Report of
National Consultative Forum (2004) Proceedings

Great Southern Hotel, Dublin Airport

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This report was documented by the Office for Health Management on behalf of the Department of Health and Children.

It should be noted that the views expressed by participants do not necessarily reflect the policy of the Department of Health and Children

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Introduction – John Cullen, Chairman
In his opening remarks, Mr John Cullen, Director General of the Institute of Public Administration, who chaired the Forum welcomed all present and said it was heartening to see such a representative cross section of so many of the stakeholders in the field of healthcare. Consultation was a key part of the process of health service reform now taking place. This process represented the most fundamental reform undertaken in the past 35 years and the importance of the Forum was underlined by the fact that the attendance included Mr Kevin Kelly, Chief Executive of the Health Services Executive and later in the day they would be joined by the Tanaiste & Minister for Health & Children Mary Harney Tdwho hoped to be able to stay and listen to the debate and feedback from the discussion groups.

Opening Remarks – Michael Kelly, Department of Health & Children (DoHC)
The Secretary General of the Department of Health and Children, Mr Michael Kelly, said the national consultative forum in which health professions, representative bodies and various agencies participated played a key role in health service reform. "The participative and consultative approach has proved its worth and underpins the entire reform process", he said.

Future progress would largely depend on continuing to work together in a partnership model. The Health Strategy had set out an agenda of growth, development and modernization underpinned by proper investment and the value of having such a framework document was self evident. The widespread and enduring support for the principles and goals on which the Health Strategy was based has been fundamental to the broad support for carrying through the action points it set out.

New organizational structures had been put in place and they had seen the development of other strands and would see further development and growth in 2005. One focus of the DoHC would be maintaining quality of service in a period of uncertainty including some strengthening of services in particular areas. Overall they were concerned to build on the momentum that had been established. Open management had been a hallmark of the health reform process to date and would continue to be important in the future.

"Ireland's presidency of the European Union, at a time of major expansion of the Union, provided a wealth of opportunities to showcase our work and bring leadership to the EU agenda on a broad range of public health issues. We brought both our leadership in and personal experience of promoting tobacco control and cardiovascular health to the European stage and have set a course of action at EU level in this regard. Ireland's ban on smoking in the workplace was now recognized as making history.

We had also sought to progress the harnessing of ICT to solve practical problems in service delivery and to oversee the developing health provisions in the new European Treaty. The Irish presidency had also provided opportunities to discuss health policy challenges with colleagues in other member states who also faced problems regarding system pressure, population ageing, technology and financing", he said.

Mr Kelly added "These problems are shared by all developed countries but the opportunities to learn from others has never been greater." All health systems are going through reform and the agenda internationally is usually based around four points, Access, Safety/Quality, Responsibilities and Sustainability. It is important to remember that Ireland is not unique and we should be prepared to learn from experiences elsewhere."

"Organisational change of itself does not generate reform. It is an instrument rather than an end product and needs to be seen in that light. It requires participation to fuel the co-operation required to get results."

Preparing for Change – Kevin Kelly
HSE Interim Chief Executive Kevin Kelly told the Consultative Forum that although there would be no big bang he was confident that the new authority would be up and running on January 1st provided there were no legislative holdups in the Oireachtas.

Mr Kelly said "I would like to refer first of all to our roadmap. We started with Quality and Fairness, decisions put together by the Department of Health & Children and conversations with many people and then you had a number of reports, Prospectus, Brennan, Primary Care Strategy and so on. These were put in place in January and in a sense they give us a roadmap but we have to find a practical way forward to translate what is in all these reports to get a sense of direction. In trying to get this we spent the first couple of months out on the road talking to people around the health services and I came to three views at that time.

One is that the deadline we are debating in terms of the 1st January is very tight but I would like to tell you that I am confident that the HSE will be live and up and running on the 1st January. I also formed the view that the people will decide by the 2nd January on how much risk in terms of the delivery of services can be taken at that point in time and we will agree to that point of view and I will share that with you in a few moments.

The second view I formed is that the some good work has been done, led by the Department in defining divisions but that we were now facing into practical matters. I had to bring on board a group of people in the Health Services who are practitioners to advise me and that led me to put in place a Change Management team of around 40 people. They have been working with me for the last 6 months and they have helped me to define the way forward, how we will start, and I will talk through some details of that next.

The third, and this is the most important thing that I came to share this with my Board and my colleagues, is that we will do everything by three tenets. The 1st tenet is the most important one of all, that everything has to be measured over a period of time - that is a period of time that from a patient/client point of view the journey has to be proven. Secondly, we have to create better environments for staff. We have to empower staff more, we have to take out a lot of the bureaucracy that you see there, excessive structures and whatever, and bring people up for more frontline delivery.

But one very interesting thing that the Change Management people have done and I would like to say this at the outset, is that they have traced a number of what I call patient/client journeys and family journeys as individuals met the Health Services. They were disappointed with what they found. What came out of that is that, and this is no reflection on the past or a criticism of the past, but it is very fragmented and it has given me enormous optimism from a patient point of view that over time, we all working together can really improve the patient/client journey.

Moving on down to the Change Management Team we initially divided their work. We used the terminology of the three pillars, the National Hospitals Office, Primary Community and Continuing Care and Shared Services. You can broaden that out to include Human

Resources, Information Technology,and all the other areas you would expect, and out of that was recommendations that we are going to be formulating.

If I take the first area – the National Hospitals Office, there is a configuration there around Hanly because Hanly has made certain preliminary recommendations as you know – two pilots have been recommended. They are on hold at this point of time. So what we are going to do on the first of January is put in place ten national Hospital Officers who will co-ordinate the activity of individual hospitals and that will be nothing really different that what is in place at this point of time.

We have looked at a whole lot of issues around clinical governance, clinicians in management, we're keeping them under active consideration. We are starting from next year to focus more on those issues. But there are these practical problems around the European Working Time Directive and everything that are there in a way and negotiations have to take place with the Irish Hospital Consultants Association, the IMO and others. I hope they will achieve a breakthrough soon in these negotiations to get progress, get talking and then we can make more definitive recommendations on the structure.

I make the point in terms of the 62 hospitals, many of them are public others are voluntary. What we want is parity of treatment for all, but we do recognise that in terms of the voluntary hospitals that they have their own ethos and their own governance and we don't want to interfere with that in any way. But what we want is a level pitch in terms of parity of treatment, in terms of performance, in terms of allocation of monies.

On the Primary and Community side one view and this is the first view I have formed, having read the Government documentation it has set out a five year plan, I personally think that's far too long. I think that the Primary side is just as important as the Acute side, I believe that if we can achieve wins on the Primary side patient journeys in particular can be improved.

It is a very fragmented area for patients and for their families and we have to make it more patient centred and, I hate using this word and I cannot find a better one for it in a way, but it is the only word that springs to mind at this point, that in terms of the individual we have to move closer to a 'One Stop Shop'.

When you look at the journey that we have chartered for the patient or client, the journeys are too fragmented and I believe, I am very optimistic that we can make a lot of improvement in that area. What we want to do, and what we have decided is that we will put in place 32 Local Health Offices which will empower locally and they are referring closely to the local community offices at this point of time. But the difference is that we will get far more empowerment locally to deliver services locally.

As such, it obviously leads to national performance guidelines that have been set by the Headquarters of the Health Services Executive in Naas. We will also put in place four regions, there has been a lot of discussion around would these regions be four Health Boards who will replace the eleven Health Boards – they will not be. They will be small light offices and their roles will be co-ordinating activities in the regions that they cover. A lot of the services, as many of you know and you would be closer to it than me, take the disability area for example – they span counties and the role of the Regional Offices will be to make sure that there is proper co-ordination. Also, their role will be, and a lot of this is in the legislation now or will be as soon as more details have been published, they will help to ensure that there

is communication at regional level. Local Representatives, be it at Council level, Patient level and all other voluntary groups and that's what there is.

But there will be small offices, the focus will be on the Local Health Offices and that is where the empowerment will be, but the price of empowerment will be set in performance standards nationally that would have to be met. One pleasant thing that I have learned as I travelled the country talking to every Health Board is that you find pockets of excellence everywhere, wonderful standards of performance. What we want to do and what I want these Regional Offices to do is to capture those centres of excellence and make that the lowest kind of common denominator that we will then apply to all 32 Local Health Offices. So we hope we will have that up and running soon. We have some issues in terms of discussions with unions around that, that I will touch very briefly on in a few moments.

The third area is the Shared Services – they are very fragmented, the whole question of systems, the technology at this point in time is that the eleven Health Boards are using many, many different systems. A lot of good work has gone on particularly on the Human Resources side and on the Finance side over the last two years, a lot of that technology is coming into place and we will move that forward quickly and I believe a lot of savings will come out of that, that we will be able to re-invest in front line delivery for patients/clients.

But the one area where I believe there has been serious neglect, even though, a lot of work has gone on in the last couple of years to try and find a solution is on the patient side. The quality of information on the patient's side leaves a lot to be desired. I visited lots of hospitals and I see the state of the records and even from a risk point of view, in terms of an individual patient you see files bulging, down in the basement, papers all over the place. We have got to change that, we have got to bring in technology that will improve things from the patient's point of view. And we are well on the way to providing a system. Work has been done over the past couple of years, the recommendations are with the Board of the Interim Health Services Executive and we intend to bring these recommendations to Government.

This won't happen overnight, but in a year or two the contact of each person with the Health Services will be captured electronically and that will travel with us for the rest of our lives. I believe that will improve service delivery, but it also will take an enormous amount of waste out of the system that is there because of the enormous paper system.

The other issue I want to touch on is patients. We are dealing with the biggest change programme ever in the history of the state. The Change Management team have only been working for six months. We recognise that people are anxious. On the 1st January, 70,000 will be employed directly by the Health Services Executive, 30,000 indirectly. We will be the largest employer in the state. I appreciate the anxieties of all the staff, but we are now in a position to alleviate those anxieties.

We have just published a document which is on its way to you all, and if you haven't got it we will make sure that we get it to you. It will bring you up to date on where we are at this point in time and what we intend doing on the 1st January. There will be a small number of people whose reporting roles will change on the 1st January. We will clarify their positions within the next two to three weeks.

The next point to make is that there will be no big bang on January lst. There will be no big change. This is a journey and it is a journey that is going to take some years and it can and

will be done in consultation with staff, and all their representatives. That leads me into the question of representative groups – we have some issues at this point of time and I don't think that this forum is the time to bring them forward – but I would want to say to you personally, the environment I have come from is that I have always believed in trade union representation and my record shows this.

I have believed in partnership and in the last job I was in, I was instrumental in bringing in, and certainly in the sector I was in, the first national partnership ever. It took three years to negotiate it and the issues half of the time were not on the union side, they were with my own management – my co-managers, to get them to buy into it. I believe in the concept of partnership, I have seen what exists now at this time point of time in the Health Service. What has happened locally is fantastic and there are some wonderful local initiatives that you pick up and some of them are masterpieces, but what is happening nationally is not acceptable in my view.

I think we will have to stand back and take time now to talk with all the union representatives and various groupings, and maybe you might talk about in your discussions today, to find at a national level an effective working partnership which is not in existence in my view at this point in time.

The legislation I cannot comment on. It is now working its way through the political process. The Board through the Health Services Executive made its recommendations, I could tell you the Board are happy at this point in time but I can't make any calls, I can't comment, that is a matter for the Oireachtas to make their decisions over the next six weeks or so to bring in the legislation. But the legislation is a show-stopper.

If the legislation doesn't go through by the middle of December the HSE cannot start on the 1st January. That is a political point. So, overall, what I want to say to you is that is a journey, there is going to be no big bang. It is a very complicated process but if all we did was just reorganise then in a year or two there would be simply more cynicism.

I am optimistic that staff and patients can make that journey together resulting in better services, less bureaucracy and more value for money for the State. My view of value for money was a simplistic one in the past. I now realise it is a more complex subject and that VFM is not just about cost reductions and that as you are more successful in the health service it will in fact bring about more costs but that is a matter for society and government to face up to. Improving the quality of life for patients and clients will cost more money not less.

If you ask me what values I want that company starting on January 1st to have, then I say I would like it to be a company where people can say
I made a mistake.
A company where people say to other people "You did a good job."
A company where people say "What is your opinion ?"
A company where people say "You tried."
A company where people say "Thank you."
And a company where the most important word should be "we" and the least important word should be "I".

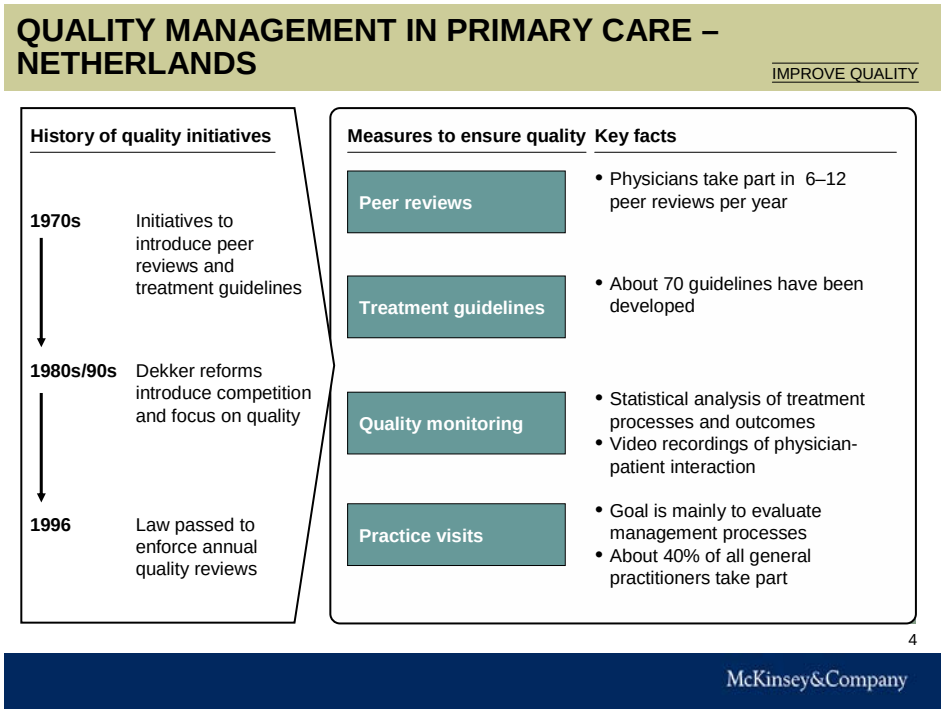
Health Systems Reform- Some Current International Trends (McKinsey Consulting)
In introducing his work, and that of his colleague Martin Dewhurst, on international trends and challenges in health systems reform, Dr Nicolaus Henke of McKinsey Consulting said that what they were interested in was finding solutions.

"What we would like to share with you are some of the successes and failures from other parts of the world. Our exposure in 2004 to health reform at system level and payer provider/level ranged from the United States to Mauritania.

It is immediately apparent that there are large quality variations in spite of growing levels of investment. Patients are starting to act as consumers and are demanding better services but are unwilling to pay additional taxes to fund them. The main elements of reform are agreed at policy level but the challenges lie in executing them. "

Dr Henke put forward four ideas for transforming healthcare systems
*Improve quality
*Increase capacity
*Improve efficiency
*Increase contestability.

He went on to examine each of these concepts in relation to particular experiences of healthcare providers in the Netherlands, England, the USA, Sweden and Portugal.



CHRONIC DISEASE MANAGEMENT AND PRO-ACTIVE CASE MANAGEMENT

Disease	Disease management interventions	Effects on existing treatment structures: GPs	Nurse	O/P	A&E	Emergency Admissions	LOS
1 Congestive heart failure (CHF)	• Constant weight checks • More healthy nutrition • Best practice medication	↓	↗	↓	↓	↓ 40-90%	↓ 30%
2 Diabetes	• Daily blood sugar checks • Expert patient programme • Best practice medication	↓	↗	↘	↘	↓ 25%	↓ 45%
3 Asthma	• Best practice medication • Expert patient programme • Peak flow monitoring	↓	↗	↘	↘	↓ 38-73%	↓ 90%
4 COPD	• Best practice medication • Expert patient programme • Peak flow monitoring	↓	↗	↘	↓	↓ 20%	↓ 70%
5 CHD/ Hypertension	• Monitoring risk profile • Behaviour modification • Best practice medication	↓	↗	↓	↘	↓ ??%	↓ ??%
6 High risk / older people / Frequent flyers	• Identification of patients • Allocation of case manager • Regular monitoring and review • Pro-active assessment and treatment • Best practice medication	↓	↑	↘	↘	↓ 15-70%	↓ 40-50%

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Source: McKinsey analysis; Chronic disease management compendium, DH, 2004

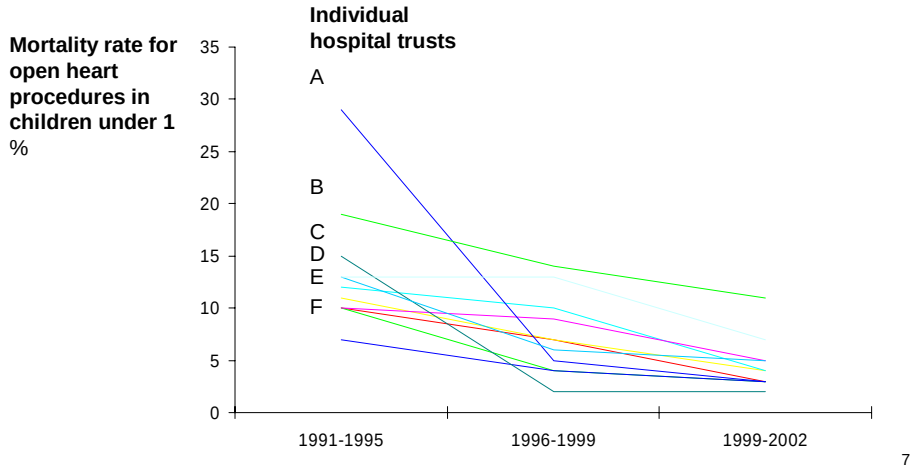
McKinsey&Company

On the use of information to drive quality, Dr Henke and Mr Dewhurst, gave an example of a dramatic reduction in mortality rates for child cardiac surgery in one UK hospital since data on operations began to be published by a private company.

USE OF INFORMATION TO DRIVE QUALITY

U.K. EXAMPLE

Reduction in mortality rates since data began to be published by a private company



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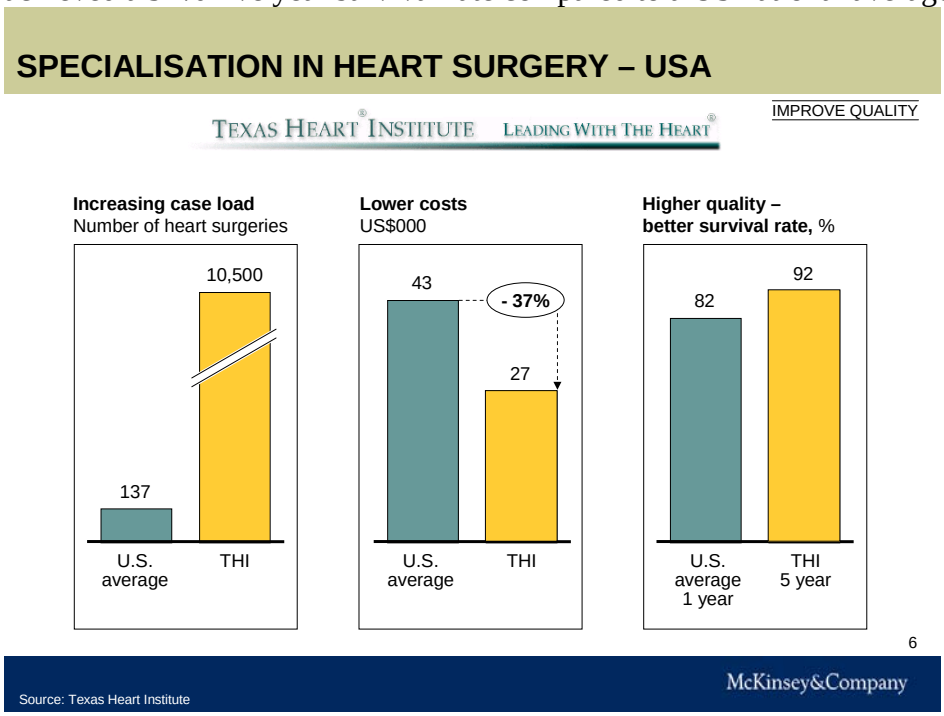
Source: Aylin et al. British Medical Journal, October 2004

McKinsey&Company

Martin Dewhurst said in any reform process it was important to take on board the lessons that had been learned elsewhere. He instanced what had been learned from specialization in heart surgery in the United States, in particular the findings of the Texas Heart Institute which had achieved a 92% five year survival rate compared to a US national average of 82%.



Address by Tánaiste and Minister for Health & Children Mary Harney TD (Ministers of State O'Malley and Power in attendance)

In her keynote address the Tánaiste and Minister for Health, Mary Harney TD, said the reform process had now reached its most difficult stage, that of moving from planning to action. She said she was confident that although no overnight solutions would be achieved measurable progress would be attained in a matter of months.

The Minister noted the representative nature of the Consultative Forum, the third of its kind to be held, and the number of stakeholders from every level of the health services present. They all had, as members of society, a huge stake in how health care is delivered and the quality of health care we have access to.

"I am conscious that here today we have representatives of patient groups, professionals working in health care, administration and management at every level together with representatives of the new interim board of the HSE and the DOHC. Clearly consultation with those who know best is always important. We spent a long time strategizing but at the end of the day it's not about plans or processes or what people will pay for or how things can be integrated, it's about action and implementation.

In the world of business there are two classical views of strategies and plans. There is the top down plan that is devised by those who have expertise from the perspective of the issue that is being addressed but equally there is the approach which consists of looking from the bottom up and seeing what actually works. You look at it from the intuitive reaction of those who know a subject from day to day experience.

Irrespective of where we are working I think everyone here wants to see an improved healthcare system from the point of view of patients. It's not as easy to explain that in everything we do we have to be able to see measurable results.

Clearly there are pressure points in the health services notwithstanding the huge resources that have been invested in recent years Reform is necessary, urgent and about to happen but there is no point in going on the reform journey in terms of how the health system is administered or managed unless it is going to make a real difference to the patients.

I am conscious of the fact that we have not given the Oireachtas as much time as they and we would have liked to debate, discuss and tease out this bill but on the other hand what is in that bill has been out since the middle of June 2003. There is nothing very different from what the government agreed and for most people who take an interest in this area from a public administration perspective, or from a policy perspective, there can be no surprises.
Time is running out. The patients and the public require that we put the reforms in place and, in particular, that we should not lose momentum notwithstanding setbacks that may come our way from time to time.

We have plans to have legislation in place in relation to information and quality assurance. The Health Information and Quality Assurance Authority is going to be a new independent body. In order to expedite the production of the Health Bill we have removed those aspects from it and that will be dealt with by way of a different piece of legislation in the Spring. I am delighted to see that Pat McGrath, recently appointed Chairman of the new Health Information & Quality Authority, is here with us today. Clearly quality standards and information are crucial as we go forward if we are to deliver real improvements from the patient's perspective.

In relation to the legislation what we are doing is moving towards a model of delivery and management of healthcare that is more appropriate to the 21st century than the 1960s and 70s. I know from the debate last evening in the Dail that there is a lot of concern among various parties, independents and different parties in opposition about the abolition of the health boards. I think the model put in place over 30 years ago with 273 members of health boards in addition to166 members of the Dail and 60 members of the Seanad is no longer relevant in terms of delivering healthcare on the ground.

This is not to say there shouldn't and musn't be a role for public representatives and employees and consultative groups like yours in the new business model as we go forward. That is why in the bill we make statutory provision for regional fora and for the statutory Consultative Forum such as we have here today because feedback, interaction and engagement is essential if we are to get it right.

No one person has all the answers and health care reform is about more than one person. It is about a whole generation of people and about access to the services that we are able to provide. In the provision of services obviously we will have to ensure that more and more the money follows the patient and not simply into the system.

That means essentially that we have to have targets and we have to have the money following performance and outcomes. We cannot just allocate money on the basis that it might or might not get us a particular level of service. I said in other fora and I want to repeat it here that government does not have to be in all circumstances both the purchaser and the supplier of all services.
I suppose the National Treatment Purchase Fund is a very good example of where public money is used to buy services for those patients who need them the most, for those longest on

waiting lists for surgical procedures. We need to use models of that kind as innovatively as we can to deliver improved services for those that need them most.
In relation to the reform agenda generally, clearly the test will be the test of whether or not what is happening is seen in terms of patient outcomes. When most people are sick they are clearly concerned, firstly, about the clinical outcome and, secondly, about the care they get, thirdly, about the care setting. But they are also concerned about how responsive the system is to their particular needs, how administratively efficient it is and so on.

They are concerned about standards of hygiene and so on. And so it was that when we were determining our priorities for 2005 Accident & Emergency was clearly a priority. Many of the actions we have to take in relation to A & E are not directly connected with Accident & Emergency. Access to GP services out of hours will alleviate much of the pressure on Accident & Emergency units. We have put a package in place including new initiatives ranging from basic hygiene and cleanliness in A & E units, to security to more complex issues such as acute medical units. The package is a holistic one and we will be appointing somebody shortly to oversee its implementation. By this time next year patients will see that it is making a difference.

We will not in a couple of months transform the situation where people have to wait extraordinary long periods before they have access to A & E and the services they require. But even in a short few months we should be able to see a measurable improvement.
In relation to the extension of the Medical Card, when we have €60 million extra next year we have to make choices and it's all based on priority. We could have extended the traditional card in the traditional way and that would have covered 70/75,000 more people. Instead we chose two things. One to extend the traditional medical card to about 30,000 people and to introduce a new doctor only card to approximately 200,000 people.

I was conscious when I made that decision of the huge numbers of people, both professionals working in healthcare and parents and others, who said you know if only people could have access to the doctor sometime to get reassurance it would be a major step forward. I am delighted that generally the extension has been well received. Clearly by limiting the extension to doctor only it allows us to do a lot more with the sum of money involved.
In the context of drugs in particular and a spend of €1.2 billion, 300 million on hospital drugs and 900 million through the GMS scheme it is time to look at the high cost of drugs. We hope to have negotiations shortly with relevant parties in relation to that matter because the cost of the GMS next year will be 12% higher than last year. Over €200 million extra will go into the provision of GMS services.

We also want to ensure that the new units that have been built are fully staffed and used to their full capacity. Obviously it doesn't make a lot of sense to put huge resources into capital expenditure to build more modern and more appropriate facilities and not to be able to use them to their full capacity and that too was a priority for 2005.

In relation to the reform agenda as we go forward, my door is open within reason to anyone that has good ideas but above all else my door is open to those who work hard sometimes in extraordinary difficult circumstances to make things happen in the interests of the patient.
My decision to opt to become Minister for Health was not one I made lightly. There is a huge challenge. I have met some of the best people I have ever met in the country in the last seven weeks and I do not say that in any condescending way. It is true. At every level of our

healthcare system we have fantastic men and women whose sole focus is on how to make things better.

I know of very few people in the country who don't want to see the reform happen and to see it happen as quickly as possible. It is my determination and that of the government to make sure that the reform happens as quickly as possible. As I said at the outset we are moving from the strategy into action and that is always the more difficult part. Writing down the plan, getting agreement and the targets is often relatively easy. Implementation is often difficult.

A story is told of a former politician who said "I know it will work wonderfully in practice but what does it sound like in theory". Instead of that model I prefer the Tony Blair model when he said "What works is what matters." In everything we do from a reform perspective it will be to ensure that what works will matter**.**

And so it is the lines of responsibility and accountability between the HSE and the Department of Health will be much more clear than they were in the past. The Department clearly responsible for policy and advice to the Minister, setting targets and negotiating the resources and the HSE responsible for the implementation and being accountable for all that goes with that.

The roles are very clear and I think it is only when you have clear roles that you can expect clear results. Ladies and gentlemen thank you very much for being here today. I am genuinely impressed with the huge numbers and the representative nature of the people that are with us. It confirms in my mind that health reform is important and as we get close to January 1st and of course there won't be a big bang. During the first six months of next year, the transitional phase, the Chief Executive Officers of the health boards are going to continue to function as they were in the past and that is natural with the reform agenda that is so huge, the biggest change management process that has ever undertaken in the country.

I know from previous experience bringing things together even on a much smaller scale in Enterprise Ireland had its teething pains, its difficulties, its challenges but equally it has its opportunities and it has its results. There has never been a better time in my opinion in recent years to work in the delivery of healthcare, a time of enormous change and challenge but equally a time when we know there are going to be terrific opportunities.

I genuinely look forward to working with you during the next couple of months in particular when there will be teething problems and there will be difficulties and there will be challenges and all of us will be tested but the only test that will really matter is whether or not we are decisive and determined to see the big picture and to see it all through or if we will allow ourselves to get distracted and to flounder and to take our eye away from the focus. If we do that we will betray the people that we serve most and that is the patients and the public who expect us to live up to the reputation and the excitement that they see in the new changes and to make sure that the strategy goes beyond the plans and the processes and into implementation as quickly as possible.

Discussions Groups

Subject: Health Information & Quality

Question: What should be the priority areas for action, and the related initiatives, to be considered by the Health Information & Quality Authority (HIQA) in pursuing the key policy aim to deliver high quality services that are based on evidence-supported best practice?

Rapporteur Dr Michael Boland, Director, Postgraduate Centre, Irish College of General Practitioners.

Our group discussion concluded that HIQA should have a strategy oversight function and should be patient and client driven. We found the HSE emphasis on the patient journey to be an encouraging one. The threat is the danger of HIQA being sidelined or falling behind the progress of the HSE and HIQA needs to be represented on the Board of the Health Services Executive.

Major opportunities exist for policy makers, service providers & consumers in the areas of improved information, implementation of strategies and providing a stronger focus on quality.

Above all we should focus on action. We need to get down to specifics. Issues of confidentiality have caused difficulties in the field of information exchange and this may require legislative action. A unique patient identifier is essential while giving due recognition to confidentiality concerns.
Tensions exist within the system. The quality assurance cycle has been well described. We don't need further descriptions; rather we want specifics and action. There is a danger of quality being subsumed or lost in cost issues

In terms of practical action & implementation there is need for incentives & penalties and linkages with accreditation agencies. Overall the bottom line is that HIQA needs to be set up quickly or it will lose out.

Rapporteur : Dr Peter Kearney
There is some confusion over the identity and role of HIQA. Our group sees it as an independent statutory body reporting directly to the DoHC, a small group primarily charged with developing strategy for information gathering, quality assessment and the setting of standards and health technology assessment. A second role would be running two existing large disease registers.

The best means of bringing clarity to the various issues is to get the authority up and running. Mechanisms should be put in place to ensure that deficits highlighted by HIQA will be addressed – the authority needs teeth. Ultimately the allocation of resources will be the responsibility of the accountable body.

HIQA must also send out a number of positive messages. Systematic information gathering and quality monitoring offers the opportunity to highlight success as well as shortcomings**.** It should not however be perceived as the sole agent for quality, information gathering and research. Quality is delivered locally.

Effective communications must be established between HIQA and service providers. The wide nature of the DoHC remit implies a role for HIQA in monitoring quality and setting standards in areas such as disability, childcare and mental health for which a medical model is unsuitable.

Electronic Patient Records
In response to a question from Mr Martin Cowley, Chief Executive, Mater Hospital, Dr Boland said electronic record keeping had proceeded rapidly in the field of general practice. It was crucial to the development of the process that people should see real benefits from it e.g. that they should be able to get a result from the lab into their computer without a double entry book-keeping system. Dr Kearney said hospital systems were further removed from this development but it offered great possibilities in the field of record management. On the question of patient identifiers he said all concerned were keen to see this happen although they recognized the political and other difficulties involved.

Discussion Groups

Subject: Voice of the Patient//Service User
Question: How should the "voice" of the patient/service user be most effectively encouraged, supported and reflected in the reformed health system?

Rapporteur : David Stratton, Age Action

The first point we would make is the question of definition. Whose voice is being represented and how do we define the user of the service? Is it solely the patient or the wider community and who represents the community?

The key issue is not just being listened to but also influencing the making of policy through true partnership. There are some models of inclusion and some organisations who represent particular voices eg heart organizations and different interest groups but there is no one voice – rather there is a choir and it is not always singing in harmony.

There are consumer panels within the Health Strategy but one of the points in this regard is that as many voices as possible should be heard through these panels and people should not have permanent seats on them.

The fourth issue we identified were excluded groups eg older people who do not identify with these panels so there is a need for the health services to proactively engage with consumers. There is an example from the Combat Poverty Agency and their Building Health Communities project which builds the capacity of excluded groups to make their voices heard.

Our fifth point is that information is critical. People need to know their entitlements and their rights before they will begin to lobby for change.

Our final point is that the system needs to be person centred. Reform is not all about efficiencies.

Rapporteur :Mary Hynes, Regional Manager, Acute Services, Western Health Board

There is remarkably little overlap between the findings presented by David Stratton's group and mine on this subject. Our group felt that in considering this topic the focus should not be entirely on the user but there is an onus on the service provider.

We can help if we change the culture from blame to openness, transparency and accountability. This means greater training for staff and perhaps learning from the commercial sector and the service industry.

Feed back and complaints need to be dealt with on a structured basis. Users must know that we need their feedback and must be given the necessary facilities eg dedicated phone lines and the process of feedback must be separated from that of service provision.

The many examples of good practice need to be publicized and good practices should be common across service areas. We should recognize that certain advocacy groups in particular areas eg mental health and disability are well organized but that other areas are not in this situation and we need to strive for a balance between the group voice and that of the individual.

Our group also felt that the system should be more alert to recurring themes in that a complaint in one area may require action across the entire system.

Comment
Michael Brophy, Office of the Ombudsman

Proper training must be put in place for all staff dealing with complaints. There is no point in having feedback without delivery.

Discussion Groups

Subject: Health Strategy Goals

Question : In the reformed health system what should be the priorities over the short to medium term in pursuing the goals of : Better Health for Everyone, Fair Access, Responsive and Appropriate Care & High Performance as identified in the National Health Strategy – Quality and Fairness ?

Rapporteur : Deirdre O'Connell
Europa Donna (Irish Breast Cancer Campaign)

We started off dealing with the subject question by question but there was so much overlap that I am reporting back from an overall perspective. Primary health care emerged as an absolute priority for development in the reformed health system because of the effect of well resourced and developed primary health care on every other part of the system.

Part of this development should involve planning around communities as they exist eg keeping elderly people in independent living through the necessary supports and support for carers where appropriate.

There is a need for integrated multi agency services to support this approach because the whole environment affects access to health. Developing equality of access for minority groups needs to be assured as part of the process of development. Early intervention is also vital and makes for much better health outcomes and value for money.

The issue of access to primary care was discussed mainly the provision of medical cards and the resourcing of primary care to cope with extra demands. Continuing education for clinic staff but also right across the board was identified as a priority.

Inclusion of the elderly at all levels including prevention eg screening is vital. Maintaining them at home is a priority but we should remember that those who have to go into long term residential care have to use their savings and this cannot be regarded as providing fair access to care.

The partnership approach was seen as a priority for staff and patients and patient groups. There is a need for patients to be empowered.

To have transparency we need to have the data so that we can measure quality and monitor and evaluate. Here the role of HIQA is very important as is ICT.

Rapporteur : Phil Mulligan, North Western Health Board

Our group recognized achievements to date for example the positive aspects of the smoking ban but felt there is much greater need to secure involvement of the lower income groups. Health is not the preserve of the Department of Health and Children and all public policies emanating from all Government Departments including Finance, Justice and Food(not just Agriculture) need to be health proofed.

There is an urgent need for debate on how the health strategy is to be funded going forward into the future and this is a nettle that has not been grasped. There is also a need for sequencing and timing in the reform process for example the closure of a local facility must be timed in accordance with the development of the regional service.

Discussions Groups

Subject : Public/Private Complementarity

Question : Can we establish stronger complementarity between public and private to support achievement of the goals of the National Health Strategy Quality and Fairness ?

Rapporteur : Dr Jane Buttimer, DOHC

First of all we had to decide what the question meant ? It is not a black and white situation. There is a broad spectrum of care. It's about the patient's journey through the system or the continuum of care. We have to broaden out the definition to include primary care and social services.

Is the private sector to be regarded as an alternative to the public one or to be in alignment with it ? The public sector has huge technological infrastructure, complex problems including capacity ones and a multitude of responsibilities and tasks including teaching.

The private sector is characterized by flexibility, a low cost base, fewer allied staff, no teaching responsibilities and fewer complex issues to face. If the two systems are to be aligned in a worthwhile fashion we need a proper regulatory framework and a level playing field for both players. We have to consider everything from licensing of the private sector to deregulation of some aspects of the public system.

Access, safety and quality are the key rules for complementarity. Public perceptions have also to be changed, in particular the notion of "Public not so good, Private is best".

We need to decide what we want to buy and then to buy it at the best possible price. Public hospitals have superb technological facilities and operate on a seven day week basis and there is an opportunity for the private sector to buy into this and the private hospitals could also sell beds or services to the public sector.

The involvement of private hospitals in the provision of A&E services must also be examined. We must make best use of what each supplier is good at and secure it at the right price subject to the key considerations of access, safety and quality.

Rapporteur Andy Kelly, Irish Blood Transfusion Service

The Group was of the view that the question as presented had an element of "If we can" whereas the Group felt that this needs to be stated as " How can we establish." In addition it should cover all aspects/sectors rather than the hospital sector.Perhaps the time has come to move from "Complementarity" to "Partnership".

Firstly, we need to establish where we are, what Public/Private partnerships are currently in place, are there obstacles to more integration and how can these obstacles be resolved.

Complementarity does not necessarily mean competing head-on There is suspicion and lack of trust by the Public Sector in Private Sector, i.e. Private providers should not be allowed to cherry pick, the provider is welcome to the profit but must carry the risk for losses also.

We may need to unpick the current system that has evolved rather than grown as a result of planned development. However, we need to know how to unpick this system because this may cause significant problems.

There is a major role for the Department of Health and Children setting the policy by determining:

- What should the role be for the Private sector, how should this role be structured and there needs to be clear terms of engagement, e.g. there is an approved Cancer Treatment Strategy yet a private operator is intending setting up a treatment centre in an area not included in the approved strategy. This has the potential of undermining Public Policy,
- The standards – there must be measurement which must apply to the Private and Public sector,
- Accreditation as opposed to regulation,
- The level playing pitch perhaps through funding universal service,
- How hospitals and other entities could be empowered to enter agreements with private providers for some services, e.g major public hospital purchasing services from a private hospital,
- An education programme to overcome antipathy, mind-set in the Public Sector vis-à-vis the Private Sector and cultural differences.

Insurers could play a role in contestability/improving quality through the methodology used to recover costs/pay for patient charges, i.e. move from a system of paying by volume and price to a system which is based on quality and other metrics around service delivered.

One vital question is whether the Private Sector has the capacity to become a meaningful partner? Overall our group concluded that we need to optimise the contribution from each sector/system to deliver a better experience for the patient.

Debate

Dr Ruth Barrington, Chief Executive, the Health Research Board (HRB), raised the differences in the private sector between non profit and profiting making elements and expressed surprise that no mention had been made by the breakaway groups of the question of conflict of interests ?

Dr Buttimer said that if public and private interests were accommodated on the same campus there would be a quality gain for patients. She felt consideration should be given to the responsibilities of health insurers with regard to the provision of accident and emergency services.

Andy Kelly replied that his group felt that the for profit section of the private sector should be willing to take the risk of making a loss without expecting this to be made up by the taxpayer. There should be no cherry picking allowed

Mary O'Connor, Children in Hospital Ireland, said she was worried that they were enshrining a two tier system. There was no regulation of the delivery of care to children in the private sector and she felt that such care was, undoubtedly, better delivered in the public sector.

Questions & Answers

Q. Where will the DOHC stand in 2005 when the HSE is up and running ?

A. **Michael Kelly DOHC:** We believe the new arrangements will open up new opportunities for us. We will be able, for example, to look at the specific socio economic determinants of health. We already have a serious track record in engaging groups of service users and advocacy groups for the disadvantaged and I hope this will be strengthened.

Q. How do you get people to buy into improvements ?

A. **Nicholaus Henke**: Improvements are driven by accountable organisations where there is no blurring of responsibility and there is a clear line of accountability. It is very important to get clinicians involved in examining the problems and in working out solutions.

The third factor is a focus on resources. Where good results are achieved it is after a focus has been placed on a selected target. The three stages are having accountable units, consistent targets and allocating the necessary resources.

*Q.***Dr Kate Ganter,President, Irish Medical Organisation, & representing Irish College of Psychiatrists**: It seems that mental health services have been left out of the new arrangements. Where do they fit into the new delivery of services ?

A. **Kevin Kelly:** This question has come up on a number of occasions. The Change Management team recognises that mental health services straddle a number of areas. From January we will be working through a process that will be seen as a seamless experience.

Q. **Kate Ganter** : You did not talk to the frontline workers ?

A. **Kevin Kelly HSE**: In the past six months we have talked to as many people as possible. There are many representative organisations involved and we have taken their comments on board. We recognise the conflict and we are in constant dialogue on this, I hope we will find a solution you will be happy with.

A. **Michael Kelly DOHC:** This was always going to be one of the quandaries in devising policy territories. The whole emphasis has been towards community based services. What would be tragic would be if the degree of joined up thinking were diluted in any way and that would be uppermost in our minds.

Q. **Dr Jane Buttimer:** We have heard very little from you with regard to education and training over the past year?
Q. Dr. Ruth Barrington: Dr. Barrington (HRB) asked for clarification on the question of future health research and the need for investment in this area.

A. **Michael Kelly:** The Department of Health is most concerned that there should be secure arrangements in place from January in the areas of education, training and health research particularly, to give one example, in the field of communicable diseases. We will not see any sudden change. There will be a process of connecting responsibilities and this is being worked through. Research is an integral part of a modern health system. We can empower the

HSE to commission research. Within the Department of Health we have given greater focus to policy research. We are also encouraging clinical leadership and investment in health research has been increased.

***A.* Kevin Kelly:** Having spent many years lecturing I have a passion for education, training and research. I was stunned to find how little has been spent in the health areas, not just in research but also in education and training. I will be looking for more.

Partnership

An exchange of views on the concept of partnership between HSE chief Kevin Kelly and NWHB Chief Executive Pat Harvey ended in mutual disagreement. Mr Harvey defended the work of the National Partnership Forum which he felt had gone from a tentative start where everyone was walking on eggshells to a situation where it had the capacity and robustness to deal with difficult issues.

Mr Kevin Kelly stuck to his previously expressed view that partnership had done wonderful work at local level. He expressed his view that real partnership did not exist at national level.

Closing Remarks

In his closing remarks, Mr Frank Ahern, Assistant Secretary, Department of Health & Children thanked all who had attended the Forum and said that once again it had proved its value in helping all involved in the provision of healthcare to get a clearer picture of the reform process. It was now important, he said, to move to the stage of implementing reform. The Chairman, Mr Cullen, said he felt the proceedings showed the value of the consultation process and thanked all who had attended and the many individuals who had assisted with the preparation and running of the Forum.

Appendix 1

Attendance List – National Consultative Forum 2004

Firstname	Lastname	Organisation
Frank	Ahern	DoHC
Catherine	Anderson	The Dublin City Network
Ruth	Barrington	HRB
Paul	Barron	DoHC
Gerard	Barry	HSEA
Vincent	Barton	Prospectus
Yvonne	Bohane	DOW Residential Services
Michael	Boland	Irish College of General Practitioners
Roisin	Boland	IHSAB
Colm	Bracken	iHSE
Vincent	Breheny	An Bord Altranais
Christine	Brennan	DoHC
Brian	Brogan	DoHC
Michael	Brophy	Ombudsman Office
Aidan	Browne	iHSE
Paddy	Burke	GMS
Eileen	Burke	Breaking Through
Margaret	Burns	Childrens Rights Alliance
Jane	Buttimer	DoHC
Marian	Byrne	Dept of Agriculture & Food
Ian	Callanan	ISQSH
Kevin	Callinan	IMPACT
Elizabeth	Canavan	National Children's Office
Bernard	Carey	DoHC

Bob	Carroll	NCAOP
Monica	Cassidy	Congress Centres Network
Brid	Clarke	MHC
Kevin	Cleary	South Western Area Health Board
Hilary	Coates	RCSI
Gerry	Coffey	DoHC
Eibhlin	Connolly	DoHC
Sean	Conroy	WHB
Tara	Coogan	Equality Authority
Ivan	Cooper	Crisis Pregnancy Agency
Chris	Costello	DoHC
Martin	Cowley	Mater Hospital
Fiona	Coyne	Irish Sports Council
Jackie	Crinion	OHM
Ger	Crowley	iHSE
John	Cullen	Institute of Public Administration
Mary	Culliton	MHB
Chris	Cully	IMPACT
Frank	Cunneen	IBEC
Audry	Deane	St Vincent de Paul
Michael	Dempsey	Bristol,Myers, Squibb Pharmaceutical Ireland Limited
Sean	Denyer	HeBE
Donal	Devitt	DoHC
John	Devlin	DoHC
Martin	Dewhurst	McKinsey Consulting
Annie	Dillon	National Womens Council of Ireland
Denis	Doherty	HeBE

Gerry	Dolan	IMPACT
John	Dolan	DFI
Ray	Dolan	SafeFood
Pat	Donnelly	South Western Area Health Board
Pat	Doorley	MHB
Liam	Downey	Board iHSE
Liam	Duffy	Beaumont Hospital
Larry	Woods	Dept. Finance
Jimmy	Duggan	DoHC
Pat	Dunne	NAHB
Kieran	Feely	DoHC
Yvonne	Finn-Orde	Association of Occupational Therapists of Ireland
Angela	Fitzgerald	ERHA
Chris	Fitzgerald	DoHC
Muiris	Fitzgerald	Faculty of Medicine UCD
Geraldine	Fitzpatrick	DoHC
Helen	Franklin	iHSE
Dorothy	Gallagher	Consumers Association of Ireland
Jack	Gallagher	Institute of Obstetricians & Gynaecologists
Kathleen	Ganter	Irish College of Psychiatrists
Deirdre	Garvey	The Wheel
Pat	Gaughan	MHB
James	Gibbs	DoHC
Alan	Gillis	Tallaght Hospital
Mary	Golden	National Children's Office
Mary	Gorry	South Western Area Health Board
Nicola	Gurr	DoHC

David	Hanly	National Steering Group
Adrienne	Harrington	The Psychological Society of Ireland
Cate	Hartigan	iHSE
Pat	Harvey	NWHB
John	Hayes	DoHC
Mairead	Hayes	Community and Voluntary Pillar
Sheila	Heffernan	Drug Treatment Centre Board
Nicolaus	Henke	McKinsey Consulting
Dora	Hennessy	DoHC
Tom	Hogan	iHSE
Tony	Holohan	iHSE
Geralyn	Hynes	RCSI
Mary	Hynes	WHB
Teresa	Hynes	DoHC
Brendan	Ingoldsby	DoHC
Mary	Jackson	DoHC
Nicky	Jermyn	St Vincents Healthcare
Ann	Judge	OHM
Des	Kavanagh	Psychiatric Nurses Association
Peter	Kearney	Cork University Hospital
Owen	Keenan	Barnardos
Colm	Keenan	DoHC
Conor	Kehoe	McKinsey Consulting
Andrew	Kelly	IBTS
Kevin	Kelly	iHSE
Brian	Keogh	Royal College of Physicians
Eileen	Keogh	DoHC

Jim	Kiely	DoHC
Aidan	Kinch	Dept of Environment
Geoff	King	PHECC
Marie	Laffoy	ERHA
John P.	Lamont	Medical Council
Paul	Ledwidge	National Federation of Vol Bodies
Anna	Lloyd	NTPF
Christine	Long	Academy of Medical Laboratory Science
Geraldine	Luddy	Womens Health Council
Fergal	Lynch	DoHC
Patrick	Lynch	HeBE
Maureen	Lynott	NTPF
Michael	Lyons	Tallaght Hospital
Shauna	Lyons	iHSE
Pat	Madden	SHB
Gavin	Maguire	ECAHB
Seamus	Mannion	WHB
Una	Marren	Mater Hospital
Margaret	Martin	Womens Aid
Tommie	Martin	Comhairle na nOispideal
Geraldine	McCarthy	School of Nursing and Midwifery,UCC
Mary	McCarthy	DoHC
Michael	McCarthy	Irish Herbal Practitioners Association
John	McCormack	Irish Cancer Society
Mark	McEntee	Irish Institute of Radiography
Maura	McGrath	National Steering Group
Pat	McGrath	HIQA

Caroline	McGrath	Mental Health Ireland
Laverne	McGuinness	iHSE
Joan	McKenna	DoHC
Mary	McKiernan	Irish Nutrition & Dietetic Institute
Peter	McLoone	ICTU
Pat	McLoughlin	SEHB
Catherine	McManus	DoHC
Bernie	McNally	DoHC
Mike	McNamara	Social Services Inspectorate
Tony	McNamara	iHSE
Tony	McQuinn	Comhairle
Matt	Merrigan	SIPTU
Ray	Mitchell	Office of Tobacco Control
Catherine	Molloy	Patient Focus
Tom	Mooney	DoHC
Tony	Morris	DoHC
Laurianne	Muller	DoHC
Brendan	Mulligan	HSEA
Phil	Mulligan	NWHB
John	Mulry	Doctor from Australia
Catherine	Murphy	SHB
Noel	Mulvihill	NAHB
Eugene	Murray	Irish Hospice Foundation
Helen	Murray	DoHC
John	Murtagh	The Dublin City Network
Bairbre	NicAongusa	DoHC
Triona	NicGiolla Choille	Community Workers Co-operative

Anne	Nolan	IPHA
Tony	O'Brien	Breastcheck
Tadhg	O'Brien	iHSE
Deirdre	O'Connell	Europa Donna Ireland
Mary	O'Connell	ECAHB
Maura	O'Connell	Irish Medicines Board
Edel	O'Connor	DoHC
Mary	O'Connor	Children In Hospital Ireland
Sheila	O'Connor	Patient Focus
Lauren	O'Dea	DoHC
Brian	O'Donnell	National Federation of Vol Bodies
Dee	O'Donnell	The Wheel
Ita	O'Dwyer	Coombe Womens Hospital
Anne	O'Dwyer	The Samaritans
John	O'Farrell	DoHC
Fergus	O'Ferrall	Adelaide Hospital Society
Darina	O'Flanagan	NDSC
James	O'Grady	MWHB
Ursula	O'Hanlon	DoHC
Peter	O'Mahony	Irish Refugee Council
Tim	O'Malley T.D.	DoHC
Yvonne	O'Neill	ERHA
Caroline	O'Regan	OHM
Jim	O'Reilly	NEHB
Larry	O'Reilly	DoHC
Sophia	O'Reilly	IMPACT
Michael	O'Shea	Irish Heart Foundation

Yvonne	O'Shea	National Council for the Professional Development of Nursing & Midwifery
Ivan J.	Perry	Dept of Epidemiology and Public Health, UCC
Sean	Power T.D.	DoHC
Priya	Prendergast	iHSE
Fiona	Prendergast	DoHC
Liam	Preston	DoHC
Brian	Redahan	ECAHB
Pauline	Redmond	DoHC
Alan	Reilly	FSAI
Joseph	Richardson	IMO
Paul	Robinson	NEHB
Sheelah	Ryan	WHB
Simonetta	Ryan	DoHC
Eamonn	Shanahan	Irish College of General Practitioners
Cathy	Sheehan	Federation of Catholic Voluntary Nursing Homes
Emer	Shelley	DoHC
Ian	Simeatan	McKinsey
Paul	Simpson	DHSSPS
Alan	Smith	OHM
Ray	Smyth	DoHC
Frances	Spillane	National Children's Office
David	Strattan	Community and Voluntary Pillar
Leo	Stronge	iHSE
Aoife	Sweeney	National Social Work Qualifications Board
Larry	Walsh	HSNPF
Michael	Walsh	OHM

Brenda	Wheeler	Irish Patients Association
Sheelagh	Wickham	School of Nursing, DCU
Maureen	Windle	NAHB
Joyce	Worrell	Irish Society of Chartered Physiotherapists
Peter	Wright	NWHB

Appendix 2 -HSE National Directorate Team announced by Kevin Kelly IHSE

Kevin Kelly (IHSE) made the formal announcement of appointments of the new HSE national directors at the Consultative Forum. They are:

National Hospitals Office: ***Mr Pat McLoughlin***

Primary, Community and Continuing Care: ***Mr Aidan Browne***

Population Health: ***Dr Patrick Doorley***

Change Management & Organisational Development: ***Ms Ann Doherty***

Shared Services: ***Ms Laverne McGuinness***

Finance: ***Mr Diarmuid Collins***

Information & Communication Technology: ***Mr Sean Hurley*** **(acting)**

Human Resources: ***Not filled at present***
The position of National Director of Human Resource Management has not been filled as yet. The interviews have been completed, but discussions with candidates are still ongoing.

Pending a permanent filling of the job the iHSE is appointing Mr John Magner as acting Human Resource Director.

Most of the appointees will be able to take up their new roles immediately. All will be based at the HSE headquarters in Naas, Co Kildare.

Acting CEO of the iHSE, Mr Kevin Kelly, said "I am delighted to announce these very important appointments and to congratulate the individuals concerned. The quality of applicants from within and without the existing heath boards was very high. I am very pleased that we have assembled a team that brings together a wide range of experience, some in the private sector but also with a great focus, knowledge and in-depth understanding of Ireland's health service."

"I look forward to bringing the new team of leaders for the health service together at the earliest possible opportunity. The next step is for them to begin to shape and resource their directorates, in an agreed and consultative manner."

Other senior management team jobs, at corporate level, are currently being scoped and will be advertised in the New Year. However the HSE will be announcing the appointment of an Acting Chief Medical Advisor next week. This person will play a key role in supporting the work of the CEO and the management.

The Board of iHSE decided that the post of Chief Executive Officer would be re-advertised nationally and internationally in the New Year.

A total of 200 applicants applied for National Director roles, 45% of those were people already working in the Irish health service.