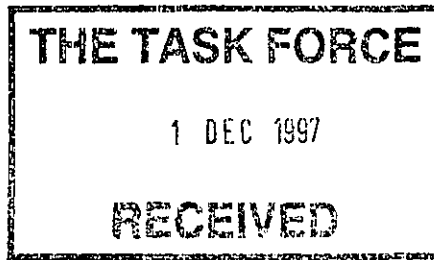
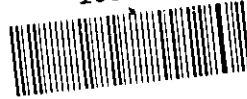


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**TASK FORCE ON THE
EASTERN REGIONAL HEALTH
AUTHORITY**

FINANCIAL SKILLS AND STRUCTURES

FINAL REPORT

Presented by First Consulting Group

November 1997

353.6

CONTENTS

EXECUTIVE SUMMARY

1. INTRODUCTION 1

2. BACKGROUND AND METHODOLOGY 3

 2.1 Background 3

 2.2 Methodology 3

3. KEY FINDINGS AND UNDERLYING ASSUMPTIONS 4

 3.1 Key Findings 4

 3.2 Assumptions 6

4. ORGANISING THE FINANCE FUNCTION 8

 4.1 Corporate Holding Company Model for Social Welfare Commissioning 9

 4.2 Internal Contracting Amongst Area Councils 10

 4.3 Levels and Structures for Information Management 11

5. FINANCIAL REPORTING BUSINESS PROCESSES 13

 5.1 Business Processes 13

 5.2 Reporting and Timing 15

 5.3 Sample Business Process: Payroll 16

 5.4 Sample Business Process: “Service Plan Actualisation” - Voucher & Invoicing 17

 5.5 People: Estimated Staffing Levels for Finance Functions 19

 5.6 Systems Architecture 21

6. GETTING THERE 23

 6.1 Financial Systems 23

 6.2 Next Steps 26

EXECUTIVE SUMMARY

This report describes the options and specifies recommendations for the financial structures and skills needed at the new Eastern Regional Health Authority (ERHA) and its three component Area Health Councils (AHC). The report recommends that the ERHA adopt a corporate holding model for structuring the financial functions of the authority and integrating the information activity link with the voluntary organisations into the ERHA information and financial management system, through the adoption of a universal monthly invoicing system based on the service plan/ agreement. It further recommends that a separate implementation project for a new financial management system be specified and co-ordinated with the Eastern Health Board's current initiative.

The report briefly reviews the background and our methodology; states our key findings and the underlying assumptions and context; recommends organising financial functions, business processes and personnel based on a "generic" corporate holding company model as applied to social welfare agencies, including a discussion of business processes, reporting structures, levels and skills of financial personnel; and outlines a systems architecture for key business processes and financial information technology that will need to be in place to support the commissioning and monitoring process. This includes a discussion of reporting cycle times and data collection. The relationship of that architecture to the required total information system's architecture is discussed in greater depth in a companion report concerning the systems and technology. The final section discusses our conclusion that there is only one viable option to meet the standards and objectives within the constraints and time deadlines. It also describes our recommended near term and longer term next steps.

Our key finding is that it is an ambitious undertaking to have financially skilled people, strong reporting structures and appropriate systems and procedures in place by 1 January 1999. There is one viable strategy open to meeting this deadline, based on extending EHB's planned replacement financial systems to encompass the needs of ERHA. That strategy requires an intense collaborative effort to ensure that work on the specifications required for upgrading the EHB systems begins now to meet ERHA's future needs. Our findings are discussed under three categories: business processes, structures and staffing, and information systems. The report details the underlying assumptions to our findings and recommendations. They are summarised as follows:

- ERHA should apply a holding company model to organise its financial processes. There will be:
 - A parent company, ERHA Corporate with three operating divisions, the Area Health Councils.
 - 35+ independent/subsidiaries or affiliated companies (with perhaps up to 400 others).
 - Systems capability to process, consolidate and review data for a number of independent companies reporting aggregated activity and financial data.
- Each operating entity should have its own financial officer and finance office.
- We recommend adoption of a multi-company based financial system. One with three "subsidiary" companies (the AHCs) and 35+ independent contractor service companies (the Voluntaries), which automatically aggregate/consolidate to the "parent" holding company (ERHA). The systems architecture is presented in more detail in the companion information systems plan. The key over-riding requirements for finance management systems include:
 - Consistent specifications for general ledger, chart of accounts, asset register, cash management, reconciliation, reporting, item tracking, costing etc., that are specific to ERHA requirements, and are planned, designed and tested as an integrated suite of financial management systems;

- The systems work, are reliable, consistent and integrated; However, the financial systems can operate stand-alone from the other ERHA systems if required;
- Policies and procedures are written and maintained to audit (C&AG) standards;
- Financial systems/data cannot be corrupted by any other component system of the system; and
- The security and back up of financial data is paramount.
- We recommend the establishment of an " internal bureau" across the ERHA and AHCs to accrue economies of scale for high volume or complex, non-geographically constrained transactions (e.g. payroll, creditor payments, materials & supplies, IT support and maintenance).
- Preliminary estimates suggests a need to hire, (recruit, process and train) and organise 20-25 persons for the finance function at ERHA corporate, with an additional 47-57 persons in three finance offices and a bureau for the three AHCs.
- ERHA should be represented in any development and/or change specification of the current Service Plan system. It is to be the key report to support the commissioning of care and must meet four basic criteria:
 - ERHA must meet the DoH mandate that funds cannot be expended beyond budgets;
 - enable ERHA to determine that it has obtained 'value-for-money' from the services it has funded;
 - C&AG statutory audit standards for dispersion of public funds; and
 - voluntary agencies independent governance and ownership.
- We recommend design of a monthly invoicing and voucher system to actualise the service plan as a financial reporting tool and report. All Voluntary Agencies will present a monthly invoice, based on service plan, budget, approved adjustments to cash position, and a detailed activity report based on current IMRs. We recommend that the transfer of money or parts of money will eventually be dependent upon the presentation of a complete invoice.
- New reports and reporting systems are required for ERHA to prepare consolidated monthly reports to meet statutory accounting requirements and the usual accounting standards. All reports and reporting must integrate with other key ERHA operational functions: planning, commissioning, monitoring and human resources.
 - A policies and procedures unit is required to maintain, transmit and train finance and other relevant persons on financial policies and procedures.
 - A group that can provide financial and capital planning expertise is required throughout the ERHA and AHCs.
 - An internal audit unit is needed at ERHA corporate and at each financial office of the AHCs to ensure compliance with ERHA standards and compliance with contracted obligations by the voluntary organisations.
- We recommend that a collaborative planning and specification process be organised immediately to ensure that the capabilities of the EHB financial systems be extended to meet the requirements of the broader ERHA (e.g., consolidated monthly reporting of Voluntary and Area Finances) and to define how current business processes and systems will be replicated or used by the three Area Health Councils. We suggest a comprehensive action plan, implementation project, is required to ensure system migration and change allows testing and transfer over occurs on time.

- We recommend meetings with the DoH to define the migration and changeover time table for processes and systems currently under their control that will be switched to ERHA.

This report will benefit from continued discussions within the Task Force and the Financial Working Group. This should continue with reference to the companion report on information systems prepared by FCG. We suggest that the ERHA Task Force approve appointment of a project manager and team as soon as possible to:

- Assess specific needs or arrangements to ensure a sufficient and adequate financial system will exist by 1 January 1999; this includes collaboration with the EHB for developing the Financial Management System, the definition of the "bureau" concept for financial services across ERHA and the identification of financial and accounting services for inclusion in the bureau;
- Specify action steps and responsibilities to ensure the financial system is in place and integrated with other systems by 1 January 1999;
 - Clarify nature and extent of "commissioning" and "invoicing" mechanisms;
 - Determine availability of financial personnel and organise a hiring and training plan;
 - Understand time lines and critical paths for migration;
- Design systems and specify interfaces and migration strategies; and,
- Monitor legislative progress to ensure compatibility.

One cannot over-emphasise the scale and magnitude of this challenge. Nor the opportunity to improve social welfare gain through the introduction of proper expeditious business processes.

1. INTRODUCTION

This Final Report describes the options available to the new Eastern Regional Health Authority (ERHA) and specifies the financial structures and skills needed at the new ERHA and its three component Area Health Councils (AHC). The financial structure is typically an independent yet inter-dependent part of the overall management and information mechanisms necessary to meet the purpose of an organisation. The special designation of independence stems from the desire for greater probity and accountability in the business purpose of the organisation. In particular, there is a need for controls that allow continuous oversight on how public funds are spent, separately from those persons or controls involved with the budgeting and monitoring of funds appropriations. The business purpose of the proposed ERHA is to:

- Improve the co-ordination, accessibility and provision of social and health care services for people in the Dublin, Wicklow & Kildare Counties; and
- Be accountable to the Minister of Health for the expenditure of funding for the:
 - range of services and service units and staff currently operated and employed by the Eastern Health Board (EHB);
 - range of voluntary organisations currently funded directly by the EHB; and
 - voluntary mental handicapped organisations and voluntary hospitals currently funded by the Department of Health.

The overall objective in establishing the ERHA is to remedy the deficiencies in current service co-ordination throughout the region by extending authority closer to the point of patient/client contact, whilst improving accountability over the approximate billion pound spend.

The ERHA Task Force has asked First Consulting Group (FCG) to assist them in preparing for the changeover by defining the financial skills and management structures they will need to effect the commissioning of care. They have asked too, for comment on the consequences and implications of the various options. The Task Force has set as its challenge a vision to design and implement:

- A fundamental and dramatic improvement in responsiveness and equity in serving patients' needs, regardless of geography, through well designed and implemented processes;
- A more simplified set of processes, shifting the emphasis to a more patient-oriented focus characterised by measurably better outcomes from a more efficient and effective utilisation of ERHA and component providers' human resources; and
- Introduction of clarity in financial controls and accountability and preparing for the next step of implementing an effective management of the change process at ERHA, including increased participation by and with key external stakeholders.

We have organised this report into sections that: briefly reviews the background and our methodology; states our key findings and the underlying assumptions and context as we understand them; recommends organising financial functions, business processes and personnel based on a "generic" corporate holding company model as applied to social welfare agencies (including a discussion of business processes, reporting structures, levels and skills of financial personnel) and; outlines a systems architecture for the key business processes, financial information technology and that will need to be in place to enable the commissioning and monitoring process. This includes a discussion of reporting cycle times and data collection. The relationship of that architecture to the required total information system's architecture is discussed in greater depth in a parallel report

concerning the systems and technology. The last section, "Getting There" discusses our conclusion that there is only one viable option to meet the standards and objectives within the constraints and time deadlines. It also describes our recommended near term and longer term next steps. A key recommendation is that a detailed collaborative plan and design process must begin forthwith.

This report will benefit from continued discussions within the Task Force and the Financial Working Group. We suggest that a project manager and team be appointed as soon as possible to:

- Assess specific needs or arrangements to ensure a sufficient system will exist; this includes collaboration with the EHB for developing the Financial Management System, definition of "bureau" concept and identification of financial and accounting services for inclusion;
- Specify action steps and responsibilities to ensure the system is in place and integrated with other systems;
- Clarify nature and extent of "invoicing" and "commissioning" mechanisms;
- Determine availability of financial personnel;
- Design systems and specify interfaces and migration strategies; and,
- Monitor legislative progress to ensure compatibility.

One cannot over-emphasise the scale and magnitude of this challenge. Nor the opportunity to improve social welfare gain through introduction of proper expeditious business processes.

2. BACKGROUND AND METHODOLOGY

2.1 Background

The first workshop on strategic context reaffirmed the Task Force Report's basic structure and strategy for the new ERHA. Concepts and ideas and recommendations were discussed at additional workshops with the Financial Systems Working Groups. The key new structural element driving the ERHA is the devolution of accountability and responsibility to three AHCs. Each Area will have a council of members who also serve on the ERHA (ERHA or Authority). The Authority is accountable to the Minister of Health for ensuring health and social gain is achieved in the region. Legislation is being prepared that will ensure the statutory legitimacy of the ERHA and the three component AHCs. Overall policy, control, responsibility and accountability situated at the ERHA. Accountability, day to day management and specific responsibility is being devolved to the three area chief health executives and their districts. The legislative process is on track to meet the Task Force recommended time frames. This is critical for accountability, commissioning and employment policies. As of 1 January 1999, the new ERHA will be in place to manage and co-ordinate a spend that exceeds IR£1.2 billion for the IR£1.3 million Dublin and wider environs populace.

2.2 Methodology

FCG conducted an assessment of the environment in which the new ERHA can be expected to operate in the future. We interviewed the members of the Task Force and its directorate, Department of Health principals and leadership of the EHB. We undertook a literature review of published and internal reports, plans and memoranda. Our primary focus was on published documents:

- The Interim Report of the Task Force on the ERHA;
- Department of Health document, "Shaping a Healthier Future";
- The Health (Amendment No. 3) Act 1996;
- Funding Mental Health;
- Various national health initiative programme reports; and
- Internal planning and organisational report EHB's finance function.

We also researched models of financial reporting structures for holding company type corporate organisations, examples of structures of health authority purchasers in other health systems and reviewed the timing and implementation experience of related types of structures for other FCG engagements.

The scope of the study did not include skills assessments of any financial staff, nor review of whom might be seconded to the new ERHA. We have also not evaluated the local employment market. Similarly, the scope of the study did not ask for a comprehensive and detailed evaluation of the finance functions at the EHB, District level nor at the voluntary hospitals/agencies. The scope of the study also did not ask for review of the implications of the forthcoming accountability legislation and the role of the Comptroller and Auditor General. However, it is thought that the outline of recommendations asked for at this juncture will be compatible with whatever legislation unfolds. We suggest that ERHA Task Force monitor progress on these issues and undertake these tasks as early next steps.

3. KEY FINDINGS AND UNDERLYING ASSUMPTIONS

3.1 Key Findings

Our key finding is that it is an ambitious undertaking to have financially skilled people, strong reporting structures and appropriate systems and procedures in place by 1 January 1999. There is one available strategy open to meeting this deadline, and that is extending EHB's financial systems to meet the needs of ERHA. That strategy requires an intense collaborative effort to ensure specifications for upgrading begins now to meet the future ERHA's needs. Our findings are discussed under three categories:

Business Processes

In terms of business processes, there is a need to develop an entirely new financial reporting system for the ERHA corporate centre, one that integrates market information, activity analyses and service plan prospects and progress towards social welfare gain. The current EHB financial reporting system can be and will need to be replicated (not necessarily of equal size) at each Area and amended to allow integration of corporate ERHA needs and to facilitate specific accommodations for data to be input from the 35 voluntaries hospitals/agencies. (300 other voluntary organisations might require changes depending on the split across the 3 AHCs.) We suggest that the adoption of a corporate holding company model will allow business processes to be independently developed and integrated.

Financial services (business processes) can be separated between "corporate" (presents statutory accounts for the entire region and requisite summaries of management reports to Department of Health) and "divisional" reports, (those that detail and frequency allow proper financial management of Area and District/Unit activities. In addition, to accommodate the voluntary hospitals/agencies autonomy, yet meet ERHA and their statutory and public scrutiny of public funds, we suggest the development of a "health and social care" invoicing and payment system for the service providers, i.e. the voluntaries and the AHCs, to the corporate holding company as a supplement to service plan submission. The invoicing system will require a tight time frame cycle, to minimise costs of working capital.

Structures and Staffing

In terms of structures and staffing, we find that the finance function as structured in a corporate holding company model is applicable to ERHA. This requires early definition, split of responsibilities, and will need to be in accordance with the final enabling legislation. A financial officer, staff and office is needed at both ERHA corporate, and at each Area. Corporate would require a strong "chief financial officer," financial and programme planning analysts, plus accounting staff with the expertise to prepare budget reports, statutory accounts and interface with Area financial staff. The corporate financial office will require staff to develop, circulate and assess financial policies and procedures, supervise internal audit and commissioning/contracting functions.

Each Area office will require its own financial officer who will oversee policies and its own financial operations. The office will have skilled finance staff, plus internal audit and service plan invoicing/ monitoring functions. Areas and reporting Districts would require some skilled staff in service plan invoicing/ monitoring, account maintenance and in data entry and in financial and contractual reconciliation. Accountants will also be required to develop a costing policy.

We suggest that a "bureau" concept for certain transaction-oriented business processes should be developed. Similarly, certain administrative functions can be centralised at one Area for all Areas. These should be organised on a contract basis, each bureau contracts specifically with area, district, division or unit locations to provide certain specific services. Payroll, purchasing, estate management, creditor, payments, information technology, human resources are all administrative functions that gain from economies of scale and where proficiency and technical excellence might be better achieved through the bureau concept. "Bureaus" can be allocated amongst the three area councils or grouped together and attached to one Area.

The organisation will also need market research analysts, clerical staff, and information technology specialists to interface or provide central policy lead to other stakeholders. However, we have not established whether such staff are "finance" or will be housed elsewhere in the information network corporate structure.

Information Systems

In terms of information systems we have outlined a generic architecture for the financial systems that are needed to ensure that the identified financial information flows of ERHA can be achieved. We provide description of how the addition of an invoicing and vouchering system might work to keep financial (budget and cash) control over the range of some 338+ service plans and the accounting for expenditures. An urgency is that a deliberate management focus on "how" financial information systems would be planned, designed and implemented for meeting the 15 month dead-line needs to start immediately. We examined three options for discussion, (i) build new systems, (ii) extend EHB systems, (iii) outsource at a large voluntary agency or other vendor. It rapidly became apparent that only one option, (ii) **extending EHB systems**, that will allow the ERHA to meet the deadline. This finding is discussed in the last section of this report but colours recommendations throughout the report.

We recommend that this second solution, is adopted, and that the agreement of EHB and the Department of Health is sought for the Task Force to proceed with a Financial Management System (FMS) implementation project for the ERHA, in close concert (with same vendor) with EHB's own implementation project, now underway. A first and immediate step is that ERHA's requirements for a FMS should be documented and incorporated into the contract with EHB's FMS vendor.

Significant work and preparation is in progress, but more hands-on development and project management is needed to develop the minimum business process structure and staff to support the disaggregation of the current EHB management functions amongst three AHCs and eight Districts and monitor the spend of all providers - voluntary and statutory hospitals and agencies.

The findings are based upon our understanding of the assumptions listed below. The most significant assumptions concern the ambitious time plan for completing enabling legislation and transfers of duties between and amongst the Authority, new Councils, EHB, and the Department of Health, and information systems creation/renewal. Although it is outside the scope of the study, we have implicitly assumed that recruiting and organising the necessary skilled personnel and resources for the new Authority and Councils can be accomplished within the time frame. Task Force management is aware of the implications of these concerns.

3.2 Assumptions

Based on interviews, discussions and a preliminary working paper on thoughts, FCG has narrowed the focus of options to follow an over-riding need for a minimal necessary financial management system to be operable by the "go live" date, 1 January 1999. The following assumptions within the broad vision and context described above are understood by FCG to be particularly relevant to financial reporting and are incorporated in the recommendations of this interim report:

- ERHA's purpose is to ensure that health and social care gain is achieved for the resident population of Dublin, Wicklow & Kildare Counties within the specified goals and targets of the minister of health:
 - Meet goals of access, equity and quality of care through identifying and monitoring community needs and by commissioning care provision of a high quality and accessibility within Department of Health guidelines, strategies and budget appropriations;
 - Be accountable for annual spend including commissioning, budgeting, contracting and service planning; and
 - Manage and supervise all statutory and voluntary care delivery organisations, on an equal ("level playing field") basis.
- The EHB will cease to exist as of 31 December 1998. Legislation is to be in place to assign previous statutory responsibility, transfer previous protections, retain relationships of interested parties and enable responsibilities to be continued at the direction of the new Authority. All of the assets, staff and care functions of the EHB will move to the Authority and its Area Councils on 1 January 1999.
- ERHA will establish standards and policies to ensure its mission, statutory reporting and accountability are met. All of this is to be in place by 1 January 1999. ERHA seeks to extend accountability closer to the patient by introducing a "holding company" corporate structure. All direct management of facilities and care will be located at three AHCs or subordinated to their District operations.
- ERHA and/or the AHCs will not take on the payroll or purchasing functions of any voluntary agency unless it is specifically contracted for by that agency.
- DoH will devolve its funding/ resource allocation functions (commissioning/contracting) with the voluntary acute and mental health care providers to the ERHA.
- DoH will retain influence if not control over national health initiatives, e.g. planning for national specialties.
- DoH will retain influence if not control over capital planning and allocation. There appears to be no plans to charge revenue allocations with capital charges as in the UK's NHS.
- DoH will allocate resources to the ERHA (and other Councils) to undertake new or transferred responsibilities.
- DoH will transfer (in advance) funds to the ERHA, including working capital & probably a proportionate sum of budget for each specified period for timely disbursement to all service providers. DoH will need to provide ERHA with a reconciliation of what is already expended and outstanding to whom as of the 31 December 1998.

No //

- Service Plans, will exist between all relevant care provider agencies/agents and the ERHA. Service plans will be the primary commissioning method. These will be required prospectively, will be activity related, contain budgetary detail and timing similar to current and will tie to area needs analysis. They will be the basis for monthly payments and will have sufficient data and detail to meet customary and usual financial audit standards.
- ERHA will establish health/ social needs, prepare a strategy and an annual business plan and “commission providers” to propose to fill those needs (probably for a 3 year rolling period defined through Service Agreements). Providers will agree Service Plans with ERHA. The ERHA will review and consolidate the service plans from the voluntary hospitals/agencies, the AHCs and reconcile them against the business plan. A composite regional annual service plan for all of the Eastern Region and budget for submission to the DoH.
- ERHA will develop a capability to centrally handle several financial processes currently undertaken by the DoH. These include a new monthly reconciliation process (over spend or under spend versus budget), business controls for three years of guaranteed funding levels and an “education and training” scheme to assist preparation of all new forms, invoice and other financial systems.
- ERHA, AHCs and its executives will operate under a different statutory regime than do the present DoH personnel. Report time cycles will allow fiduciary responsibilities to be met.
- The proposed Health (Amendment) Bill is expected to stipulate that ERHA and AHCs shall not incur expenditure for any financial year in excess of the amount of expenditure specified in its plans and that indebtedness is controlled within an appropriate and agreed amount. There is a 3 year guarantee that provider funding levels will remain at no less than current levels.
- The proposed Health (Amendment) Bill is expected to put more direct responsibility on the CEO as well as the Council. The 1970 Act limits CEO legal roles (to personnel, charges and eligibility matters) and puts other compliance at the Board level who in turn delegates this to the CEO.
- The Comptroller and Auditor General audits Health Board accounts. It is presumed that legislation for forming the ERHA will extend this to the Authority and the AHCs’ accounts.
- Voluntary agencies and charities are subject to regular audit under the particular statutes relevant to their corporate form.

In essence, although autonomy will be preserved where necessary, the monitoring of public expenditure, the main financial function and business process, will be the direct statutory responsibility of the ERHA and its AHCs.

4. ORGANISING THE FINANCE FUNCTION

The corporate functions of a commissioning agency include:

- Statutory;
- Commissioning; and
- Resource Management.

The commissioning functions sub-divide into:

- Needs Assessment;
- Strategy Planning; and
- Commissioning and Monitoring.

The role and functions of the organisation align along the key goals and processes. The new ERHA will seek to find the optimal organisation mix, in terms of effectiveness, responsiveness and leadership. Figure 1 is a table arraying functions under the three key categories of managerial processes: Set & Meet Policy (mission, vision & strategy), Manage Resources (execution and administration of business purpose through processes and resources and Ensure Comparative Performance (measurement and reporting of results and actions). Each of the major business processes are inter-related. The scope of this assignment, although limited to defining the structure and process for only one of the boxes, requires comment on the implications for the new organisation as a whole.

FIGURE 1: ARRAY OF MANAGERIAL PROCESSES AND MANAGERIAL FUNCTIONS

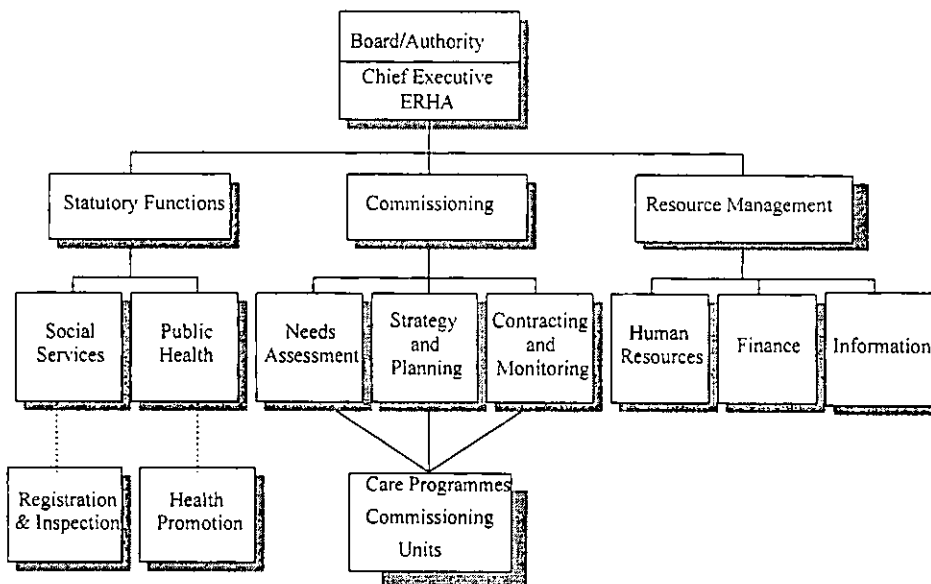
<i>Set & Meet Policy</i>	<i>Manage Resources</i>	<i>Ensure Comparative Performance</i>
Access	People	Outcomes: Health/Social Gains
Accountability	Facilities	Consumer Relations (including businesses)
Equity	Technology	Provider & Clinician Relations (Including suppliers)
Future Strategy	<i>Funds & Finances</i>	External Relations

A generic functional organisational structure for a corporate office of a commissioning authority for health and social care services for the Eastern region is depicted in Figure 2. As discussed above there are a number of combinations functions or "boxes" and an equal number of definitions. Assignments as to where and in which box or boxes does one locate the responsible executive is an art form and not a science. We expect a number of organisation formats will "work" for the ERHA within the framework of the generic model.

The scale of the new organisation suggests a need to move deliberately. Approximately 300 separate organisations/ units, a variety of sizes and managerial sophistication will not necessarily fit easily into the best drawn organisation chart nor the cleverest of reporting schema; even when staffed with the best managers and personnel. In the ERHA, the care giving structure will range from fully-owned to fully private organisations, harnessed together through service plans and contracts to deliver the access and care required for measurable social welfare gain. Although autonomy will be preserved where desired, the monitoring of public expenditure, the main finance function, will not be delegated away from the ERHA.

The financial functions and processes for the commissioning authority arrayed in Figure 1 or as drawn in Figure 2 will be broadly mirrored in the AHCs, plus a range of service delivery functions. This will enhance assignment of accountability, facilitate information reporting and structure management of broad care objectives. The finance functions, as highlighted in the exhibits, only represent one key resource management functions and one part of the commissioning function.

FIGURE 2: GENERIC FUNCTIONS CHART - COMMISSIONING AGENCY - I.E. ERHA HQ



4.1 Corporate Holding Company Model for Social Welfare Commissioning

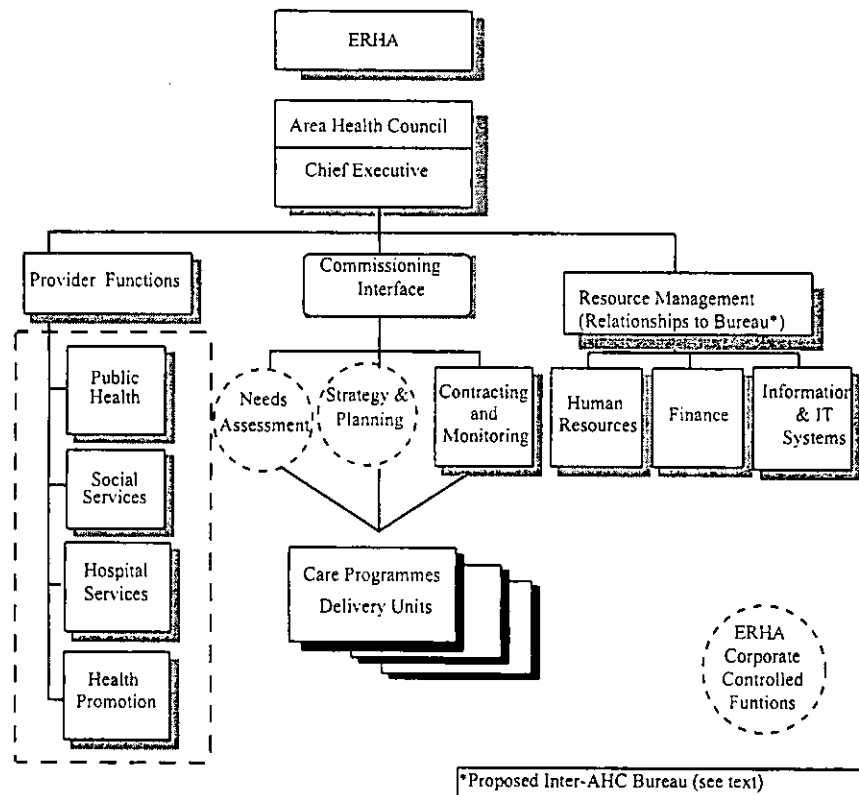
The use of a corporate holding model allows flexibility to suit a number of relationships. Finance functions in corporate holding models can be strongly centralised or decentralised. The advantage of a decentralised approach is that transaction-intense operations are closer to the point of service. This is exactly what is suggested by the DoH's "Statement of Strategy" and "Shaping a Healthier Future". Centralised financial functions are often suggested when there appears to be either a scarcity of qualified personnel, opportunities for considerable economies of scale for systems operations, or, a desire or need to enforce centralised cash control and/or desire or need to alter funding mid-cycle.

In the corporate holding model, there is a tendency to put most transactional accounting functions at the division or subsidiary company level and tie them together with strong mandatory reporting, demand for common policy and procedures, retention of key treasury functions, especially cash management at the central corporation. This allows operating autonomy and/or independent governance whilst maintaining financial control.

Applying this model to social welfare, the commissioning agency sets standards of quality and expected results. There is an increased responsibility on the commissioning agency to insist on collaborative relationships where they are proven necessary and to educate the providers on how to remedy inadequacies of care delivery. These extra requirements put an added burden on financial reporting systems and structures to be fast, reliable, accessible and where possible be prospective or contain dynamic financial modelling "implications" reporting modules.

Figure 3 annotates the differences in functions between generic Corporate role and division or subsidiary Area or district roles. Mirrored functions, those with functional responsibilities at corporate and at divisional levels, will require collaborative and "dotted line reporting." The voluntary agencies can retain autonomy in all their corporate functions and will only contract and provide services within clearly defined "purchased" parameters and time frames. The Service Plan is the contracting agreement, which will have a strong financial component and which will specify the means and ends of the reporting relationship, including budgets, usage of cash appropriations, timing, electronic vehicles etc.

FIGURE 3: GENERIC FUNCTIONS CHART - AHC

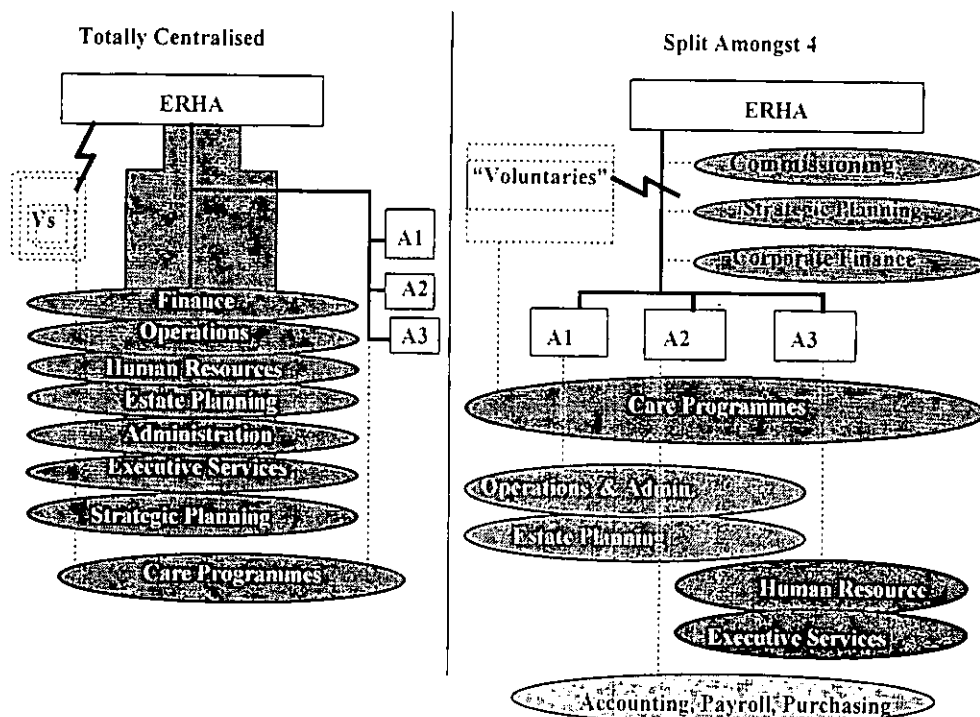


4.2 Internal Contracting Amongst Area Councils

The bureau concept is another feature of the holding company model that can be applicable to ERHA. A bureau typically groups critical, yet non-location sensitive, processes to attain economies of scale or respond to scarcity of key human or technological resources. The bureau can report to any one of the key organisational units, or can even be out-sourced via a joint venture to an independent but wholly owned (or split ownership) third party. The addition of new responsibilities, and the division of the current EHB responsibilities and programmes amongst three AHCs, suggests that a number of functions, finance being just one, are candidates for sub processes to be split amongst the four main corporate and central divisional bodies. As we will discuss later in the report, there are scarcities of systems infrastructure and perhaps of qualified financial personnel. Figure 4 illustrates two models of business processes and reporting functions-totally centralised and decentralised within a holding company model, for the new ERHA.

It is suggested that applying corporate holding company model and selectively using the bureau concept will provide the most effective and flexible framework for managing the billion pound operation.

FIGURE 4: SPLITTING ERHA REPORTING FUNCTIONS/CENTRES (ILLUSTRATIVE)



The next step of work is to determine the optimal structure and location of each policy, control and/or transaction function.

How one determines the optimal location for each business process and finance function is dependent on the balance between a simple line structure for getting consolidated and individual management and unit reports, and with management's "need to know/to act".

4.3 Levels and Structures for Information Management

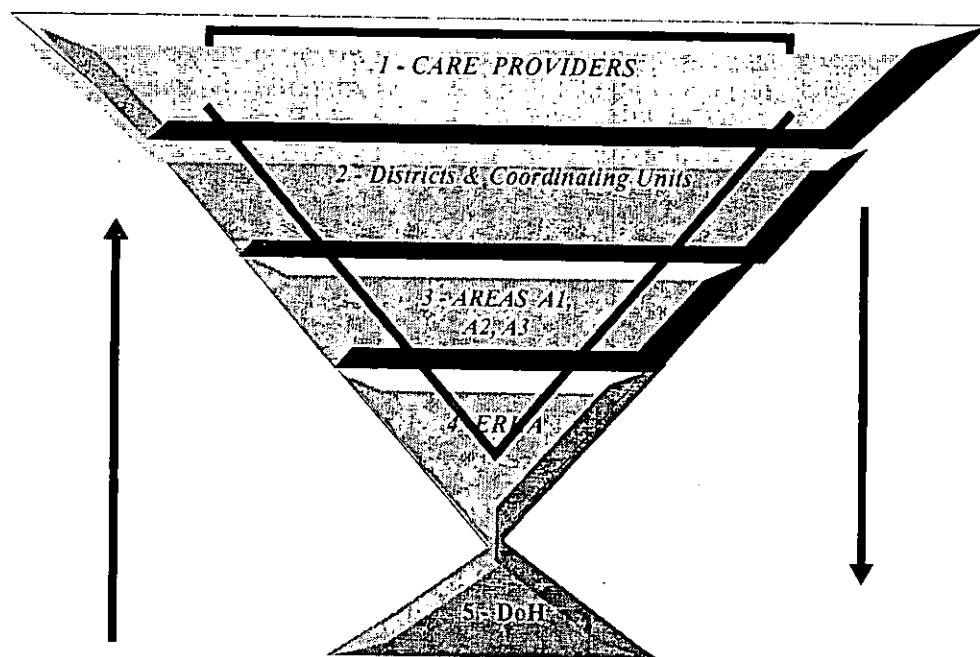
The reporting cycles will "layer" information through the continuum of five to six levels and structures. Information management can easily become very resource intensive. It is imperative that one streamline the reporting process and the reports, yet provide representation of meaningful measures and effective levers.

Each management level requires specific information to manage its responsibilities and reflect accountability for its activities. Each structural level needs sufficient data to report to the next level on the effectiveness and implications of its actions. As shown in Figure 5, a schematic for ERHA: the first level is the care provider, the second level is the Area coordinator or district manager, the third level is the Area Executive, the fourth level the Chief Executive Office of the ERHA and the fifth level is the Department of Health. Simply put,

the management reporting system is to and from managers with the acknowledgement, acquiescence or approval of each level's boards:

- Level 1 Provider Boards of Directors,
- Levels 2 & 3 AHCs,
- Level 4 The ERHA Board,
- Level 5 The Department of Health representing the Government.

FIGURE 5: LEVELS OF REPORTING



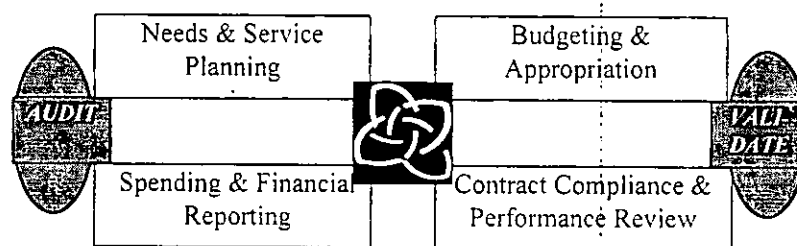
Reconciliation and consistency is necessary at each level. The flows of information through the hierarchy is: policy and targets go (disaggregate) from Level 5 (DoH) to Level 1 (providers); projections, supply, performance data go the other way (aggregate) from Level 1 to Level 5. Management and personnel must be in place at each level to gather, organise, analyse, report and manage the information. The number of people involved depends on the complexity and frequency of reporting desired. A major impetus for "flattening" the hierarchy is to eliminate duplication and redundancy in management reporting. The voluntary hospitals/ agencies will follow a similar level of aggregation at various levels. Their data entry into the system will most likely be at a central point in ERHA.

5. FINANCIAL REPORTING BUSINESS PROCESSES

Strong financial reporting requires inter-connection with at least four distinct information cycles. Figure 6 is a representation of the typical manager's dynamic involvement in key information cycles. As discussed previously, information is aggregated differently at each level of the holding company. The cycle of information processing: planning, collection, entry, processing, comparing, reviewing, reporting has to consider distinct and separate data sets for each level. Structurally, this suggests overlap in functional offices, mirrored structures (a similar group in corporate as in the operating division or sub-contractor) exist to ensure consistency and to allow aggregation and comparability. Concurrent with the information cycles are two external and parallel process cycles: audit and validation. As each of these information cycles require different calendar times to ensure accuracy and totality, reconciliation is complicated. Financial reporting must reconcile and be reconciled with all other information reporting systems, if it is to pass normal procedural audit.

Although the social welfare organisation must be financially prudent, it is often equally judged on perceived valuation of activity, not just productivity. That is, did the money expended purchase a reasonable amount of valued activity. Business processes are required to report not only on expenditure but on (in some cases very subjective) value for money.

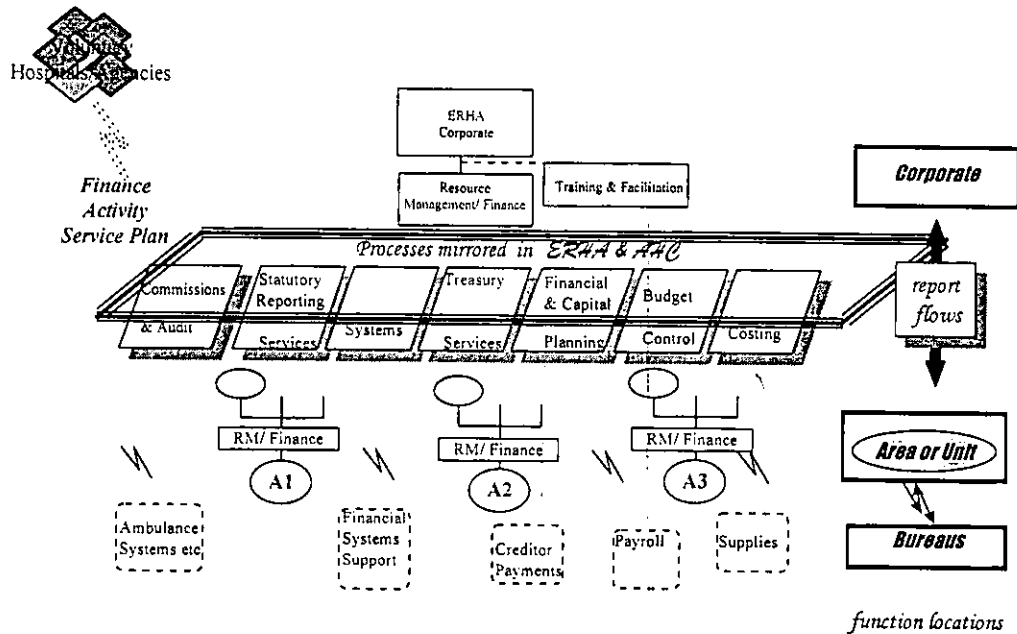
FIGURE 6: INFORMATION CYCLES



5.1 Business Processes

Figure 7 is a generic illustration of the corporate holding model for finance suggested for the ERHA. The chief financial officer for the Authority is located at headquarters of the ERHA. It is a fundamental axiom of financial items that procedures and policies need to be clearly stated and can be audited. That means that there are "audit trails" and periodic and annual reconciliation(s) (bank statements versus budgets & general ledger etc.) for all transactions, especially those involving cash. This is the key fiduciary responsibility of the Chief Financial Officer. A chartered accountant with prior public financial management experience is a minimum qualification for this post. Financial and programme planning analysts, accounting clerks and clerical staff are required to prepare management reports, statutory accounts and interface with Area financial staff. The corporate financial office will require other expert staff to develop, circulate and assess financial policies and procedures, supervise internal audit and commissioning/contracting functions.

FIGURE 7: POSSIBLE ERHA FINANCE (BUSINESS PROCESS) FUNCTIONS & LOCATIONS "MIRRORED" CONCEPT - CORPORATE HOLDING COMPANY



Finance and accounting functions (business processes) that are required at ERHA corporate can and should be constrained to include those:

- for preparation of accounts and reports as required by statute and standards,
- for processes and reports necessary for ensuring financial probity and prudence in accounting for the public expenditure. This includes:
 - an internal audit facility to establish commissioning/contracting compliance across all Areas and to assure the public that the money is in safe hands and as been appropriated wisely for the public benefit;
 - banking relationships and cash reconciliation; and
 - a cash management/financial planning mechanism to independently assess and prevent negative situations;
- support the regional health and social care planning/commissioning process and monitoring the financial aspects of Service Plans and contracts; and
- that provide an appraisal mechanism to assess and promote capital projects from the point of view of social (ERHA-specific) return on investment.

As noted above, corporate finance functions, those related to regional commissioning, strategic planning and all other financial functions that produce consolidated reports going to the DoH, are to remain at corporate. There is also need for a payroll interface unit and an accounting office for detail purchase and spend vouchers related solely to the operations of the corporate body.

The major work effort of all of the businesses processes will be replicated at the AHCs. As per holding company models, it is suggested that each AHC have its own finance function but "contract" with a central finance bureau(s), possibly located at/ reporting to any one of the Areas, to manage all transactional functions and others where there are economies of

scale, etc. We have attached as Working Reference IV a sample internal letter of contract developed elsewhere. Each Area and the corporate ERHA authority should have its own audit and reporting unit led by a management accountant to ensure local control and accountability of input data and management of training for sub units.

The AHCs and the districts, and the voluntary hospitals/agencies¹ will be responsible for managing their own operations, cash expenditure and financial planning to ensure funds are used as budgeted and/or planned. They will require personnel that can collect, amass, analyse and synthesise financial transactions data so that commissioned and owned (self-commissioned) health and social care units can operate. This entails not only reporting status and process of invoice presentations but reconciliation(s) of budgets with employee payrolls, suppliers paid, purchased supplies ordered, vouchers prepared and processed, materials received and audited, and cash flow managed at all levels. Similarly, there will be a need to interface with other funds flows and inter agency/region transfers.

A "pricing" function will evolve which will require cost accounting, activity based costing, activity based budgeting, and ultimately, activity based management for delivery of provider services. These impose two additional requirements on financial systems and processes: systems be flexible and have capacity to grow in scale and scope; and, that there be an ongoing training and development function to facilitate introduction, adoption and compliance.

5.2 Reporting and Timing

ERHA will establish health/ social needs, prepare a strategy and an annual business plan and "commission providers" to propose to fill those needs (probably for a 3 year rolling period defined through Service Agreements). Providers will agree Service Plans with ERHA. The ERHA will review and consolidate the service plans from the voluntary hospitals/agencies, the AHCs and reconcile them against the business plan. A composite regional annual service plan for all Eastern Region and budget for submission to the DoH.

There is a wide range of reporting time frames within the regional providers. For example, activity and cash reporting of providers within the present EHB structure currently takes three to five automated accruals only - manual accruals 18 days, from close of books to report through to the finance office. Payroll reporting apparently operates at different pace at different agencies.

The Voluntary hospitals/agencies reporting function currently goes directly to the Department of Health. Working capital is extended for one month prospectively and cash and spend reconciliation occurs monthly. That cycle starting in the last week of the month. However, activity data, although reported monthly, is a separate reporting process and is not tied to the cash management process. Currently, this data can come 30 to 60 days after prospective cash money has been "signed off" on. This time delay is not acceptable under the new statutory legislation enabling ERHA, as it will be inconsistent with Health Board & CEO's statutory responsibilities. The non-synchronised timing can also lead to delay in knowing an overspend has occurred. This costs the system additional interest expense and possibly future mis-direction of resources.

¹ Voluntaries are obliged to have some form of a finance function as well. (This is outside the scope of this report.)

An important area for immediate discussion is the determination of exact specification and time line of statutory report requirements on the ERHA and financial and activity reports on all providers. Specification is to the level of detail sufficient to meet demands and requirements Comptroller and Auditor General, the Department of Health and customary and usual financial reporting. Figure 8 is a table listing the minimal level and approximate periodicity of financial reporting needed.

FIGURE 8: FINANCIAL PROCESSES: KEY MANAGERIAL REPORTS

Finance (Business) Process	LOCATION		
	ERHA Corporate	Area	District
Periodicity: A/Q/M/W/D/O**			
Consolidated/Aggregated IMR or Monthly	A, Q & M	M	M,W
Voluntaries IMR Aggregation	A, Q & M	M	M,W
Total Budget for all Care for the Region -Annual	A, O	A, O	A, O
Total 3 Year Budget for all Care for the Region	A	A	A
Budget Variance for all Care for Area & tie to:	M	M	M+?
Commissioning Reports: Service Plans - All Care Units Service Plan Reconciliation	A, Q? A,Q & M	A, M A, M	A, Q? A, M
Working Capital Reconciliation	M,O	M,O	O
Income Negotiation -e.g. VHI	A	A	A
Total Payments to all Providers	M	M	M
Creditor Payments	M	M	M
Payments by Major Category:	<i>Introduce Invoice/Voucher System:</i>		
Personnel (payroll and pension)	O	O	O
Material & Supplies	O	O	O
Capital Goods	O	O	O
Bank Reconciliation	W	W	W
FUTURE			
Costing	Q	M	D
Activity Based Management (ABB, ABM)	Q	M	D
Costing in Hospitals/Districts (ABC)	Q	M	D
"Bureau" Reporting	Q,O	M,O	D,O
Outcomes Of Health Gain	Q	M	D

**A/Q/M/W/D/O = Annual, Quarterly, Monthly, Weekly, Daily, Other

5.3 Sample Business Process: Payroll

Payroll is an example of a financial function that has separable parts.

- Part 1 is recording of employment data, ensuring qualifications are met for grades of pay.
- Part 2 is ensuring wages are earned, sick, holiday or training leaves are recorded, etc.
- Part 3 is to ensure that payments are made when and where specified and withholdings are taken and accounted for. This includes pensions or other arrangements.
- Part 4 ties payrolls to unit budgets and prepares internal management and productivity reports and
- Part 5 involves preparing and sending all requisite reporting to tax authorities and the individual at appropriate times.

Figure 9 is a listing of typical social welfare agency categories of employees. As this is further complicated by the nature and periodicity of reporting employment hours and details. This varies by location and area; pay rates vary by grade and other differences. Each Area will require a human resource function to ensure statutory employment rules and regulations are followed. A "bureau" model for payroll payment: parts 3, 4 & 5 above, should be considered so as to process payrolls expeditiously, accurately and at lowest cost.

FIGURE 9 : STAFFING & ADMINISTRATIVE & FINANCIAL REPORTING RESPONSIBILITIES

Category	Typical Pay Arrangement
Management	monthly
Nursing	weekly, bi-weekly, monthly, per diem
Consultants	annual paid monthly, by session
Other Medical	weekly, bi-weekly, monthly, per diem
Social Work	weekly, bi-weekly, monthly, per diem
Other mental Health	weekly, bi-weekly, monthly, per diem
Allied Professions	weekly, bi-weekly, monthly, per diem
Clerical	weekly, bi-weekly, monthly, per diem, hourly
Maintenance	weekly, bi-weekly, monthly, per diem, hourly
Contract personnel	various
Other	various

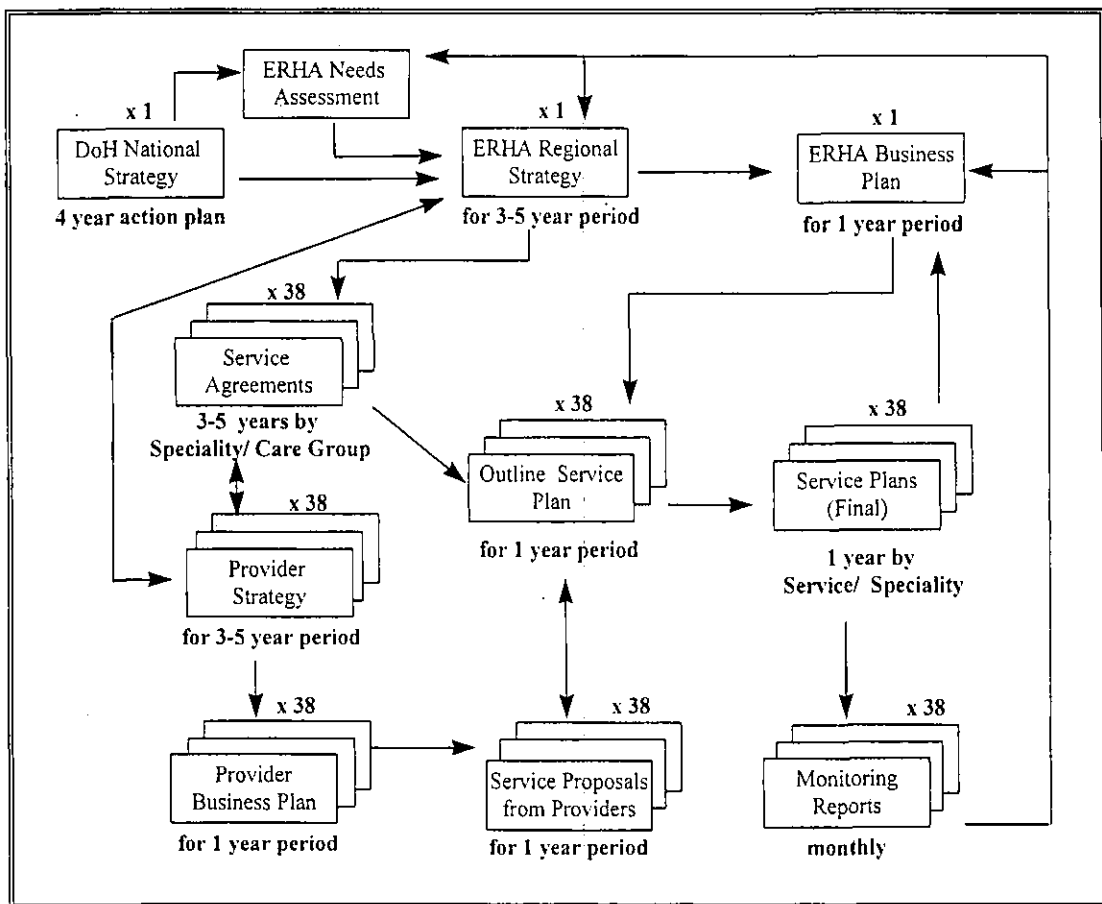
5.4 Sample Business Process: "Service Plan Actualisation" - Voucher & Invoicing

The new fiduciary requirements of the ERHA as defined in the Health Act underline the necessity for a strict audit, accounting and reconciliation function. The ERHA chief executive will be accountable for expenditure relating to both the formerly directly DoH funded voluntary hospitals, mental health agencies and the statutory services formerly provided under EHB. Accountability, under the corporate holding model, as discussed earlier, can be localised but typically is joint and severable under the law. (That is, accountability is at all levels combined and separate).

The Service Plan will be used to authorise a stream of monthly payments to all/each units. The monthly invoice is the beginning of a voucher and reconciliation system that looks at spend versus promise. The invoice (to be designed as a compendium of current monthly reports) will bill for the ensuing month's share of the twelve months and present activity data for the past month's actuals. Current reporting systems include an Integrated Management Report (IMR) (Working Reference V) for the voluntaries and a detailed monthly expenditure report for the large statutory agencies (Working Reference VI). It is proposed that these reports make up the monthly invoice from the provider units to the ERHA. For larger providers, the information may be required in thirteen four week periods and transmitted electronically.

An initial preparation period is needed to get the process in place. Figure 10, borrowed from the companion report on information systems previously mentioned, is a schematic for the overall service plan process. As one can see, there is a need to translate National strategy into a regional strategy and design a business plan. ERHA will have prepared a needs analyses for the region. It will then commission agencies to provide services. In the initial three years interim period, guarantees have been made to current providers to ensure stable transition. However, the need or desire for value for money has not been waived. Management and control of the financial elements are critical components of the service plan process. Not only during transition but constantly.

FIGURE 10: ERHA - STRATEGY / SERVICE PLAN CYCLE



In the proposed invoicing system, monthly data are compared against the agency's prospective annual service plan and budget (monthly proportion) for consistency and variance analysis. Where there is a variance, over or under spend, the invoice will require submission of an additional report to identify actions and time periods the unit will take to bring spend into line. The content and legitimacy, enforceability of this report requires debate. Although the description seems complex the reality is that this is a simple invoicing system that establishes a solid audit trail of where, why and for what public money was expended. In the case of the voluntary hospitals/agencies, the invoice is consolidated or aggregated and does not ask for the lower level of detail on whom they spent the money. Did they deliver the amount and quality of services paid for as promised in their Plan? This is the minimum requirement if the ERHA is to meet financial accounting standards. There will

need to be a quarterly reconciliation so that cash issues are flagged before they become a crisis or before overspends occur.

As mentioned previously, a pressing and most difficult issue surrounds timing of submission and penalties and risks. If agencies do not forward complete Service Plans or if the invoices are not completed or they arrive "late", can/will the payments stop? Under the proposed legislation to bring ERHA in accordance with the present Health Act, the answer is yes, it must. What will be the actual policy? This will need to be discussed with the DoH and other relevant parties. The process and recourse then must be explained to all agencies: Voluntaries, AHC's, Districts, etc. prior to the start-up date.

5.5 People: Estimated Staffing Levels for Finance Functions

Figures 11A & B set out an approximate head count of the number of personnel required for an ERHA corporate holding model at both central and area levels. This is based on a recent² financial accountant consulting report for the Irish Health System. The corporate holding model we suggest implies a central corporate ERHA finance staff of 20-25 persons (this depends on the skill mix and interfaces with AHS staff and "bureaus", and the requirements for procedures documentation and training). There are several new duties involved in terms of processing monthly invoices for 38+ organisations and managing the progress against service plan submission in terms of activities and cash.

FIGURE 11A: CORPORATE CENTRE -FINANCE FUNCTION - SUGGESTED SKILLS NEEDS

ACTIVITY	KEY FUNCTIONS	ESTIMATED NUMBER OF PERSONNEL	LOCATION
Chief Financial Officer (Finance Director)	Ensures Compliance Statutory & Standards; Oversight for Area Controller(s); Directs treasury function	1	Corporate
Costing & Performance Commissioning, Monitoring & Audit	Establish Standards & Co-ordinate Training Policy & Procedures; Internal Auditor, Budgets Consolidation	5 - 6	Corporate Eventually might be 10-12
Treasury & Funding	Banking Bank Reconciliation Cash flow Consolidate IMR's to DoH	4 - 5	Corporate
Capital, Technology, Manpower Planning	Financial Planning	1 - 2	Interacts with Strategic Planning
Financial Services	Service Plans Invoices; Internal Control, Corporate Payroll, Creditor Payments, Statutory Reporting G/L Reconciliation etc.	10 - 11	Corporate or Bureau
TOTAL		20-25	

² Deloitte, Touche, Tohmatsu International, 1997, "Resourcing the Finance Function in Health Boards"

It is important to note that several items of importance as the ERHA moves forward where beyond this study. For example, the identification or evaluation of any current Board or DoH finance staff to be transferred tot ERHA has not been undertaken nor an assessment of the availability of skill mix and qualifications in the Dublin area. Similarly, we have not reviewed pay scales, job requirements and career planning in the health service. Despite these caveats, we have undertaken to describe the skills and general numbers needed at the top two corporate holding company "levels". It is assumed that the Voluntary agencies will continue to operate their own finance departments.

FIGURE 11B: AHCs -FINANCE FUNCTION - SUGGESTED SKILLS & STAFF NEEDS

ACTIVITY	KEY FUNCTIONS	ESTIMATED NUMBER OF PERSONNEL	LOCATION
FINANCIAL SERVICES			
Financial Controllers	Overall Responsibility for Co-ordinating Area	3	Area CFO (Deputy CFO)
Financial Accounting	Statutory Reporting G/L Reconciliation & Control	6 - 8	Area
Financial Services	Payroll/ superannuation Accounts Receivable Accounts Payable Final Accounts Fixed Assets	15 - 17	Area or Bureau
Systems Development & Control	Job Running Housekeeping Security Timetables Financial Systems Development	8 - 10	Area or Bureau
Treasury Management	Cash flow	2 - 3	Area
Internal Audit, Commission and Procedures	VFM smaller Voluntaries Training Acctg Standards	1	Area CFO re-design; Eventually 6-8
MANAGEMENT ACCOUNTING			
Asst Financial Controller	Overall responsibility for Management Accounting Design/implement VFM Initiatives	3	to Area FO Direct to CEO Dotted to CFO
Service Plan Invoices; Costing, Performance Monitoring & Budgetary Control	Invoice Control & Case mix Pricing specialty costing, etc. Monthly Reporting Variance Analysis Budget Compilation Forecasting	8 - 9	Area/Districts Relates to Commissioning Includes new tasks
Capital Planning	Capital Planning, Budgeting and Appraisal	1 - 2	Area CEOs Commissioned
Total AHC's		47 - 57	

Each AHC finance unit will need to have persons who are computer literate, knowledgeable of spreadsheet programmes, numerate, understand accounting, finance and cash management and reconciliation. Clerical assistance, with similar capabilities, are also needed to meet the data input requisites of most cost accounting programs. As the organisation matures over the first year, there will be a need and desire to move into activity costing and value for money analyses. This will increase the skill level requirements and alter the duties of current staff.

There is a need for an analysis of where experienced staff may come from, and or if transferred from other duties in other units or departments, what new skills training will be required to interface with the new systems whilst new systems are being tendered for and even more essentially as that design and procurement phase proceeds. We believe this is a critical step for the Task Force to embark upon once the statutory legislation is assured. This discussion is continued in the following section concerning systems architecture.

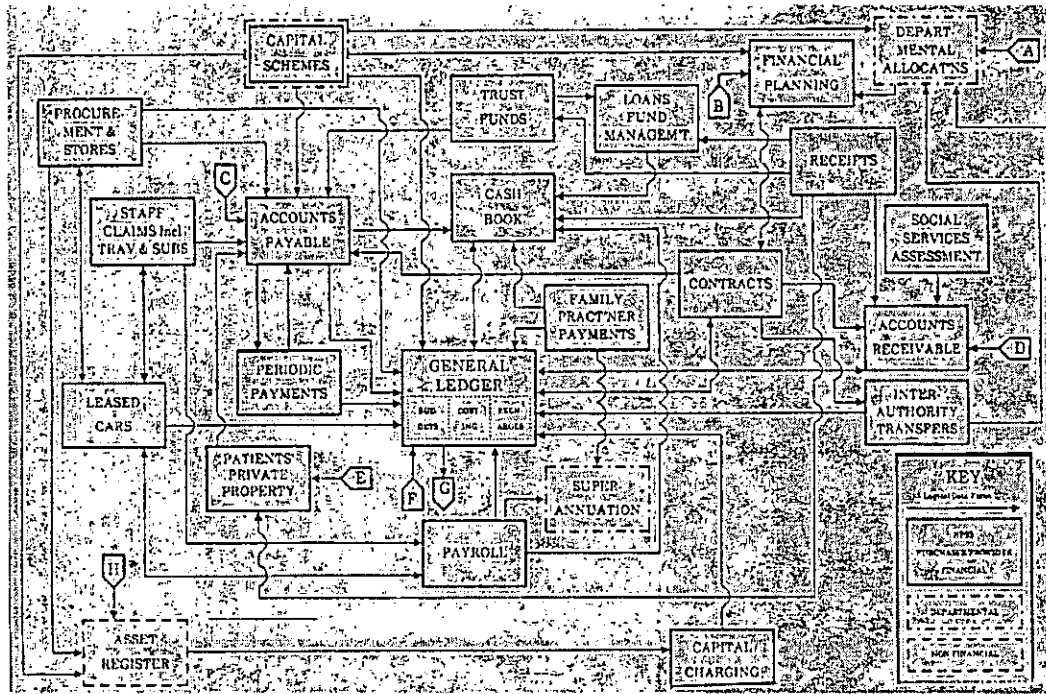
5.6 Systems Architecture

The people and financial processes suggested above will require computer system support and specific process interfaces. As we have recommended a holding company concept for corporate organisation, concomitantly, we recommend adoption of a multi-company based financial system. One with three "subsidiary" companies (the AHCs) and 35+ (the Voluntaries) independent contractor service companies, which automatically aggregate/consolidate to the "parent" holding company, ERHA. The systems architecture is presented in more detail in the companion FCG information systems plan. The key overriding requirements for ERHA finance systems are that:

- specifications are defined for general ledger, chart of accounts, asset register, cash management, reconciliation, reporting, item tracking, costing etc. that are specific to ERHA requirements;
- the systems work, are reliable, consistent and integrated;
- the systems can be partitioned and held away from other systems and can operate stand-alone from other ERHA systems if desired or necessary;
- policies and procedures are written and maintained to audit standard;
- financial systems/data cannot be corrupted by any other component system of the system nor by unauthorised users (there must be tight security around hiring of all permanent and temporary staff; and
- the security and back up of data is paramount.

Figure 12 is a proto-type example of the financial application architecture from a similar holding company model type commissioning agency and its providers.

FIGURE 12: LOGICAL FINANCIAL APPLICATION ARCHITECTURE HPSS



Source: DHSS (NI) 1990

This proto-type can be modified/ built or developed in parallel with the development of Service Plan processes. The diagram contains “tabs” Figure 12 illustrates the dynamic cycle of planning, each of the Tabs in the architecture schematic below either represents sub-system connection for each of the providers or for the ERHA total commissioning/planning function.

- Tabs A and B are start points for base line data and relationships to be inputted for from Population Needs Analyses/planning modelling and from Service Plan Reporting.
- Tab C is representative of inputs from our invoice/voucher system described earlier.
- Tabs D & E represent provider transactions concerning income, etc.
- Tab F is budget, activity, and non-financial data from operational systems.
- Tab G is output data to drive planning and other functions.
- Tab H is to input capital projects and asset register maintenance.

The collaborative planning phase we suggest will need to describe the new processes and linkages. It will also require a migration plan and a testing plan, so as to ensure that health and social care efforts can continue whilst supported by systems, not dominated by systems successes, “glitches” or failures.

6. GETTING THERE

Getting the maximum possible from what there is. Will there be enough systems and processes in place within 15 months?

6.1 Financial Systems

Three options have been considered to ensure that an adequate financial system is in place for ERHA on 1 January 1999: (1) New build or "off the shelf" package; (2) Design extensions and additions around the planned replacement EHB financial systems; or, similarly, (3) design extensions around a voluntary acute financial system or other health board system. The decision matrix presented in Figure 12 summarises key criteria. Although the evaluation might benefit from more detailed investigations, option 2 has distinct advantages of existence of an already working part of the future ERHA, working staff and systems, nearness to control and the willingness to collaborate, the eventual ownership relationship (ERHA will inherit EHB systems, and EHB purchases or requirement specifications today might be considered in the new broader context). The timeline for creating new systems -they can't be specified, designed, purchased and installed in less than two years- rules out the option one. The third option is moot because further extensive legislation and considerable staffing would be required to make the ERHA Task Force a contracting and/or operating body prior to the planned changeover. The ERHA will be a contracting body when legislation is passed.

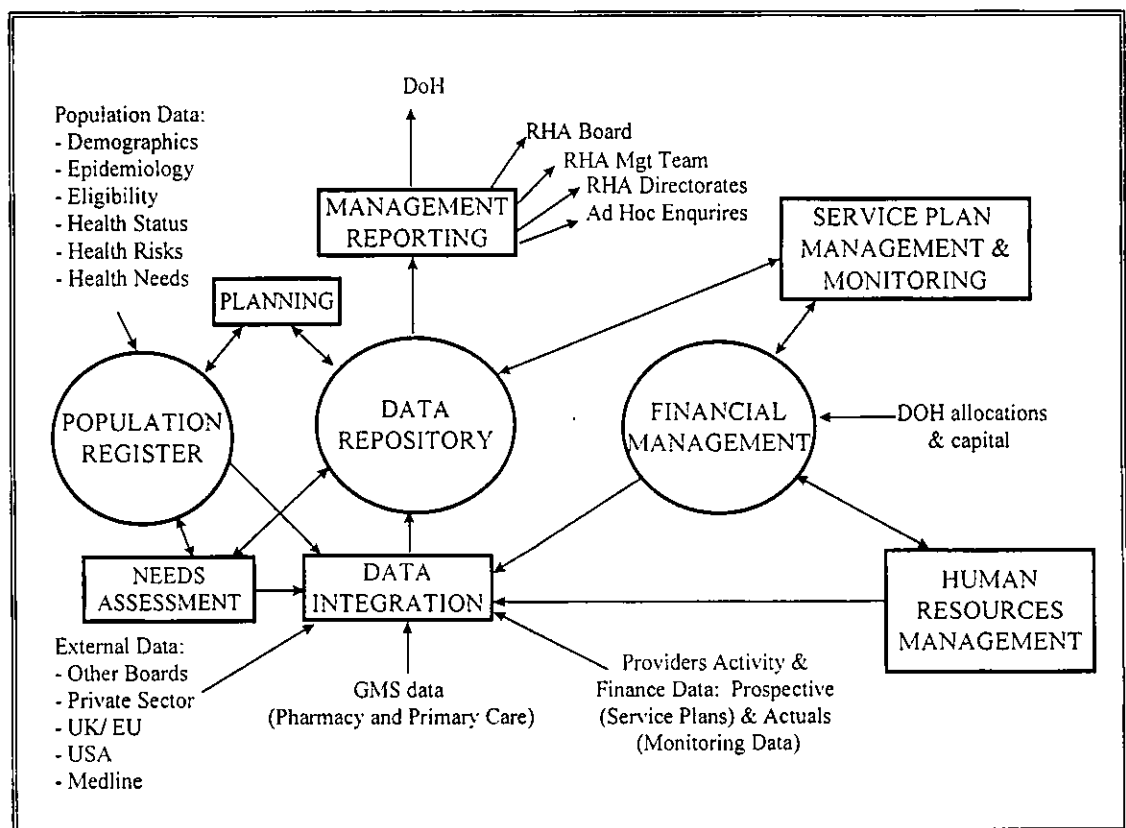
FIGURE 13: OPTIONS FOR FINANCIAL SYSTEMS

	Advantages	Disadvantages
Option 1 New: Specify Needs & Outsource Design for ERHA from scratch; Talk to other Health Councils, Vendors etc.	<ul style="list-style-type: none"> • Newest & latest ideas • Bespoke • Cheaper in long term than Repair 	<ul style="list-style-type: none"> • Expensive, • Time scale for implementation • Needs training • Manual linkages of activity to spend
Option 2 Extend A : ERHA to Specify that EHB Extend its systems development so they can process all ERHA & AHC transactions and new hierarchical reporting; organise interface engines, require open architecture etc. Relationship will be "cross-contracts" with Area Councils 2 & 3 and ERHA	<ul style="list-style-type: none"> • High control • Already working • Financial system rebuild is at start • Understand Maintenance & Training Needs 	<ul style="list-style-type: none"> • No ERHA input to specifications • High maintenance? • Lack of priority re ERHA requirements • Manual linkages of activity to spend
Option 3 Extend B: ERHA Contracts with the Leading Voluntary to Design extensions of their Programmes if feasible.	<ul style="list-style-type: none"> • Already Working • HL7/HIPE spend linkages for Acute in place(?) • Large Investments in advanced technology • Understand Maintenance & Training Needs 	<ul style="list-style-type: none"> • Low Control • Their 2nd Priority • Not sure of quality • Not Feasible? • Price

It is proposed that the current EHB financial control and systems capabilities are expanded to meet the needs of the AHCs, districts and provide capacity for the expanded corporate role for the ERHA. The ERHA Task Force Directorate will need to work closely with the EHB, as there is considerable shortfall in current EHB systems in meeting the requirements of the new Authority. For example, the reports identified previously in Figure 8 do not exist in the systems architecture; nor is there hardware or network capacity to integrate minimal financial data from the 38 Service Plans, nor the 300+ voluntaries. Equally imposing is that the system hardware, software and licenses may not be divisible or operated in triplicate to meet needs of the AERHA and the AHCs. This collaborative design stage must start now.

The new financial system architecture will need to be highly sophisticated and capable of handling significant amounts of transaction data from a variety of sources. Figure 14 is a representation of the architecture for the entire information systems. It shows the relationship of the Finance function and processes and indicates the need for new and sophisticated technology -interface engines and warehouses to mention two. This diagram is discussed fully in the companion report, Information Systems strategy for the ERHA, as commissioned by the Task Force.

FIGURE 14: CONCEPTUAL INFORMATION ARCHITECTURE DESIGN FOR THE ERHA



The highest priority system for the Task Force on the Eastern Regional Health Authority (ERHA) to consider is the adoption of a Financial Management System (FMS) for the new central authority. The FMS will be required to process data concerning care commissioned from a network of 38 principal service providers (35 Voluntary hospitals/mental health agencies, plus 3 Area Health Councils (AHCs), which will deliver the statutory services currently administered by the Eastern Health Board (EHB).

We suggest that extending the planned replacement EHB financial systems is the only way to go forward to meet ERHA's deadlines. The time frame issue is of special relevance because of the time it takes to specify, procure and let contracts for the design or purchase of systems. We specifically rule out procuring new independent systems that are either totally stand alone from EHB or tied to EHB (use EHB FMS for AHCs , procure a new system for the central RHA for use by AHCs) ERHA because of the time factor. This leaves two potential solutions for implementing a FMS for ERHA in time for the go-live date for the new authority of 1 January 1999:

- use EHB FMS (both the system and planned implementation project), reconfigured for all of ERHA;
- use EHB FMS for AHCs, plus a separate implementation of the *same software* for the central authority.

Use EHB FMS (and EHB's planned implementation project) for all of ERHA, seems on the surface, the most obvious way forward, as EHB is about to conclude a procurement for a new FMS to replace its current non-Y2000 compliant system. The availability of this software obviates the need for ERHA to go through a lengthy procurement process prior to commencing implementation. The principal disadvantage, however, of this approach is that the main focus of the Board is on replacing its obsolete system, rather than meeting the future needs of ERHA. It is understood that provision has been made in the Chart of Accounts for the new system for a cost centre at 'Area' level, which implies that some 'forward compatibility' with the needs of the AHCs has been incorporated into the EHB FMS design. The new central Authority, however, will also need cost centres to be set up for each of the 35 main voluntary hospitals/agencies. There appears therefore, that there is a risk that "piggy-backing" on the EHB FMS implementation will result in the needs of the RHA being seen as second priority to those of EHB.

An alternative approach involves using the new EHB FMS software, but establishing two separate (but closely coordinated) projects for its implementation, one focused on the short term needs of EHB, with the capability of transformation to meet the initial needs of the AHCs, with a second project set up under the direction of the Task Force to meet the needs and deadlines of the RHA. This approach has the following major advantages over the options discussed above:

- obviates need for procurement process;
- strategic priorities of the RHA are met;
- reduces risk of failure to meet RHA deadlines;
- cost implications can be quickly quantified and provided for;
- systems integration problems are mitigated through retaining compatible software and Chart of Accounts for AHCs and the RHA.

For this solution to proceed, it requires the agreement of both EHB and the Department of Health for ERHA to progress their own FMS project. Also, the requirements of the RHA have to be defined and incorporated into the EHB contract to minimise possible cost variations from the FMS vendor.

We recommend that this second solution, as discussed above, is adopted, and that the agreement of EHB and the Department of Health is sought for the Task Force to proceed with a FMS implementation project for the RHA, in close concert with EHB's own implementation project. In addition, ERHA's requirements for a FMS should be documented and incorporated into the contract with EHB's FMS vendor.

6.2 Next Steps

The next few months are critical. This is a large undertaking that involves hundreds of people. A working financial system must be in place on 1 January 1999. We suggest the formation of a finance working party to design and validate an invoicing system, ensure service plan definition and development is sufficient for ERHA needs, and review financial functions and business processes to the next level of detail based on the outline presented in this report. There is also need to define the detailed processes and procedures for Service Planning and reporting. There remain some critical issues concerning statutory risk of failure to maintain budgets and funding. Approval in concept is needed for applying the corporate holding company model specifically to the proposed ERHA. Similarly, ERHA must begin to take an active role in current EHB financial systems projects³ to represent the future owner's needs. A project plan for collaborative planning and design of the financial systems and processes for 1999, defining how processes will work on day one and an outline of milestones for design, testing and installation is a first requirement.

Over the longer term the ERHA will need to design radically new systems to integrate outcomes and activity based management monitoring in the financial process. It is important that this is recognised, expectations are set and managed up throughout the reporting hierarchy.

It is suggested that leadership of ERHA also concentrates on defining the vision operationally by designing new measures: outcomes, evidence based care, wholesale measures of gain etc. ERHA should adopt a collaborative model with providers, but insist that the service planning mechanism specifically documents the provider's contribution toward the health and social gain of the resident population of the region, how they wish this to be measured and what are the programmes they anticipate to ensure barriers to meeting these are recognised early and overcome. One example in corporate accountability is the "manager's discussion" in quarterly reports and periodic press releases.

The findings of this report require user-testing and where valid, work should be assigned to ensure the development and installation of minimum system and architecture needs, design of basic processes and hiring of qualified personnel can be project managed forthwith.

Separate Attachments are part of Interim Report Attachments, October 1997:

Working Reference I:	Commissioning Agency- Finance Department -Typical Duties
Working Reference II:	AHC: Typical Finance Department Functions
Working Reference III:	Sample Intra-Regional Business Process Bureau Contracting Letter
Working Reference IV:	Current IMR and Other Hospital Reports to DOH
Working Reference V:	DoH Minister's Letter: Determination Of Health Expenditure and Service Priorities for 1997- Voluntary Hospital
Working Reference VI:	DoH Minister's Letter: Determination Of Health Expenditure and Service Priorities for 1997 and Health Board Reports (excluding capital appendix)

³ EHB has several systems projects on its drawing boards. These include upgrades of current CA 2.0 to 3.0 to meet year 2000 needs; There is also talk of adopting SAP and of an all health board Irish Healthcare payroll system and a revision to GMS, etc. As ERHA will come into being before the year 2000 and new systems may take longer to install or migrate to than the half life of EHB, it is reasonable to assert ERHA's presence in these design stages now.