close to where people live without reducing quality;
- Better local decision making; and
- Services in which communities have confidence.

Health Services People strategy 2015 - 2018\textsuperscript{21}

The People strategy planned outcomes are the statements that describe what will be achieved and what can be reliably demonstrated or measured at the end of the strategy implementation process.

Adopting this approach supports our ambition and challenges the whole system to deliver on a common agenda.

The combined outcomes from each of the priority areas in the People Strategy will result in improved performance, workforce optimisation and a learning organisation delivering the overall goal of Safer Better Healthcare.

\textbf{Figure 12: Outcomes from priorities of People Strategy}
Table 5: Priorities of People Strategy

<table>
<thead>
<tr>
<th>Priority</th>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Leadership and Culture</td>
<td>Effective leadership at all levels, working collectively towards a common purpose, creating a caring and compassionate culture and inspiring innovation, creativity and excellence throughout the organisation.</td>
</tr>
<tr>
<td>2</td>
<td>Staff Engagement</td>
<td>Staff have strong sense of connection to the service, take personal responsibility for achieving better outcomes and support team colleagues to deliver results.</td>
</tr>
<tr>
<td>3</td>
<td>Learning and Development</td>
<td>A learning culture that prioritises development to ensure staff are equipped to confidently deliver, problem solve and innovate safer better healthcare.</td>
</tr>
<tr>
<td>4</td>
<td>Workforce Planning</td>
<td>Comprehensive workforce plan in place based on current and predicted service needs, evidence informed clinical care pathways and staff deployment.</td>
</tr>
<tr>
<td>5</td>
<td>Evidence and Knowledge</td>
<td>Work practices and client pathways are evidence informed and decision making is based on real time and reliable data.</td>
</tr>
<tr>
<td>6</td>
<td>Performance</td>
<td>Staff and teams are clear about roles, relationships, reporting and professional responsibilities so that they can channel their energy and maximise performance to meet organisational targets.</td>
</tr>
<tr>
<td>7</td>
<td>Partnering</td>
<td>Partnership with staff, service managers and stakeholders effectively developed and managed to add value and support the delivery of safer, better healthcare for local communities driving change and improving the client experience.</td>
</tr>
<tr>
<td>8</td>
<td>HR Professional Services</td>
<td>HR Services designed to create value, enhance people capacity and positioned to deliver organisational priorities.</td>
</tr>
</tbody>
</table>

The Department of Health “Better Health, Improving Health Care” (2016) 22
This is a strategic briefing document prepared by the Department for the incoming Minister for Health, in advance of the publication of the Programme for Government. It sets out some strategic considerations to inform the task of developing a clear and coherent agenda for action to improve the health service.

Some strategic considerations that were outlined in the document include:
- Short-term action must support the long-term vision
- Health services should be planned, organised and delivered to meet population health needs
- The starting point for a more effective and integrated model of care is the development of comprehensive primary care, not least because the existing system is unsustainable
- Investing resources where they can make the greatest impact
- Irish People are living longer, which brings with it new healthcare needs
- Changing the Model of Healthcare
- Role of Acute Hospitals
- Developing social care and mental health services
- System- wide thinking and reform is also required
- Structural reform is necessary but not sufficient

Health Service Executive Corporate Plan 2015 – 201723
The HSE Corporate Plan was developed to set out the vision, mission, values and the five goals that want to be delivered in order to improve the health service.

Vision - A healthier Ireland with a high quality health service valued by all
Mission

- People in Ireland are supported by health and social care services to achieve their full potential
- People in Ireland can access safe, compassionate and quality care when they need it
- People in Ireland can be confident that we will deliver the best health outcomes and value through optimising our resources

Table 6: HSE Corporate Plan - Values

| Care                                      | - We will provide care that is of the highest quality  |
|                                          | - We will deliver evidence based best practice        |
|                                          | We will listen to the views and opinions of our patients and service users and consider them in how we plan and deliver our services |
| Compassion                               | - We will show respect, kindness, consideration and empathy in our communication and interaction with people |
|                                          | - We will be courteous and open in our communication with people and recognise their fundamental worth |
|                                          | - We will provide services with dignity and demonstrate professionalism at all times |
| Trust                                    | - We will provide services in which people have trust and confidence |
|                                          | - We will be open and transparent in how we provide services |
|                                          | - We will show honesty, integrity, consistency and accountability in decisions and actions |
| Learning                                 | - We will foster learning, innovation and creativity |
|                                          | - We will support and encourage our workforce to achieve their full potential |
|                                          | - We will acknowledge when something is wrong, apologise for it, take corrective action and learn from it |

The corporate goals are shown in Figure 13 below:
Appendix 2 – Population Needs Information

Examples of information that informs health needs assessment of a population are outlined in the below table (not an exhaustive list):

Table 7: Information for Population Needs Assessment

<table>
<thead>
<tr>
<th>Demographic Data</th>
<th>Health System</th>
<th>Stakeholder Perceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Statistics Office</td>
<td>HSE, Health Atlas</td>
<td>This includes the experience and feedback from patients, service users and their families and carers on the perceived needs. It also includes people providing services including health and social care providers, and community and voluntary services if appropriate.</td>
</tr>
<tr>
<td>• Population and migration estimates and projections, births, deaths, life expectancy, migration</td>
<td>• Population by County, Community Healthcare Organisations (CHO), Small Area (SA), Electoral Division (ED) and Local Authority (LA)</td>
<td></td>
</tr>
<tr>
<td>• Educational attainment</td>
<td>• Deprivation by County, CHO, SA, ED and LA</td>
<td></td>
</tr>
<tr>
<td>• Social conditions; Risk of and consistent poverty (deprivation)</td>
<td>• EU and OECD – comparative information on the OECD countries including information on health</td>
<td></td>
</tr>
<tr>
<td>• Health status and utilisation (quarterly household survey)</td>
<td>• Health service utilisation including Hospital In-patient Enquiry System (HPO), National Psychiatric Inpatient Reporting System, PCRS</td>
<td></td>
</tr>
<tr>
<td>• Health Accounts – health expenditure (include comparisons with Europe and OECD)</td>
<td>• HSE performance and monitoring data</td>
<td></td>
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<td></td>
<td>• HSE reports including reports for service planning e.g. Health Information for Planning</td>
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<tr>
<td></td>
<td>• National Registries and agencies including National Cancer Registry, National Screening Service, Health Protection and Surveillance Centre, National Immunisation Office, National Disability Register.</td>
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<tr>
<td></td>
<td>• Health Research Board</td>
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<tr>
<td></td>
<td>• Institute of Public Health</td>
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<tr>
<td></td>
<td>• Community indicators e.g. social capital</td>
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</tr>
<tr>
<td></td>
<td>• Government Departments including: Department of Health( include Key Trends, National Healthcare Quality Reporting System), Department of Children, Department of Social Protection, Department of Education</td>
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<tr>
<td></td>
<td>• Regulators – professional and service including HIQA, Medical council, Bord Altranais</td>
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<tr>
<td></td>
<td>• Academic institutions including the Universities and Colleges (Royal Colleges of Physician and Royal College of Surgery)</td>
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<tr>
<td>Abbreviation</td>
<td>Term</td>
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<td>B</td>
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<tr>
<td>BI</td>
<td>Business Intelligence</td>
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<tr>
<td>C</td>
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</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
<td></td>
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<tr>
<td>CHO</td>
<td>Community Health Organisation</td>
<td></td>
</tr>
<tr>
<td>CIO</td>
<td>Chief Information Officer</td>
<td></td>
</tr>
<tr>
<td>CO</td>
<td>Chief Officer</td>
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</tr>
<tr>
<td>CSP</td>
<td>Clinical Strategy and Programmes</td>
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<tr>
<td>CSPD</td>
<td>Clinical Strategy Programme Division</td>
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<tr>
<td>D</td>
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<tr>
<td>DPER</td>
<td>Department of Public Expenditure &amp; Reform</td>
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<tr>
<td>DG</td>
<td>Director General</td>
<td></td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>E</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<td>G</td>
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<tr>
<td>H</td>
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<tr>
<td>HCAI</td>
<td>Healthcare-associated infections</td>
<td></td>
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<tr>
<td>HSE</td>
<td>Health Service Executive</td>
<td></td>
</tr>
<tr>
<td>HG</td>
<td>Hospital Group</td>
<td></td>
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<tr>
<td>HIPE</td>
<td>Hospital In Patient Enquiry (System)</td>
<td></td>
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<tr>
<td>HIQA</td>
<td>Health Information &amp; Quality Authority</td>
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<td>K</td>
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<td>KPI</td>
<td>Key Performance Indicator</td>
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<td>M</td>
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<tr>
<td>N</td>
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<tr>
<td>NAS</td>
<td>National Ambulance Service</td>
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<tr>
<td>NHS</td>
<td>National Health Service (UK)</td>
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<tr>
<td>NPOG</td>
<td>National Performance Oversight Group</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>QAV</td>
<td>Quality Assurance &amp; Verification</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>QID</td>
<td>Quality Improvement Division</td>
<td></td>
</tr>
<tr>
<td>RCPI</td>
<td>Royal College of Physicians of Ireland</td>
<td></td>
</tr>
<tr>
<td>RCSi</td>
<td>Royal College of Surgeons in Ireland</td>
<td></td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
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<tr>
<td>SPOT</td>
<td>Spend and Outcomes Tool</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>
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