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Activity-based funding programme implementation plan 2015 – 2017

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Activity-Based Funding Programme

Implementation Plan 2015 – 2017

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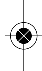

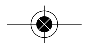

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Executive Summary

Introduction

Activity-Based Funding[1] (ABF) is a new model for funding public health care. The Government committed to the introduction of ABF in its "*Programme for Government*" and in "*Future Health: A Strategic Framework for Reform of the Health Service"* (2012) and published details on how the model would operate in the "*Policy Paper on Hospital Financing"* (2013). This *"Activity-Based Funding Programme Implementation Plan"* defines the mission, objectives and high-level actions for the period 2015-2017 that will guide all stakeholders as the ABF Programme is implemented in the years to come.

What is ABF?

ABF is an approach to funding which sees providers funded in line with the activity that they undertake. Implementation of ABF represents a significant change from the existing block-grant allocation model which was unable to link funding with activity and led to criticism of the health service's ability to stay within its budget.

The ABF approach is a fairer and more transparent system of resource allocation that will establish a clear link between money and activity because hospitals will be funded based on the quantity and quality of services they deliver to patients. In effect, this means that *patient care* as opposed to *hospitals* will be funded with revenue being determined on the basis of agreed target levels of activity using national average prices for each Diagnosis-Related Group (DRG) [2].

Hospitals will be encouraged, subject to overall budgetary ceilings, to pursue the most cost-effective means of achieving this standard of performance. Budgetary discipline will be delivered through the use of specified budgets for ABF activity. This means that hospitals that exceed their activity targets will not attract additional funding under ABF. If efficiency gains allow providers to do additional work, within their envelope of funding, this can be supported by the Programme. It is important to note that while the new funding model will encourage hospitals to use resources at their disposal more efficiently, it does not seek to reduce overall expenditure in the acute hospital system. Instead it provides a more transparent funding mechanism and it more fairly rewards hospitals for the activity that they undertake.

Benefits of ABF

The need for change in the way we fund our health service has been emphasised in recent times due to the significant challenges which have arisen as a result of the difficult economic environment and ever growing demand. ABF is an important part of the wider reform agenda that will combine to ensure that the health service is sustainable into the future and delivers the services that our population needs.

Five principal benefits of the implementation of ABF are outlined below. The identification of these benefits provides a basis for future assessment of the ABF Programme's effectiveness.

(i) Drive structural and efficiency improvements in the health system;
(ii) Drive improved quality;
(iii) Greater transparency and efficiency in the allocation of hospital resources;
(iv) Greater transparency leading to allocation of resources based on quality of care and improved patient outcomes; and
(v) Improved national healthcare data.

[1] Activity-Based Funding was previously referred to as Money Follows the Patient.
[2] Diagnosis-Related Groups (or DRGs) are a classification which groups hospital case types that are clinically similar and are expected to have a similar hospital resource usage.

Mission and Objectives

The Mission of the ABF Programme is:

- To improve patient access to care together with the overall quality and safety of care they receive.
- To establish and facilitate an evidence-informed system of healthcare resourcing that drives transparency, equity and efficiency.
- To promote stakeholder cooperation and trust, healthy competition and the greater use of quality health data in the Irish health system.
- To improve the health status of service-users by, in time, combining accurate cost measurement systems with the systematic measurement of outcomes

The ABF Programme cannot deliver on its Mission without a clear set of objectives. As such, the following objectives, which are of equal importance and should be read together, have been identified for the period covered by this Implementation Plan.

Objective 1	Develop and maintain an appropriate pricing framework for Activity-Based Funding
Objective 2	Support the development of mechanisms to determine activity levels, service targets, quality and patient safety targets and other patient-outcome measures in line with the National Service Plan
Objective 3	Transition from existing block budgets to ABF allocations
Objective 4	Develop a programme of actions to ensure key healthcare providers are in a position to fully implement an Activity-Based Funding approach, initially in the hospital setting
Objective 5	Ensure the ABF Programme has the appropriate resources to deliver its priorities
Objective 6	Ensure the ABF Programme has the appropriate interim and long-term governance and organizational structures
Objective 7	Undertake a programme of engagement with key stakeholders

Implementation

Given that implementation of ABF represents a radical change in the way the health service is funded and the potential risk to operational stability in service providers, the ABF Programme will be developed in phases over a number of years. Initially, the focus will be on inpatient and day-cases before widening to other areas such as outpatients. In the longer term, the Programme will examine areas such as emergency care, and community and home care.

Preparatory work under the ABF Programme has been under way since January 2014 and significant progress has been made since then including: establishment of the Healthcare Pricing Office; engagement with key stakeholders with a particular focus on clinicians; undertaking of extensive financial modelling to benchmark hospitals against the standard national price; work focused on improving the timeliness and quality of HIPE[3] coding; introduction of a new business intelligence system; analysis of provider preparedness; and upgrading of the HIPE coding classification to the 8th Edition of ICD10-AM.

It is now intended to build on the good progress made to date and further implement the Programme. Each of the seven objectives has been translated into detailed, timebound actions (Chapter 3, Section 3.5).

[3] HIPE (Hospital Inpatient Enquiry) is the principal source of national data on discharges from acute hospitals in Ireland.

A summary of the key milestones over the coming three years is set out below:

2015
• Benchmark budgets for hospitals on an ABF basis and apply transition adjustments[4] • Continue work on an outpatient classification system • Develop pricing structures to incentivise shifts from inpatient to day-case • Commence development of systems to link clinical data with provider reimbursement
2016
• Convert each hospital from block grant to ABF allocation • Commence phasing out of transition adjustments • Design a price-setting mechanism for outpatients • Evaluate approaches to classifying and costing community services
2017
• Ongoing price-convergence in hospitals by continuing to phase out transition adjustments • Commence linking payments with clinical objectives • Pilot early payment system for outpatients • Develop work on classifying and costing community services

Governance, Oversight and Structures

Appropriate governance arrangements have been put in place to oversee implementation of the new funding system including an ABF Oversight Group which is comprised of senior officials from the Department of Health and the HSE; and a HSE ABF Steering Group.

An important development in relation to the structures required to underpin the ABF system was the establishment, on an administrative basis, of the Healthcare Pricing Office (HPO). The HPO plays a central role in the implementation of ABF with its key functions being to: (i) set the national DRG prices on which the ABF system is based; and (ii) manage the HIPE dataset. The new Office was formed by merging the HSE Casemix Unit and the ESRI's Health Research and Information Division. While the HPO is currently a unit of the HSE, it is intended to establish it as a separate statutory body in the future.

Clinical Engagement and Quality

Effective engagement with clinicians is essential in order to ensure that the design of the ABF Programme is aligned with the work of the clinical programmes and medical schools, and creates incentives for the right changes in clinical practice. This will help to ensure that quality is at the core of the ABF Programme. Good progress has been made in relation to the establishment of strong clinical and academic links and these will continue to be built upon during the timeframe of this Implementation Plan.

Staffing and ICT Resource Requirement

Implementation of ABF will require a significant increase in workload for providers and the HSE/HPO on an ongoing basis. The importance of investing in resources to support implementation cannot be over-emphasised. Following an assessment of the system's capacity, it has been determined that implementation of ABF will require investment across the system in both staff and ICT resources over the coming years. It is also crucial that the HPO is appropriately resourced in order for it to effectively deliver on its remit. Specific resource requirements and a brief explanation of why the resources are needed is outlined below (this is covered in more detail in Chapter 4):

[4] Transition adjustments will be made for hospitals which are operating above the national average price in order to avoid financial instability. Plans will be developed by those hospitals to reduce their unit-costs and their associated need for transition payments over a defined period. This is described in more detail in section 3.4.

Requirements in Hospitals

(i) Clinical Coders: Timely and accurate clinical coding is the foundation stone on which the ABF system is based. It is the responsibility of the clinical coders to translate information on hand-written patient charts into HIPE codes. HIPE data are primarily used for clinical care purposes. However, the data are also used for several other purposes, including research and service planning. In terms of ABF, the coded data is used to facilitate payments to hospitals. Without this coded data, hospitals will not be paid under ABF. Following a study of best practice in coding, it has been ascertained that a total of 12 clinical coders are required for the hospital system.

(ii) Clinical Coding Managers: It is essential that effective management of hospital coding functions takes place. Effective management would include: evaluating coding processes; assessing the quality of coding; working with clinicians in relation to data quality; and ensuring that up-coding[5] does not take place. While some hospitals have dedicated resources to fulfil these tasks, it is not the case across the system. A total of 7 clinical coding managers is therefore required.

(iii) Accountants and Data Analysts: Hospitals need to have a clear picture of their costs under an ABF system in order to: (i) provide cost data which informs the national prices for DRGs to the HPO; and (ii) allow the hospital to understand whether their costs are above or below the prices paid by the funder. An analysis has identified shortages in the number of staff with the required expertise across the hospital system. An additional 24 accountants and financial analysts are therefore required to support ABF implementation.

(iv) Data Analysts: Hospitals use a number of ICT feeder systems in developing their unit costs. Many of these feeder systems are legacy systems from which it is difficult to extract data. A total of 8 data analysts are required to support the completion of this task across the hospital system.

(v) New ICT Systems: The ICT infrastructure required to develop accurate costs at the unit level is extensive. The absence of such infrastructure means that hospitals are facing major issues in accessing the minimum dataset to determine unit or patient-level costs. Addressing this issue will require a significant level of investment in relevant ICT in hospitals.

Requirements in the HPO

(i) Accountants: Implementation of ABF means that the HPO will be responsible for the completion of a range of new tasks which were not previously required. This includes: initially benchmarking hospitals against the national average; investigating reasons for differences in costs; managing transition adjustments; more regular financial audits; and assisting hospitals with the development of patient-level costs. 4 accountants are therefore required to develop audit capability and a further 4 are required for the national system for consolidating unit-costs into prices.

(ii) HIPE Clinical Auditors: Under ABF, there is an increased need for audit of hospital activity coding. Currently, responsibility for HIPE training and auditing is held by a single team in the HPO. It is intended to separate the team into two so as to allow an appropriate focus on these important areas. 4 additional HIPE clinical auditors are needed for this purpose.

(iii) HIPE Trainers: Investment in the training of coders pays dividends in terms of improved coding performance in hospitals. Given the importance of the coded data to ABF, investment in training is therefore seen as essential. A total of 3 HIPE Trainers are required for the training function of the HPO.

(iv) Support Staff: Support is also required in the HPO to develop a Data Governance Framework and a National Clinical Data Dictionary as well as manage the clinical advisory panels, stakeholder committees and data oversight committee. The HPO will also be undertaking work in relation to the linkage of clinical objectives with payments. 1 business manager and 1 support staff member is required to carry out this work.

[5] Up-coding: This involves fraudulent reclassification of patients so that they are assigned to a higher DRG, e.g. by falsely adding secondary diagnoses.

Stakeholder Participation and Support

Implementation of ABF will not be possible without the support and assistance of many stakeholders across the system. A clear commitment at political, departmental and senior management level is also essential in order to drive the cultural, process and technical changes required to make the ABF Programme a success.

1 Context for the Activity-Based Funding Programme

1.1 Introduction

When the Government published the "*Policy Paper on Hospital Financing*" in February 2013, it set out its plans to radically change the way that hospital services are funded through the introduction of an Activity-Based Funding (ABF) model. Implementation commenced in January 2014 and detailed work has been on-going since in relation to preparing for the major changes that are associated with further implementation of ABF.

This Implementation Plan aims to translate the policy principles established in the "*Policy Paper on Hospital Financing*" into an operational reality. It briefly outlines the progress to date in relation to the ABF Programme as well as defining the mission, objectives and high-level actions for the period 2015 - 2017. The Plan is intended to be a reference document for all stakeholders and partners in the health system whose participation, support and assistance will be essential for this important initiative to be effectively delivered.

1.2 Context for Introduction of ABF

The Irish health service has faced unprecedented challenges as a result of the extreme economic difficulties which have been visited upon the country in recent years. Although we now appear to have come to the end of the period of severe contraction in budgets, the health system will continue to face challenges on a number of fronts both in the near term and over the coming decades.

Immediate challenges identified in "*Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015",* published in November 2012, included: long waiting lists and inequitable access to care; lack of service integration; capacity deficits in terms of clinical management systems, IT and financial management systems; and the need for improved national systems for measuring, reporting and ensuring accountability for quality and patient safety. There are also challenges around having adequate systems to allow informed decisions to be made in relation to prioritisation and planning of services.

Over the medium to long term, like many countries, the health service will also have to respond to very significant increases in demand driven by: an ageing and changing population; a significant growth in the incidence of chronic illness; new health technologies; as well as patient empowerment and consumerism.

Individually, any one of these challenges would constitute a serious problem for the health system. Collectively, they raise profound questions about its long-term sustainability in the absence of real change.

In light of these challenges, the Government has concluded that the health system must change significantly in order to ensure long-term sustainability and the delivery of a service that meets the needs of the population. It committed in its "*Programme for Government*" to fundamentally reform the health system including a restructuring of service delivery, organisational, financial, governance and accountability processes and systems across the primary, community and hospital sectors. These commitments, among others, were set out in more detail in *"Future Health"*. That document placed a heavy emphasis on the need for financial reform and in particular, introduction of a Money Follows the Patient[6] funding model. The aforementioned "*Policy Paper on Hospital Financing*" then set out the parameters for introduction of an ABF system, initially in hospitals, including the following policy reasons for implementation:

- To have a fairer system of resource allocation whereby hospitals are paid for the quality care they deliver [This means that payments will be linked to quality and patient outcomes]

[6] The HSE and Department of Health now refers to Money Follows the Patient as Activity-Based Funding.

- To drive efficiency in the provision of high quality hospital services
- To increase transparency in the provision of hospital services
- To support the move to an equitable single-tier system where every patient is insured and has their care financed on the same basis

This Implementation Plan incorporates the following additional reason for implementation:

- To encourage appropriate reductions in unit-costs through benchmarking and cross-provider comparisons.

As indicated in the Policy Paper and confirmed in this Implementation Plan, introduction of ABF represents a major change event with a high level of complexity and significant resource requirements in terms of both people and technology. As such, the ABF Programme will be developed in phases over a number of years, starting with inpatient and day-cases in hospitals before widening to other areas such as outpatients. In the longer term, the Programme will examine areas such as emergency care, and community and home care.

The ABF Programme will also need to be closely aligned with the wider reform process in the health system and supported as a key component of change. This means that it will require sustained visible support from senior leaders in bringing change to the way in which we fund and provide services. Success in this endeavour will be a key element of delivering upon integration of care delivery across the care spectrum and shifting the focus from inputs to outcomes.

1.3 Definition of ABF and how the system will operate

The introduction of ABF represents a radical move away from the existing block-grant allocation process to a fairer and more transparent system of resource allocation. It replaces the budgeting model which previously applied in acute hospitals. Under the old budgeting model, hospitals were funded based on block allocations that were determined, predominantly, by historic factors with some limited financial adjustments based on casemix. By using this planning model, money could not be linked with activity and its application in the Irish health service has led to criticism of the system's ability to remain within budget.

The intention of the ABF Programme is to change to a model which instead allocates funding based on contracted activity. **As such, ABF can be defined as the system which provides funding to providers based on the activity that they undertake**. This means that *patient care* as opposed to *hospitals* will be funded. Hospital revenue will shift to being determined on the basis of agreed target levels of activity using national average prices for each Diagnosis-Related Group[7] (DRG).

Introduction of ABF will involve the setting of specific volumes and types of cases, initially for each hospital, related to need, with each type having its own price. This change will be facilitated by classifying care into "episodes" and then making payments associated with the delivery of such episodes. In hospitals, there are some 1,050 different types of episodes called DRGs. Each time an episode takes place, the provider is paid in line with the price for that particular DRG. If efficiency gains allow providers to do additional work, within their envelope of funding, this can be supported by the Programme.

A vital consideration in the design and delivery of the Programme is to implement a resourcing framework that provides the correct incentives to encourage safe, efficient treatment of optimal quality at the lowest level of complexity. Patients and service-users must have appropriate access to the highest quality of care in a setting that is appropriate to their needs and as close to home as possible. It is important to note that while the new funding model will encourage hospitals to use resources at their disposal more efficiently, it does not seek to reduce overall expenditure in the acute hospital system.

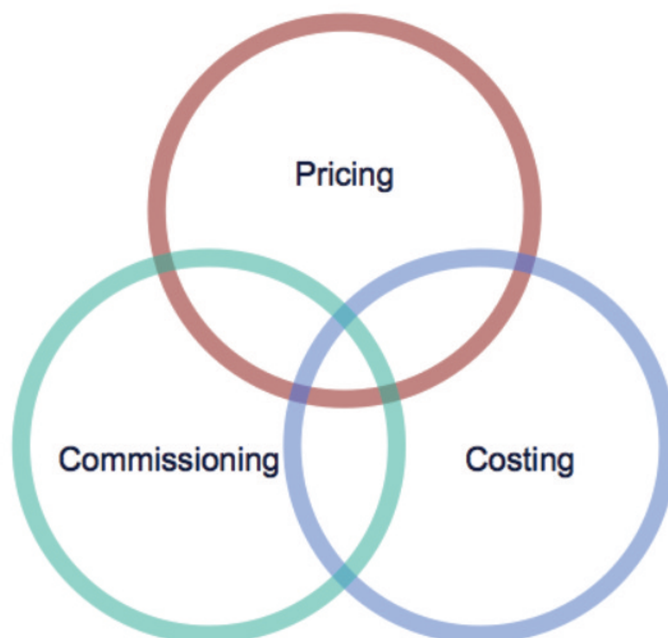
[7] Diagnosis-Related Groups (or DRGs) are a classification which groups hospital case types that are clinically similar and are expected to have a similar hospital resource usage.

Ultimately, the ABF system will be designed so that money can be tracked by patient from the hospital setting to primary care and related services. This approach, known as an integrated payment system, will require implementation of the planned '*individual patient identifier*' and will help to support effective links between non-admitted care (outpatient, community and home) and admitted hospital care. The same process will apply in other services such as disability, older persons and mental health.

It is clear that the performance of any health system is shaped not just by *how much* is spent on health care but also *in what manner* that funding is allocated. This radical reform of our funding approach will have a fundamental impact on many dimensions of the patient and provider experience – as well as posing new challenges to policymakers and fund-holders alike. Given this, the HPO determined from the outset that it is essential to locate its own work on the ABF Programme clearly in the context of the wider ambitions of "*Future Health"* for our health system overall.

1.4 Components of ABF

Three components are required in order for the ABF process to operate. These components are pricing, commissioning and costing and each is linked in such a way that the Programme cannot operate without all three elements working together.



1. Pricing - Prices are set for each DRG based on the average cost of all hospitals with activity in that DRG. These prices are determined by the Healthcare Pricing Office (HPO), which was established on 1st January 2014. The prices will be set so as to incentivise adherence to clinical and care objectives and therefore maximise benefits to patients, both in terms of their experience of health care and the quality of the care that they receive. New systems will be required to capture quality and outcome data. Critically, the ABF system links volume and complexity with price and allows funders and providers to see clearly what is being delivered for the price being paid. The variation in complexity means that there is an associated variation in the level of payment associated with delivery of episodes of care. For example, in hospitals, a birth can cost €2,200 while an ICU case can cost over €100,000.

2. Commissioning - At the national level, the system requires an assessment of need and negotiation between the funder and providers in order to set the appropriate level of activity. This process is called commissioning or purchasing. Enhanced financial control is achieved through this process by setting appropriate activity targets, related to need-assessment, for each provider and ensuring that they do not exceed those targets. This will allow the health system to budget in a much more explicit and accurate manner and to monitor performance more effectively. In time, payments can be linked with clinical objectives, driving better outcomes for patients.

3. Costing - In order for ABF to operate, providers must be able to determine their unit-costs. This critical information allows providers to understand why they are making surpluses or deficits under the new funding system when they are paid at the national average price for each episode of care.

1.5 ABF for Nursing Home Care - Fair Deal

This is not the first time that an ABF type model has been introduced in the Irish health system. ABF was introduced for nursing home care in 2012 under the Nursing Home Support or "Fair Deal" Scheme. Implementation of Fair Deal fundamentally changed the nature of the funding arrangements and introduced greater transparency, with the dialogue moving from one based on the funding of care homes, to the funding of clients.

Introduction of ABF in hospitals has the potential to now change the conversation about hospital expenditure. It is intended to move the debate from a dialogue about deficits to a focus on unit-costs, quality of outcomes, volume of activity and type of activity.

While important lessons have been learned through introduction of Fair Deal, implementation of ABF in hospitals represents a far more complex undertaking due to the large numbers of different episodes. There is only one type of episode under Fair Deal – a period of time being cared for in a residential setting. This contrasts with the 1,050 types of episodes (or DRGs) in the hospital setting.

1.6 ABF Benefit Statement - What it will achieve

The table below translates the policy objectives of the ABF Programme into clear benefits which will be delivered. The benefits below build on commentary from relevant national policy documents and outline the high-level advantages of implementing ABF across the Irish health system. Identification of these benefits provides a basis for future assessment of the Programme's effectiveness. The five principal benefits to be derived from the shift to an ABF approach are outlined.

Figure 1: Description of ABF Programme benefits

Benefit	Description
Drive structural and efficiency improvements in the health system	• Traditionally, hospital care has been provider-driven in many respects. ABF will incentivise care system innovation by reorganising the funding of care from a block grant system to case-based funding, encouraging providers to redesign themselves around the patient's treatment and care pathway, ultimately investing in resources and facilities to improve efficiency and increase margins[8]. • The Programme will create an environment within which a greater understanding and control of care provision and cost is required. • The new environment will also incentivise providers to innovate to improve the efficiency, safety and quality of care - initially to adapt to the new funding model and subsequently to remain competitive in the new market.
Drive improved quality	• The commissioning function will agree service-level agreements and performance contracts with providers, setting out strict activity targets by quarter including quality targets underpinned by financial incentives and sanctions. • The SLAs and performance contracts will form the basis for an Integrated Performance Management System, ensuring that clinical managers are incentivised to continuously review and monitor data from a quality perspective. • DRG prices will be set to reflect the optimal level of quality in overall patient experience and outcomes as opposed to the lowest possible cost.

[8] This means the gap between what the HPO will pay for a treatment and the cost at which the hospital can deliver it. Each year in which they reduce their unit cost, they increase the amount of 'gain' to the hospital for that year. Once the prices are set again the following year, their efficiency will be absorbed into the price. If a hospital does not continue to focus on efficiency, it will become uncompetitive.

Greater transparency and efficiency in allocation of hospital resources	• Providers will be paid the national DRG price on receipt of confirmation that pre-agreed activity has been delivered ensuring fair and transparent reimbursement rather than a historically determined block grant. • ABF will improve accountability in health system resourcing as poor performance is identified and addressed and the most efficient and effective healthcare providers are rewarded. • In the long term, inefficient providers will see fewer patients while high performing providers and clinicians will be able to see more patients. • The ABF national tariff list will be published allowing a wide range of stakeholders maximum insight into costs and pricing for public hospital care.
Greater transparency leading to allocation of hospital resources based on quality of care	• ABF will ensure the State gets good value and supports positive health outcomes by redesigning payments so that they are made in return for individual episodes of care provided in accordance with clear quality standards. • Improved patient-level analytics will provide visibility to clinicians and hospitals performing at high volume and high quality. • ABF offers high-quality performers the means to justify improved resourcing in the future. • ABF will be a system that in time will incentivise a preventative approach to healthcare across all care settings but focusing initially on acute care
Improve national healthcare data	• ABF will drive demand for patient-level analytics across the Irish health system as providers seek a greater understanding of the various costs and outcomes associated with each element of a patient's treatment. • Activity and patient-level cost data collected by the Healthcare Pricing Office will allow policymakers and providers to compare and benchmark current and historical service provision across the system and identify areas of progress or concern at system level down to specific care settings. • This National Dataset will feed back into national policymaking, service planning and the commissioning and performance management processes.

1.7 Stakeholder Participation and Resource Requirements

Experience internationally suggests that ABF cannot be seen as a finance or administrative initiative. ABF is a Programme which requires the mobilisation of many stakeholders including doctors, clinical scientists, nurses, allied health professionals, HIPE[9] personnel, managers and accountants. This point warrants reiteration – the evidence from other jurisdictions clearly shows that medical professionals and care staff must be at the heart of ABF systems for them to operate effectively. A clear commitment at government/departmental level to the investment required in both staffing and technology is also essential to the success of the Programme. These issues as well as other key dependencies for successful implementation are further clarified in Chapters 3 and 4.

[9] HIPE (Hospital Inpatient Enquiry) is the principal source of national data on discharges from acute hospitals in Ireland.

2 ABF Programme Mission, Objectives, Principles and Governance

2.1 ABF Mission Statement

In providing a new system for funding healthcare services, the ABF Programme cuts across the everyday roles of service-users, service-providers, funders and policymakers alike. With such a wide range of stakeholders involved, the overall mission or purpose of the Programme must be clear from the outset. Our mission communicates what the Programme will do, how it will be run and who it is for. It has been developed based on direction provided by national policy documents from the Department of Health, including "*Future Health"* and the "*Policy Paper on Hospital Financing"*.

The Mission of the ABF Programme is:

To improve patient access to care together with the overall quality and safety of care they receive

To establish and facilitate an evidence-informed system of healthcare resourcing that drives transparency, equity and efficiency

To promote stakeholder cooperation and trust, healthy competition and the greater use of quality health data in the Irish health system

To improve the health status of service-users by, in time, combining accurate cost measurement systems with the systematic measurement of outcomes

The new funding system will result in the distribution of funding in a fair and equitable fashion that maximises quality of care and improves access to care for patients. In the longer term, by incentivising prevention, hospital avoidance, quality and patient safety and the use of guidelines for appropriate care pathways, ABF will help to maximise outcomes for patients.

Secondly, the Programme will seek to introduce an approach to the resourcing of healthcare that is open, fair and in which service providers can have confidence, thereby facilitating improvement in the planning and design of care delivery, use of resources and overall value for money.

Finally, in its development and implementation, the Programme will aim to strengthen trust in a system of healthcare resourcing that is more rational and evidence-based. We will achieve this through extensive engagement and support of the hospital network in the transition to full implementation and ongoing consultation to ensure that the ABF system and the prices it sets remain accurate, current and fair. A key element of this transition process and for the Programme itself will be developing the system's capacity to provide comprehensive national demographic, clinical and cost datasets so as to inform policy and planning across the Irish health system.

2.2 Objectives

The ABF Programme cannot deliver on its mission without a clear set of objectives. Over the next three years, it is our intention to concentrate on seven priority areas: Pricing, Commissioning, Enabling sustainable transition, Provider preparedness, Programme resourcing, Planning and governance, and Communications. These objectives must be read together and are of equal importance. The corresponding objectives for each priority area are presented below:

1. Pricing	***Develop and maintain an appropriate pricing framework for Activity-Based Funding***
2. Commissioning	***Support the development of mechanisms to determine activity levels service targets and quality and patient safety targets in line with the National Service Plan***
3. Enabling Sustainable Transition	***Transition from existing block budgets to ABF allocation***
4. Provider Preparedness	***Develop a programme of actions to ensure key healthcare providers are in a position to fully implement an Activity-Based Funding approach, initially in the hospital setting***
5. ABF Programme Resourcing	***Ensure the ABF Programme has the appropriate resources to deliver its priorities***
6. ABF Programme Planning and Governance	***Ensure the ABF Programme has the appropriate interim and long-term governance and organisational structures***
7. Communications	***Undertake a programme of engagement with key stakeholders***

2.3 Operating Principles

Identifying and documenting the operating principles which will apply to the ABF Programme is also important. These principles act as a navigation aid that will provide continual guidance to stakeholders on how ABF needs to operate in order to change the trajectory of the Irish health system. The principles also communicate choices that have been made and will assist in the translation of this Implementation Plan into the everyday actions that will implement the ABF Programme over the next three years.

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Activity-Based Funding Operating Principles

Engagement

- Ongoing health stakeholder consultation, collaboration and respect
- A culture that supports key stakeholders

Responsiveness

- A dynamic system incorporating ongoing review and updates in response to emergent and evidence-informed healthcare innovation and to demographic trends

Independence

- A price-setting function that is independent of the purchasing function

Support integrated care in the appropriate setting

- Implementing and maintaining funding processes that support the delivery of integrated care
- Incentivising timely transition to provision of care in the most appropriate setting

Support health service redesign

- Design and implementation of ABF in a manner that supports the agenda of Hospital Groups and Community Health Organisations
- A system that encourages the development of the Group / Primary care interface
- A system that improves the management of healthcare by facilitating greater analysis and understanding of resourcing decisions and impact

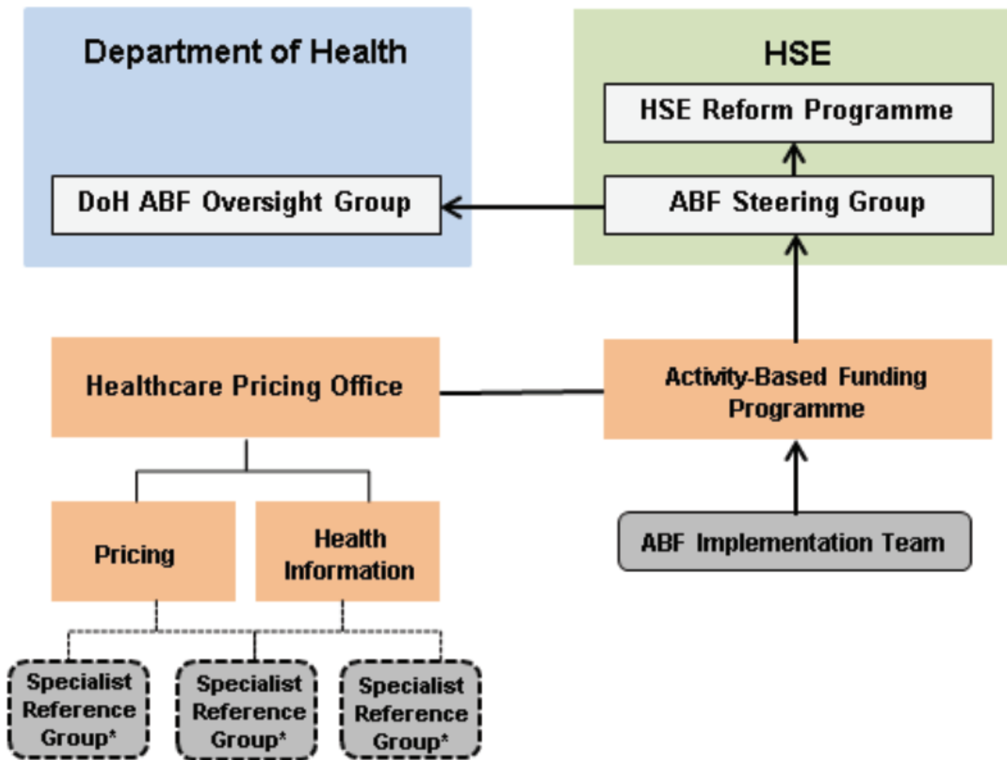
Feasibility

- Managed / phased implementation based on pilot projects and testing

2.4 Governance and Oversight of the ABF Programme

Oversight of the ABF Programme is being provided by a Steering Group in the HSE. The Programme's progress is also being monitored in the Department of Health by an Oversight Group to ensure it adheres to policy guidelines and is coordinated within the context of the overall health reform programme. An overview of this governance structure is provided below, with the role and composition of the entities involved outlined in further detail in Appendix 2.

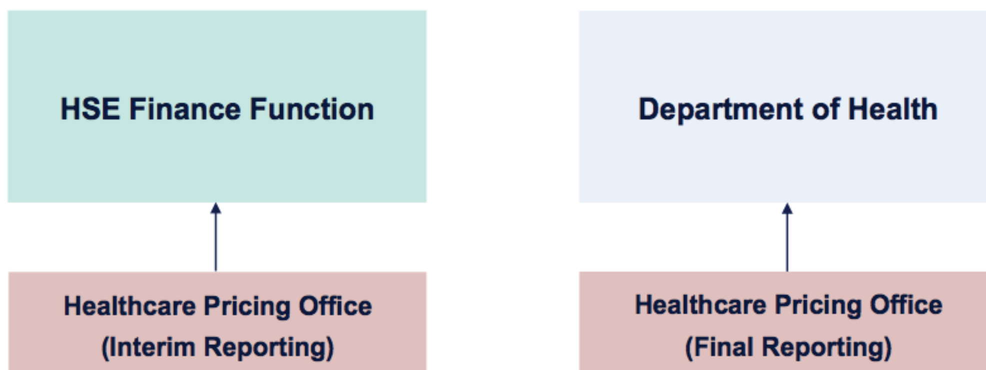
Figure 2: Illustration of the interim Governance Structure for Oversight of Activity-Based Funding



*Specialist reference groups in areas such as clinical or finance professionals will be established as required over the course of the Programme.

The Healthcare Pricing Office will play a crucial role in driving implementation of ABF. The Office was established on an administrative basis within the HSE on 1 January 2014. A senior executive was also assigned at this time to lead on the development of the HPO and the implementation of ABF in the acute hospital sector. The Head of the HPO reports to the HSE's Chief Financial Officer (CFO). It is intended that the Office will be established as a separate statutory body reporting directly to the Department of Health in the future, following the enactment of legislation. The medium term governance arrangements for the HPO are set out below.

Figure 3: Medium term governance arrangements for the HPO



3 ABF Programme Implementation

3.1 Progress on Implementation to Date

The purpose of this chapter is to describe the high-level roadmap for implementation of ABF, translate the Programme objectives into more detailed actions and outline some of the main dependencies for success. However, it also provides an opportunity to briefly outline some of the key areas where progress was made during 2014. This included:

- Establishing the HPO at operational level (including organisational structure, capability building, financial and activity audit capability, training needs assessment etc.);
- Undertaking further research on price-setting approaches to underpin pricing frameworks used in other jurisdictions and developing a suitable approach for use in the Irish healthcare system;
- Scoping the necessity for professional advice and support for the Programme and securing approval and related funding;
- Working to configure historic cost and price data to reflect current cost base;
- Undertaking extensive financial modelling work to benchmark each hospital against the standard national price;
- Evaluating overall system-wide delivery capacity with DRG prices given the resources available within the Vote;
- Considerable work was undertaken aimed at improving the timeliness and quality of HIPE coding. Coding performance has improved significantly and over 98% of hospitals are now meeting the 30-day coding timeline. However, there are some exceptions where hospitals continue to struggle to meet the deadlines due to staffing issues;
- The specification of activity targets for each hospital within the block grant. Monthly monitoring of those targets took place and reports on performance against the planned activity were issued to each hospital/group;
- A new Business Intelligence System, 'Qlikview', was implemented in each hospital allowing them to interrogate their HIPE data flexibly and quickly, down to the level of individual consultant/patient, length-of-stay etc;
- Significant mobilisation of the system was undertaken – engagement with the RCSI, the RCPI, and with a wide range of clinicians, hospital groups and other stakeholders (see section 3.2 below);
- A major programme of work was carried out to upgrade the HIPE coding classification to the 8th Edition of ICD10-AM. This involved re-training all coders nationally and re-designing all manuals, reference materials etc.; and
- Continued to work with providers towards the development of unit costs.

It is now intended to build on the substantial progress and momentum of 2014 over the coming three years.

3.2 Clinical Engagement and Quality

Given that ABF must be clinically driven and stand up to academic rigour, it is essential that the ABF Programme engages closely with clinical and other stakeholders. Engagement with clinicians is also important in order to ensure that the design of the ABF Programme is aligned with the work of the clinical programmes and medical schools, and creates incentives for the right changes in clinical practice. This will help to ensure that quality is at the core of ABF. In this regard, the ABF Programme engaged with the following stakeholders during 2014:

(i) Royal College of Physicians in Ireland (RCPI) and Royal College of Surgeons in Ireland (RCSI);
(ii) National Clinical Programmes;
(iii) Hospital Groups and National Clinical Leads Group;
(iv) HSE Divisions for Health & Wellbeing, Quality & Patient Safety, Clinical Strategy & Programmes.

The ABF Programme also engaged with clinicians through the annual Millin[10] meeting in the RCSI (attended by some 260 clinicians) and clinical consultation sessions in Dublin, Cork and Galway.

[10] This is an annual education lecture at the RCSI.

Broader stakeholder interests were engaged with at a conference focused on ABF in the University of Limerick, which was attended by over 200 people.

Engagement with the HSE 'Clinical Strategy and Programmes Division' was particularly important in developing the ABF Programme to date. The Clinical Strategy and Programmes Division was established in order to improve and standardise patient care in the health service by bringing together clinical disciplines and enabling them to share innovative solutions. This is being achieved by designing and specifying standardised models of care, guidelines, pathways and associated strategies for the delivery of integrated clinical care.

The National Clinical Programmes (NCP) were established in 2009 to deliver on these objectives. A unique feature of the NCP is the close collaboration between the HSE and the medical professional bodies in partnership with nursing, health & social care professionals and most importantly, patients.

Current governance arrangements for the NCP align with the new HSE Divisions of Care and involve the appointment of National Clinical Advisors and Group Leads for each HSE service division. This approach supports integration with senior management teams and provides clinical leadership within the divisions.

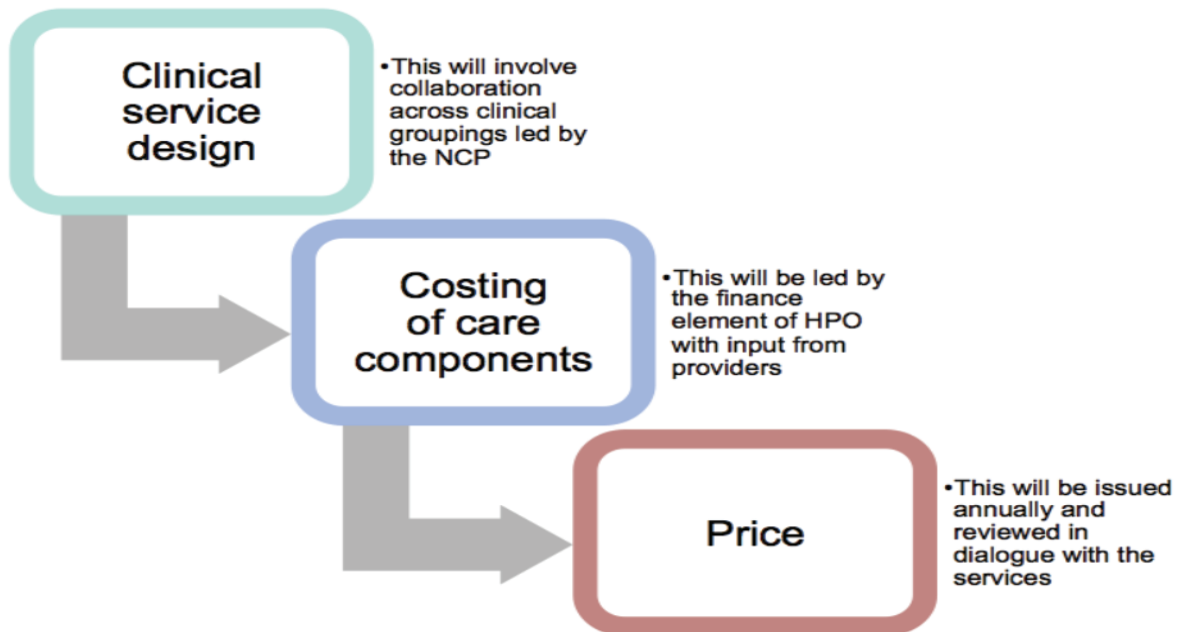
The Clinical Strategy & Programmes Division oversees all the NCPs and the Office of Nursing and Midwifery services. The current Programmes are:

National Clinical Programmes			
ACS	Acute Medicine	Anaesthesia	Asthma
Trauma & Orthopaedics	COPD	Critical Care	Cystic Fibrosis
Dermatology	Diabetes	Emergency Medicine	Epilepsy
Heart Failure	Transport Medicine	Medicines Management	Mental Health
Obstetrics & Gynaecology	Older People	Neurology	Ophthalmology
Orthopaedics	Paediatrics & Neonatology	Palliative Care	Primary Care
Radiology	Pathology	Rare Diseases	Rehabilitation Medicine
Renal	Rheumatology	Stroke	Surgery

The Clinical Strategy & Programmes Division will develop Integrated Care Programmes (ICPs) that will provide the framework for the management and delivery of health services to ensure that patients and clients receive a continuum of preventative, diagnostic, care and support services, according to their needs over time and across different levels of the health system.

It is intended to continue engaging with the NCP, other clinicians and the wider stakeholder group on an ongoing basis as part of the ABF Programme. This will include working with the medical schools and Clinical Programmes to determine how the range of clinical objectives can be linked with DRG payments. It is also intended to engage stakeholders in the price-setting process for ABF in line with the diagram at Figure 4 below.

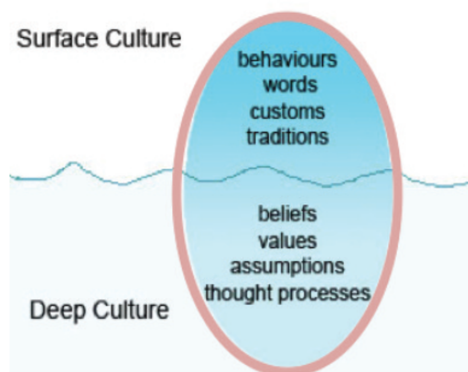
Figure 4: High level price-setting approach to be adopted by the HPO



While the approach as described above will be developed and implemented over a number of years, other methods to incorporate quality within hospital funding arrangements will be explored and incorporated as early as possible. Any substantive changes to the funding model will be implemented at the beginning of the calendar year in question.

3.3 Health Service Culture

Experience suggests that delivering on the cultural changes required to implement the ABF Programme may be even more significant that the technical changes required.



Introduction of ABF will require a shift from a culture of fixed budgets to an active and innovative approach to care delivery with a focus on outputs and outcomes. The challenge of changing the culture within the health environment is one that faces the health system more widely than the ABF Programme. The shifts required in the "deep culture" of the organisation must be led politically and at the most senior management and clinical levels. Without this level of leadership, real change in culture will not be possible. As such the technical work programme will need to be matched by a wider culture change programme which seeks to focus upon trust, respect and excellence in delivery of quality care.

3.4 Road Map for ABF 2015 – 2017

Detailed actions with timelines have been determined for each objective to guide the implementation of ABF during the years 2015 to 2017. Each action is presented at a high level and identifies areas of work including specific activities and tasks that will contribute to the achievement of the overall Programme objectives. A brief overview of the approach to be taken during each of the years 2015 to 2017 is set out below with a summary road-map included at Figure 5:

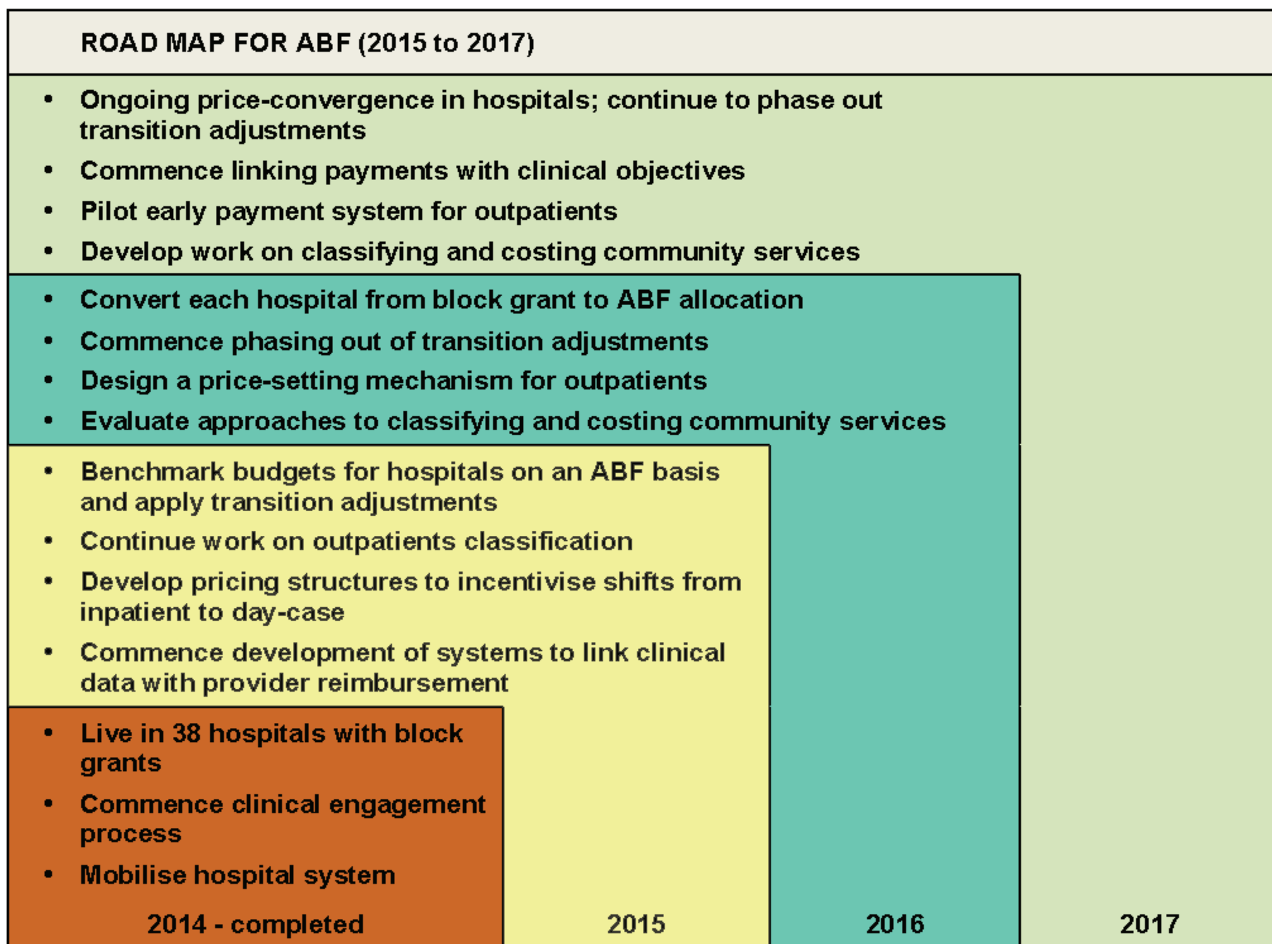
2015 – In early 2015, hospitals' budgets were benchmarked on an ABF basis using national average prices for a specified volume and complexity of service. In order to ensure financial stability during the

process of moving to full ABF, transition adjustments will be made initially to those hospitals which are operating above the national average price. Plans will be required by those hospitals to reduce their unit-costs and their associated need for transition payments over a defined period. This will require a significant amount of work in order to discover why certain hospitals are operating above the average price. It should be noted that experience both in Ireland and internationally has shown that operating above the average can be a result of "structural disadvantages" such as remote location which can have an impact on their cost base. The HPO will continue to work with the colleges and the Clinical Programmes to examine potential links between clinical data and provider reimbursement, and will commence development of systems to link clinical data with provider reimbursement. During 2015, work will also be carried out in relation to the development of pricing structures which incentivise a shift from inpatient to day-case. Ongoing work in relation to the development of an outpatient classification system will also be further progressed.

2016 – This will be the "conversion year" for hospitals in which each hospital will be converted from block grant to ABF allocations. The process of convergence to national prices in hospitals and phasing-out of transition payments will commence in 2016. This will allow the system to reward those hospitals which are operating below the national average price. A price-setting mechanism for outpatients will be designed and approaches to classifying and costing community services will be evaluated.

2017 – Further price convergence and reductions in transition payments will apply in 2017. Provider reimbursement will begin to be linked with clinical objectives and a payment system for outpatients will be piloted. Work on classifying and costing community services will be further developed.

Figure 5: Road Map for ABF 2015 - 2017



3.5 High Level Action Plan for ABF 2015 - 2017

The table below sets out specific actions with timeframes for the achievement of each ABF Programme objective as specified at section 2.2 and the Road Map at 3.4. It should be noted that these actions are in addition to ongoing improvements to the ABF system which will continue to evolve during the timeframe of this Implementation Plan. One example of such an improvement is the further refinement of the methodology for allocating costs and the subsequent calculation of unit costs. It is also intended that a review and evaluation process will take place on an annual basis in order to monitor how well the new model is operating and inform any adjustments that are required.

Figure 6: ABF Implementation Plan Actions 2015 - 2017

	Action	Timeline
1	**Objective 1 - Develop and maintain an appropriate pricing framework for Activity-Based Funding**	
1.1	Create structures to ensure both clinical involvement and transparency in the development of a national price for each DRG	Q1 to Q2 2015
1.2	Link clinical data with provider reimbursement by developing mechanisms to ensure that clinical/care objectives are reflected in the standard national price: [a] Continue to work with colleges and Clinical Programmes to examine potential links between clinical data and provider reimbursement [b] Commence development of systems to link clinical data with provider reimbursement [c] Commence linking provider payment with clinical objectives	[a] Q1 2015 [b] Q4 2015 [c] Q4 2017
1.3	Further develop and refine data-collection, coding and classification system for hospitals in line with best practice	Ongoing
1.4	Classifying and costing community services: [a] Evaluate approaches to classifying and costing community care [b] Develop work on classifying and costing community services	[a] Q4 2016 [b] Q4 2017
1.5	Design a classification, costing, price-setting and payment system for outpatients: [a] Work already undertaken to develop outpatient classifications will be progressed [b] A price-setting mechanism for outpatients will be designed [c] Pilot early payment system for outpatients	[a] Q4 2015 [b] Q4 2016 [c] Q4 2017
1.6	Operate specialty-costing and patient-level costing for DRG pricing	Ongoing
1.7	Develop pricing structures which incentivise shifts from inpatient to day-case	Q4 2015
1.8	Strengthen audit and probity mechanisms	Q4 2015
1.9	Develop and continually revise a National Clinical Data Dictionary	2015/2016

2	**Objective 2 - Support the development of mechanisms to determine activity levels, service targets, quality and patient safety targets and other patient outcome measures in line with the National Service Plan**	
2.1	Integrate performance management of ABF into Performance Contract and organisational performance management and assurance process	Q2 2015
3	**Objective 3 - Transition from existing block budgets to ABF allocation**	
3.1	Develop multi-year system to transition individual hospitals towards the national price	Q3 2015
3.2	Convert hospitals from block-grant to ABF allocations [a] Benchmark budgets for hospitals on an ABF basis and apply transition adjustments [b] Commence phasing out of transition adjustments [c] Ongoing price-convergence in hospitals by continuing to phase out transition adjustments	[a] Q1 2015 [b] (from) Q1 2016 [c] Ongoing from 2017
4	**Objective 4 - Develop a programme of actions to ensure key healthcare providers are in a position to fully implement an Activity-Based Funding approach, initially in the hospital setting**	
4.1	Monitor the development of hospital HIPE coding in terms of quality and clinical involvement	Ongoing
4.2	Review the procurement and implementation of provider ICT Systems to enable patient/client-level costing (including feeder systems)	Q3 2015
4.3	Monitor implementation of provider financial expertise for the development of unit costs	2014 and 2015
4.4	Monitor the development of provider organisational structures to allow effective operational deployment of ABF	2014 and 2015
4.5	Ensure the continuous education of coders	Ongoing
4.6	Commence implementation of Patient-Level Costing project	Q2 2015
5	**Objective 5 - Ensure the ABF Programme has the appropriate resources to deliver its priorities**	
5.1	Secure approval and funding for initial HIPE and finance staff	Q1 2015
5.2	Recruit relevant initial staff in line with work programme requirements	Q2 2015
5.3	Develop a business case for additional resources	Q2 2015
5.4	Identify training and development needs and opportunities	Q3 2015
5.5	Secure approval and funding for additional resources	Q4 2015
5.6	Recruit additional staff into key functions	Q2 2016
5.7	Secure approval and funding for ICT investments	Q4 2015

6	**Objective 6 - Ensure the ABF Programme has the appropriate interim and long-term governance and organisational structures**	
6.1	Support the Department of Health in drafting legislation to formally establish the Healthcare Pricing Office on a statutory basis	Ongoing
6.2	Develop an information-governance framework complying with appropriate legislation covering data-ownership and data protection	Q2 2015
6.3	Establish HPO at operational level (including organisational structure, capability building, financial and activity audit capability, training needs assessment etc.)	Q1 2015
6.4	Ongoing review of governance framework and terms of reference for the ABF Programme as the Programme develops	Ongoing
6.5	Establish clear lines of responsibility for priority implementation Programme actions	Ongoing
6.6	Establish Specialist Reference Groups for specialist expertise and key consultation functions	Q2 and Q3 2015
7	**Objective 7 - Undertake a programme of engagement with key stakeholders**	
7.1	Align communications planning between the HSE and the Department of Health	Ongoing
7.2	Engage extensively with the hospital network in the transition to full implementation of ABF	2014 and 2015
7.3	Develop communications and preparations for an Annual ABF Conference	May 2015 (and annually)

3.6 Dependencies and Risks

Delivering on the objectives and actions set out above will be a highly complex undertaking and will be subject to many variables. In devising this Implementation Plan for ABF, it was deemed important that the key dependencies for its success and the associated risks be identified. Figure 7 below describes a series of key dependencies or logical relationships that will be essential to the on-going delivery and ultimate success of the ABF Programme. These dependencies represent foundations necessary for building a stable and sustainable funding system. It is also important to recognise the interdependencies between ABF and the wider health reform programme so as to ensure implementation strategies and safeguards are in place throughout the transition period. An analysis of the high-level risks pertaining to the implementation of the ABF Programme can be found at Appendix 3.

Figure 7: Description of key ABF Programme dependencies

Dependency	Description
The ongoing input and support of clinicians	• The success of ABF will rely on the support of clinicians providing the patient-level activity data required for the system to function effectively, particularly in the area of quality and health improvement. Safe and efficient patient care relies on high quality data and there is significant evidence that active clinician involvement in coding improves patient outcomes. [Clarke et al, 2010, Irish Medical Journal] • Clinical representation will be required at governance level in the HPO as well as at all operational levels of ABF.

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Detailed chart documentation and HIPE Coding	• The accuracy of DRG prices, activity targets and the ultimate funding of hospitals depends on the degree to which each step in a patient's care is recorded on their chart and the corresponding quality of the subsequent coding of that information so that it can be correctly reported and reimbursed. • While hospitals have been collecting and reporting on HIPE data for several years it is recognised that gaps still exist in the level of chart documentation which is coded on HIPE and in the required quantity and experience of HIPE coders. • Hospitals will require additional resources to improve patient-level analytics, in particular their patient-level costing capacity, for the accurate financial interpretation of HIPE data and its separation from fixed overheads and other costs.
A system-wide cultural change in the way care is designed and delivered	• It is critical that hospitals understand that any provider exceeding agreed activity levels would not receive payment for that work. • The success of ABF will rely heavily on the support of healthcare professionals, from frontline staff to administration and senior management, in adapting to the new system and its requirements. From the collection and recording of health data and accurate coding to input to DRG prices at national level, healthcare professionals will determine the accuracy with which the new system will operate. • The ABF Operating Principles will require a radical shift in mindset by providers in particular to adjust to a funding system which is more obviously driven by care models and patient episodes than by traditional provider delivery systems. • Significant issues also stand to be addressed in terms of commissioning expertise within both the providers and the HSE and the move to a transactional culture with a wide range of new skill-sets not traditionally required under the block-grant funding approach.
The cooperation and ongoing viability of Hospital Groups	• Hospital Groups will form the contracting entity for Activity-Based Funding. Their development in this role must be assisted by an overarching policy framework to guide the national reorganisation of hospital services. • Assistance will be necessary to assist hospitals deemed to be at a structural or geographic disadvantage. • To improve system efficiency, hospital groups must be given the autonomy to harness the benefits of independence and greater control at local level, changing their cost base and arrangements for the deployment of staff to respond to demand.
Enabling providers to manage in the most effective manner	• It is a fundamental principle of ABF funding systems that providers are not hampered by conflicting rule-sets as they make decisions to bring their unit costs into line. There are some such rule-sets currently operating in Ireland and these will have to be addressed. The recruitment moratorium, for example, means that some hospitals are employing expensive agency staff because they cannot hire their own staff. This prevents them from competing effectively on price. • In the longer term when private hospitals enter the ABF Programme and are competing for business, it will be essential that public hospitals have a 'level playing pitch'.
The development of a Commissioning Framework	• The HPO sets prices for healthcare. The determination of activity volumes is a critical component of ABF – without which it cannot progress. Determining activity volumes must be undertaken by service personnel and be separate to price-setting.

The development of a Financial Management Plan to ensure the financial stability and sustainability of the hospital system during the transition period	• Mechanisms are required to ensure the continued financial stability and sustainability of the hospital system during the implementation of Activity-Based Funding e.g. in the event that funding is inadequate to deliver required activity levels or a provider or group of providers encounters difficulty. • Such provisions should be incorporated into the development of a comprehensive financial management plan to provide appropriate support and security to the hospital system during the transition period. The system will also need economic regulation mechanisms to safeguard good governance and financial management of health services. It should possibly extend, in exceptional circumstances, to intervention to rescue a healthcare provider delivering a service deemed essential to population health needs.
Reform of the Primary, Social and Mental Health services required to support the delivery of integrated care	• In addition to the creation of Hospital Groups, the new Community Health Organisations are essential to the success of ABF as they facilitate the system's ability to deliver integrated care across different settings, i.e. so that money can always be tracked by patient across care setting once there is a unique patient identifier. • It is important that the CHOs are developed alongside the development of the hospital groups, encouraging their collaborative and integrated working and facilitating the implementation of treatment pathways. • Revised models of care informed by the National Clinical Programmes will also be essential to inform integrated service delivery in line with best clinical practice. • New models of care must be supported by the proposed new GP contract that should encourage better care-management in the community and see GPs working as part of expanded multi-disciplinary primary care teams.
A Significant upgrading of the Information and Communications Technology (ICT) infrastructure and capacity across the Irish health system.	• Collectively, the current system, including hospitals and the HPO, lack the requisite 'infrastructure' to support the patient-level analytics essential to implement and accurately maintain ABF. • The same is true for the vast majority of Primary, Social and Mental Health services that will be expected to implement ABF as the system transitions to an integrated payment system, only to a greater extent. • An appropriate team must be established to support the healthcare Chief Information Officer (CIO), with responsibility for ensuring a comprehensive and systematic approach to health system information requirements as well as ensuring that those information requirements are enabled by ICT solutions. • Another necessity for ABF, the Health Identifiers Act 2014 provides the legal basis for "individual health identifiers" for health service users and unique identifiers for health service providers. • Delivering the necessary upgrades to health system ICT infrastructure along with the capacity and expertise necessary to operate it will require significant investment. Chapter 4 of this document provides a clear assessment of requirements for 15 hospitals involved in the patient-level costing studies. Further detailed work is necessary to quantify the wider investment requirements.
Ongoing communication and engagement with policymakers, providers, other stakeholders	• The smooth implementation of ABF will require that political, health system and other stakeholders are regularly updated to ensure that expectations are managed appropriately and that the timelines for implementation are realistic.

4 Staffing and ICT Requirements for Implementation

4.1 Need for Investment

Effective implementation of ABF will require a significant increase in the volume and complexity of financial and administrative work which hospitals and the HSE/HPO have to deliver on an ongoing basis. This is additional, new work which will have to be carried out over and above that currently undertaken by these organisations.

To date, ABF has been implemented by the existing staff cohort which has gone to great lengths to ensure that the required work is completed. However, the Programme is now at a point where investment in both staffing and ICT resources is necessary in order to translate this Implementation Plan into a functioning reality. The need for investment was not unexpected. A "*State of Readiness Review*" which was conducted by an international expert in ABF and the aforementioned "*Policy Paper on Hospital Financing"* clearly recognised the need for significant development of capacity and infrastructure for the new funding model to succeed.

The purpose of this chapter is to outline specific areas where additional staff and ICT investment is required. It has been informed by a detailed assessment of requirements at hospital level (including a benchmarking study of HIPE coding resources); consultations with agencies from other jurisdictions with similar remits to that of the HPO in order to ascertain how they operate and are resourced; as well a study carried out in 15 hospitals that identified ICT resource deficiencies (considerable further work is required to assess ICT requirements in the full 38 hospitals operating ABF). The requirements outlined below relate to the actions covered by this Implementation Plan. Additional work will be needed to identify the resourcing implications for implementation of ABF in the non-admitted sector i.e. outpatient, community and home.

4.2 Staff Requirements in Hospitals

4.2.1 Clinical Coders

In Ireland, clinical coding of hospital activity is captured through the Hospital Inpatient Enquiry System (HIPE). Translating disease, injury, condition and procedure descriptions from hand-written patient charts into HIPE codes is a complex activity. In order to code accurately, it is vital that relevant staff have knowledge of medical terminology and understand the characteristics, phrasing and conventions of ICD-10-AM/ACHI/ACS (International Classification of Diseases 10th Revision Australian Modification/Australian Classification of Health Interventions/Australian Coding Standards).

Medical codes were originally designed to support clinical care and to provide access to information contained in medical records for research, education and administration purposes. However, medical codes are now also used to facilitate payment for health services, to determine utilisation patterns, evaluate the appropriateness of health care costs and plan for the health care needs of the country. Coding also provides the basis for epidemiological studies and research into the quality of health care. Given that coded data is used for so many purposes, it is essential that the coding process is performed correctly and consistently so that meaningful data are produced.

Timely and accurate coding of inpatient and day-case discharges on the HIPE system is a cornerstone of ABF. In recent years, the number of staff which have been responsible for coding, the "clinical coders", has reduced as a result of retirements and the transfer of staff to areas other than the HIPE function. The result has been a significant reduction in some hospitals' ability to deliver on coding targets. Additional investment is required to bring hospital coding functions back to appropriate staffing levels so that they can provide the data needed to operate the ABF Programme. The loss of staff to other functions in recent years also highlights the need for the development of a career structure for coders given the specialised nature of their work and the need for their retention.

The Irish hospital system delivers some 1.6m procedures per annum, most of which are coded from patient charts to HIPE by clinical coders in hospitals (some cases like dialysis are batch-coded). The study "*Clinical coding internationally: a comparison of the coding workforce in Australia, America, Canada and England*" recommended that coders code 6,580 charts per annum. The HPO has undertaken a review of coding best-practice across the system and determined a benchmark level of 7,000 charts per annum per clinical coder.

Currently due to the recruitment moratorium, retirements etc, there are 167 whole-time equivalent clinical coders in the 38 ABF hospitals. Based on a volume of 1,245,304 discharges in 2013 (non-batch related), coders are currently attempting to code 7,473 charts each. This has led to considerable backlogs in some hospitals.

ABF cannot operate when such backlogs exist because payments to hospitals will be made on the basis of coded cases. Using the benchmark of 7,000 charts per coder per annum, hospitals need to recruit 12 additional whole-time equivalent clinical coders in order to bring resources back to the required level such that the total number of charts in the system can be coded within 30 days.

Hospital-level additional HIPE Clinical Coders	Type	No.
HIPE function	Clinical coders	12

In addition to staff recruitment, there is also a need for continuous training of coders and the HPO offers a range of programmes on a modular basis to meet this need. The RCSI delivers anatomy and physiology modules and, additionally, the HIPE clinical coder education at the HPO has been accredited by Dublin Institute of Technology (DIT). This training may now be undertaken as part of a certified training programme for coders working within the HIPE system. It will result in those HIPE Clinical Coders who successfully complete the certification course achieving a professional Level 6 certification on the National Framework of Qualifications. The first class sat their final examination in December 2014 and a further certification course will be held in 2015.

4.2.2 Clinical Coding Managers

Given that payments to hospitals will be made based on coded data, it is essential that effective management of hospital coding functions takes place. This will include:

- Evaluating coding processes within the hospital;
- Working with clinicians on the quality of their data;
- Assessing the quality of coding compared to peer hospitals; and
- Ensuring no up-coding or unnecessary treatment to move patients into higher-paid DRGs.

The existing cohort of clinical coders are typically at Grade IV level and have limited capacity to undertake these management tasks in addition to their core work of coding. While some hospitals do have resources in addition to the clinical coders to fulfil these tasks, there is no uniformity of approach nationally and resources in some hospitals are very scarce. Feedback from clinicians has confirmed that there is a considerable gap in their interface with coders and that clinical coding managers are required in order to drive clinical involvement with HIPE, thereby improving the quality of the data.

In this context, there is a need to appoint seven senior clinical coding managers across the hospital groups. The additional staff will be carefully targeted to specific locations where gaps are known to exist and will only be allocated to hospitals which adhere to best-practice in terms of coding.

Hospital-level additional HIPE Coding Managers	Type	No.
HIPE management	Clinical coding Managers	7

4.2.3 Accountants and Data Analysts

Under the ABF system, hospitals need to have a clear picture of their costs for two key reasons: (i) to feed cost information to the HPO which is used to inform national prices for DRGs; and (ii) to understand whether their cost of delivering activity is above or below the price which is paid by the funder for that activity. As such, the development of unit-costs at hospital level is absolutely critical to the success of the ABF Programme.

In the last 3 years, pilot work has taken place with 15 hospitals to try to build costs at the patient level. During this time, the HPO has also collected hospital costs at specialty level from all 38 hospitals in the system in order to carry out price-setting at the national level. Many hospitals have struggled to make staff available to prepare specialty costs or patient-level costs due to the existing volume of regular, day-to-day work and acute staff shortages in their finance functions. For instance, one major teaching hospital has 3,500 staff but only 2 accountants. This ratio of finance professionals makes it impossible to develop business intelligence on cost data.

Without specialty and patient-level data, national prices cannot be set and hospitals are already struggling to deliver this work. Implementing ABF brings new work on top of specialty and patient-level costing. Hospitals must now change their focus and begin to assess their cost base compared to other hospitals in order to understand how they are positioned vis-à-vis national average prices for their range of work. They must engage with clinicians and determine the key cost-drivers within the hospital, show clinicians the cost impact of length-of-stay, the cost impact of moving to day-case, the cost impact of day-of-surgery-admission – thereby enabling changes which will drive value. Crucially, hospitals will be financially de-stabilised if they do not know their unit-costs as they will not be able to identify why they are making surpluses or deficits in the new funding system.

In this context, the need for accountants and financial analysts has been analysed on a hospital-by-hospital basis. This process identified the existing accountants in place, ascertained which hospitals are struggling due to a lack of staff and took into account the proposed group structure which will allow hospitals to share resources. The process identified a need for an additional 24 people in hospital finance functions for ABF. In order to contextualise this figure, it represents 0.6 whole-time equivalents per hospital within a cost base of €4.8 billion. It should be noted that all of these staff do not need to be qualified accountants and any additional staff will be carefully deployed in order to ensure the right mix of qualified accountants and analysts in the hospital groups.

Hospital-level additional accountants/IT staff	Type	No.
Introducing national patient-level costing at hospital level (unit costs)	Accountants and financial analysts	24

Another critical area in developing unit-costs is the ICT feeder systems to attach costs to patients. For example, one hospital produces 4 million laboratory tests per annum and ICT personnel are needed to extract this data and link it with patients in the costing exercises. The health ICT infrastructure includes many legacy systems from which it is not easy to extract data. The system is currently relying on goodwill in many instances to obtain vital data for costing purposes and therefore, there is a need to address these known specific gaps.

Hospital-level additional accountants/IT staff	Type	No.
ICT expertise for clinical data extraction and manipulation to feed unit costs	Data analysts	8

4.3 Staff Requirements in the Healthcare Pricing Office

As previously mentioned, the HPO was established on an administrative basis in January 2014, attached to the HSE, in advance of becoming a statutory body. It was formed by merging the HSE Casemix Unit and the ESRI's Health Research and Information Division and plays a central role in the implementation of ABF. Areas for which the HPO has responsibility include:

- Ownership and management of the HIPE dataset with appropriate data governance, compliance with HIQA guidelines, development of an oversight committee etc;
- Development of the annual price list for services;
- Development of a Data Quality Framework and a National Clinical Data Dictionary;
- On-going development of the HIPE classification system including upgrades;
- 'Structured dialogue' with clinicians in relation to the DRG system;
- Training and education of clinical coders nationally;
- Capacity for routine and interventional activity audit;
- On-going development and maintenance of costing standards;
- On-going development and maintenance of coding standards;
- Development of service classifications for non-admitted care and emergency care;
- Capacity for financial audit against costing standards;
- Specialty costing for hospital price-setting;
- Development of patient-level costing software; and
- Development of price-setting capability for non-admitted care.

The HPO will also be responsible for the management of the following external specialist reference groups:

- Clinicians and care professionals;
- Finance professionals;
- Stakeholders;
- Providers;
- Audit, risk and compliance;
- Working groups on:
    - Teaching, training & research;
    - Small hospitals;
    - Non-admitted care; outpatients, primary care, home-care;
    - Emergency care; and
    - Mental health.

The HPO is a new function and it must be resourced in order to deliver on its mandate. While drawing on the former ESRI and Casemix staff, the areas for which the HPO is responsible and the associated quantum of work required to deliver on these responsibilities is significantly expanded due to the introduction of ABF. One example where this is the case is the issue of audit. Moving to a system of payments which is based on coded activity must involve a new level of audit. Hospitals are currently audited once every 3 years but more regular audits will be crucial to the success of the ABF Programme. The need for an audit and data-quality framework was specifically highlighted in the "*State of Readiness Review*" which was carried out by Professor Ric Marshall, a recognised international expert in ABF. The HPO must also now separate their teaching and education role from their auditing role so that separate teams can have a dedicated focus on each of these important issues. To date, this has not been possible due to limited resources.

The sections below outline the identified staffing requirements for the HPO.

4.3.1 Accountants

Within the HPO, three accountants are currently responsible for the specialty costing process for 38 hospitals and patient-level costing process from 15 hospitals. These accountants maintain the national costing standards and undertake hospital audits every 3 years to ensure that no 'cost shifting' takes place and that hospital costing is undertaken in line with the standards so as to ensure comparability.

Under ABF, there is a whole new range of work which needs to be undertaken. This includes initially benchmarking hospitals against the national average prices, investigating why those hospitals are above the average and managing transition adjustments. Additionally, the HPO has tendered for software to develop patient-level costing within hospitals. This work was previously provided externally. However, as this task is so central to the operation of ABF, it is no longer appropriate for hospitals to rely on an external provider. It is also intended to expand implementation of patient-level costing from 15 to 38 hospitals. Moving beyond hospitals, there will be a need to lead major pricing work in the community setting – Nursing Home Support Scheme, disability, mental health and primary care.

In order to raise the level of auditing and to develop the national pricing system in line with the above, a total of 8 additional accountants are required.

New HPO staffing resources	Type	No.
Development of financial audit-capability	Accountants	4
National system for consolidating unit-costs into prices	Accountants	4

4.3.2 HIPE Clinical Auditors

Two staff in the HIPE team are currently responsible for both the training of coders and the auditing of coding. This position is no longer sustainable given the increased workload associated with both training and auditing and the need to separate the functions. A total of four additional staff with responsibility for clinical audit is required to deliver the appropriate level of audit.

New HPO staffing resources	Type	No.
Development of data audit-capability	HIPE clinical Auditors	4

4.3.3 HIPE Trainers

Feedback from the clinical community has highlighted their view that they see gaps in the coding of data. Experience both in Ireland and internationally shows that investment in training resources for coding pays significant clinical dividends for the system. The HPO needs to be able to transform the coding environment and raise the level of training of all coders and other clinical staff who complete charts. The DIT accreditation of coders involves significant new work for the HIPE team in terms of developing training materials, conducting and marking examinations, interaction with the external examiner etc. Given the increased workload, 3 additional HIPE trainers are required.

New HPO staffing resources	Type	No.
Enhanced training capability including upgrade to ICD10-AM version 8	HIPE trainers	3

4.3.4 Business Manager and Office Administrator

When the ESRI and Casemix teams were merged into the HPO, there was no associated administrative resource in either team. The HPO manages a national dataset of every procedure undertaken in the Irish hospital system. The Office has increasingly become aware of the importance of data governance and the need for a Data Governance Framework which will allow it to share data in line with the requirements of the Data Protection legislation. The Office also needs to develop a National Clinical Data Dictionary. ABF will require the introduction of structures to manage clinical advisory panels, stakeholder committees, data oversight committee etc. In time, the HPO will also be undertaking significant work to link clinical objectives with payments. It is intended that this work will be managed by a business manager with support from one person.

New HPO staffing resources	Type	No.
Initial Business Manager and secretariat for HPO	Administration	2

4.3.5 External Audit Capacity

Some activity audit capacity is available externally in the marketplace, which could be used where an intervention is required due to anomalies in coding. Such rapid-access audits would be additional to core HPO capacity.

4.4 ICT Requirements

This Implementation Plan has shown that accurate unit-cost data is a critical component of the ABF funding system. This applies to all areas of healthcare from hospitals to primary care and disability. Access to detailed unit-costs for services is a key enabler for clinical engagement, decision-making and behavioural change to reduce unit costs.

Ultimately, healthcare providers must know their unit-costs to understand why they are making surpluses or deficits in the new funding system. The ICT infrastructure required to develop costs at unit level is extensive. While it has not been possible to put a cost on the investments required in information and communications technology for this Plan, it is clear that a substantial level of investment will be required.

4.4.1 ICT Requirements in Hospitals

As mentioned, in the last three years, 15 hospitals have been involved in a project to determine costs at a unit level, referred to as patient-level costing (PLC). It is clear from the PLC process that hospitals are experiencing both technical and resource issues in accessing the minimum dataset to enable such costing. The minimum dataset is important because it accounts for the areas of the hospital where expenditure on patients is most intensive such as radiology, laboratories, theatres and high-cost drugs. Hospitals that have systems beyond the minimum dataset see their costings improve accordingly.

Problems which have been identified in hospitals include:

(i) Lack of feeder systems;
(ii) Lack of connectivity between systems, not interfaced, manually maintained;
(iii) Existing systems were designed for operational reasons and not producing suitable or complete datasets for PLC purposes;
(iv) Data incomplete or not available;
(v) Poor data definitions (mapping data to requested fields);
(vi) Data formatting not suitable;
(vii) Multiple data files required from individual sources with limited reporting tools to link them; and
(viii) Lack of suitable expertise leading to incomplete, cumbersome, unformatted data, time-consuming corrections and constant updates.

The first table below, Figure 8, shows for the 15[11] hospitals which took part in the pilot programme, the minimum system requirements for the development of unit-costs at the patient level. It also shows how many of the hospitals do not meet these minimum system requirements. Additionally, in some hospitals, while systems exist they are old and it is difficult to extract data at the patient level.

Figure 8: Mandatory hospital data-feeder systems requirements for unit-costs

Data Feeder Systems	Admitted	Diagnosis	Procedures	Transfers	Outpatients	Emergency	Theatre	Imaging	Pathology	High Cost Oncology Drugs
AMNCH	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Beaumont	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Cappagh	Y	Y	Y	Y	Y	N	Y	Y	Y	N
Cork UH	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Cavan	Y	Y	Y	Y	Y	Y	N	Y	Y	N
Connolly	Y	Y	Y	Y	Y	Y	N	Y	Y	N
Crumlin	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mayo	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Mater	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
MWRH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Naas	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rotunda	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
James's	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Vincent's	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Temple St.	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
WRH	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
UCHG	Y	Y	Y	Y	Y	Y	N	Y	Y	N

The second table below, Figure 9, shows for the same hospitals where additional systems exist which improve the quality of the unit-costs.

Figure 9: Additional hospital data-feeder systems available for unit-costs

Data Feeder Systems	Pharmacy to Ward Level	Pharmacy to Patient Level	Allied Health[12]	Endoscopy	Cardiology	Critical Care
AMNCH	Y	Y	Y	Y	Y	N
Beaumont	Y	N	Y	Y	N	Y
Cappagh	Y	N	Y	N	N	N
Cork UH	Y	N	N	Y	Y	N
Cavan	Y	N	N	N	N	N
Connolly	Y	N	N	Y	Y	N
Crumlin	Y	N	Y	N	N	Y
Mayo	Y	N	N	N	Y	N
Mater	Y	N	Y	Y	Y	N
MWRH	Y	N	N	Y	Y	N
Naas	Y	N	N	N	N	Y
Rotunda	Y	N	Y	N	N	N
James's	Y	N	Y	Y	N	Y
Vincent's	Y	Y	Y	Y	Y	Y
Temple St.	Y	N	Y	N	N	N
WRH	Y	N	N	N	Y	N
UCHG	Y	N	N	Y	Y	Y

[11] The pilot programme consisted of a series of PLC studies spread over 5 years. While the 17 listed hospitals participated, not all of these took part in all of the studies. Typically, 15 hospitals were involved on average over the study period.
[12] In some incidences the systems mainly capture outpatient activity.

There are four national ICT infrastructure projects currently under way targeted at acute hospitals. These will contribute towards dealing with the PLC data feeder system challenges and will need considerable resources at hospital level.

- **NIMIS** (National Integrated Medical Imaging System) in Radiology: allows for medical imaging tests to be electronically stored centrally, ensuring that patients' imaging information is available when required. NIMIS installation has been targeted at Beaumont, Mater, Crumlin, Naas, Cappagh, Cavan, Mayo, Waterford, Connolly, Cork and Tallaght hospitals. Other hospitals will follow.
- **ORMIS** (Operating Room Management Information System): aims to electronically manage patient-flows from the waiting list through theatres to recovery to facilitate a more efficient scheduling and tracking of patients. ORMIS was introduced as a pilot project in 2013 into two PLC hospitals (Temple St and the Rotunda) and work is required to align the system with patient-level costing requirements.
- **TPOT** (The Productive Operating Theatre Programme): provides a tool for improving the scheduling of operating theatre procedures. Currently 8 of the 15 PLC hospitals have no theatre system, including major sites such as Beaumont, Mater and UCHG. Five acute hospital sites have been targeted to engage with the TPOT Programme: Beaumont, CUH, Mater, Waterford and AMNCH, Tallaght. Considerable further work is required.
- **MedLIS** (National Medical Laboratory Information System): provides a standardised data system that supports the delivery of laboratory services. This project is currently in the process of selecting a vendor to provide the system.

For ABF, the most critical investment requirements in the short term are in theatre systems and systems to capture high-cost drugs. No hospital has a pharmacy system which can track drugs to individual patients and where pharmacy systems do exist, they only track drugs to ward level. The hospitals participating in the PLC project must be the starting point for investment. In order to deliver ABF in the 38 participating hospitals, a further comprehensive programme of investment is required. A proposal for a 'Patient-level Costing' system for Irish hospitals is currently under review by The Office of the Government Chief Information Officer (OGCIO). The solution required is best described as a 'data warehouse' that will receive patient-level data from hospital feeder systems. However, without the feeder systems there is no data.

4.4.2 In the Community

At community level, there are good systems in place for costing of public homes under the Nursing Home Support Scheme (NHSS) in line with legislation. Monthly financial and bed data feeds automatically from individual Community Nursing Units into an NHSS system and the cost of each bed can be calculated on a monthly basis. ABF has been in place in NHSS since 2012.

The ICT infrastructure in the Primary Care Reimbursement Service (PCRS) is also well developed. ABF is operating and costs are available at the client level for the following:

(i) Medical Cards including Hi-Tech drugs;
(ii) Long-term Illness Cards;
(iii) Drug Payment Scheme;
(iv) Dental Treatment Services Scheme;
(v) Community Ophthalmic Scheme

Apart from NHSS and PCRS, costing of services in the community is not currently taking place and there is no ICT infrastructure in place to deliver such costing. Clearly, as ABF moves into the community, further investment requirements will arise.

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Appendix 2: Membership, Roles and Terms of Reference for the ABF Oversight Group, HSE ABF Steering Group and HSE Implementation Group

ABF Oversight Group

Role: The purpose of the ABF Oversight Group (OG) is to drive and oversee implementation of an Activity-Based Funding (also known as Money Follows the Patient) system in the health service on behalf of the Minister for Health.

Terms of Reference: The terms of reference for the OG are to:

(i) Approve a Programme Plan for ABF with appropriate actions, deliverables and milestones.

(ii) Ensure that the ABF Plan is aligned with the policy principles as articulated in the ABF (MFTP) Policy Paper and the wider health reform programme.

(iii) Monitor progress relating to implementation of the Programme Plan.

(iv) Consider further policy development aimed at extending ABF beyond hospitals and driving integration in health services.

(v) Ensure that implementation of ABF dovetails with the transformation of hospital structures and the wider health reform programme.

(vi) Provide a forum for the resolution of issues arising from implementation.

Composition (at 1 January 2015):

- Fergal Lynch (Chair,DOH)
- David Smith (DoH)
- Fiona Prendergast (DoH)
- Charlie Hardy (DoH)
- Deirdre Mulholland (DoH)
- Robert Deegan (DoH)
- Tony Flynn (DoH)
- Laverne McGuinness (HSE)
- Stephen Mulvany (HSE)
- Tony O'Connell (HSE)
- Maureen Cronin (HSE)
- Maeve Raeside (HSE)
- Valerie Twomey (HSE)

HSE ABF Steering Group

Role: The Steering Group, representing key organisational stakeholders, is the principal governance group and is responsible for:

1. Ensuring the objectives of the ABF Programme are delivered.
2. Programme governance, management and control.
3. Overseeing the development of the overall Programme Plan including any business case for investment.
4. Ensuring Programme objectives are met and Programme impact/benefits are realised.
5. Ensuring the Programme's direction is consistent with overall reform priorities.
6. Monitoring and evaluating Programme implementation.
7. Ensuring key intra and inter-programme linkages and dependencies are identified and addressed.
8. Managing escalated Programme-level issues and risks.

The Steering Group determines the overall direction of the ABF Programme ensuring it is in line with the ABF Policy Paper and "*Future Health*", monitors the implementation, acts as a guide to the implementation group, approves operational policy and rules etc. The group presents periodic updates to the Department of Health ABF Oversight Group.

The ABF Steering Group is jointly led by Finance and Acute Hospitals with the Chief Operating Officer/Deputy Director General acting as Chair of the Steering Group. The Chair reports to the Director General in relation to the overall work of the ABF Programme.

Composition (at 1 January 2015):

- Laverne McGuinness (Chair)
- Tony O'Connell
- Aine Carroll
- Leo Kearns
- Philip Crowley
- Stephen Mulvany
- Maureen Cronin
- Patrick Lynch

HSE ABF Implementation Team

Role: The Implementation Team is appointed by the Steering Group to deliver on the objectives of the Programme and is responsible for:

1. Working with the HPO Executive Lead to deliver on the Programme objectives.
2. Developing the project plan.
3. Providing expertise to the project.
4. Ensuring assigned tasks are completed to the standard required.
5. Overseeing Programme disciplines concerning timeframes, budgets, quality and deliverables.

The Executive Lead in her role as Head of the Healthcare Pricing Office reports to the Chief Financial Officer (CFO) and is the key link with the Steering Group in relation to the ABF Implementation Programme.

Composition (at 1 January 2015):

- Maureen Cronin (Executive Lead)
- Patrick Lynch
- Ciaran Browne
- Angela Fitzgerald
- Maurice Power
- Tony McNamara
- Anne Dee
- Brian Donovan
- Deirdre Murphy

Appendix 3: Risk Analysis

The following section contains an analysis of the high-level risks pertaining to the implementation of Activity-Based Funding. The ABF Implementation Team has developed this analysis as part of an ongoing Programme risk identification and monitoring process. It includes:

1. The identification and classification of risks associated with ABF implementation
2. An evaluation of each in terms of impact/probability of occurrence
3. An estimation of the potential consequences should the risk occur
4. Strategies to mitigate against all risks identified

The analysis is intended to provide information for the management of the Programme to ensure that the primary risks associated with its implementation are easy to understand and communicate and risk management decisions may be prioritised. However, as an ongoing process it is recognised that the list is not exhaustive and will require periodic reflection and updating as more information comes to light over the course of the implementation process.

Identified risks have been categorised according to their nature:

Risk Categories	**Colour Coding:**
Strategic (S)	
Financial (F)	
Operational (O)	
Governance, Reputational & Compliance (G)	

The Impact and Likelihood of each risk has been estimated using the Risk Likelihood – Impact Assessment Matrix shown below:

		Impact				
		Minimal	Minor	Moderate	Major	Catastrophic
Likelihood	Certain					
	Likely					
	Possible					
	Unlikely					
	Rare					

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Strategic Risks

Risk	Cat.	Impact	Likelihood	Consequences	Mitigation Plan
ABF will not prevent hospital financial deficits and this not being understood by key stakeholders.	**S**	**Major**	**Likely**	• Perceived 'failure' of ABF to deliver financial breakeven in hospitals.	• Address volume control as part of the 'rule-set'. • Ensure robust activity management is integrated with the HSE Performance Assurance process. • Carry out a significant communication and education process with key stakeholders.
Non-availability of accountants and IT staff to develop provider unit-costs.	**S**	**Catastrophic**	**Possible**	• Without knowledge of their unit costs providers will be financially de-stabilised by the new funding system. • Lack of resources may lead to cynicism and lack of participation by hospitals.	• Recruitment of accountants with the appropriate skill-sets to manage this complex requirement. • Recruitment of IT professionals who can deliver the system infrastructure necessary for patient-level costing. • Obtain senior management support and buy-in to the requirements.
Non-availability of skilled staff to deliver high quality HIPE coding in a hospital setting.	**S**	**Catastrophic**	**Possible**	• Programme will be jeopardised by the lack of specialist skills required for HIPE coding.	• Ensure the continued involvement of those staff already specialised, utilisation of current 'specialists' to train new staff and by careful recruitment of new staff with the appropriate experience. Training of staff is critical.

Financial Risks

Risk	Cat.	Impact	Likelihood	Consequences	Mitigation Plan
Failure to invest in ICT systems to deliver clinical data and unit-cost capability.	**F**	**Major**	**Likely**	• Lack of financial data for pricing and unit costs. • Lack of clinical data for measuring outcomes.	• Provide clear statements of requirements, expression of benefits and engage at the most senior levels within the organisation and with the Department of Health to achieve delivery.
HPO receives insufficient funding to adequately address its priorities.	**F**	**Major**	**Possible**	• Poor progress in delivery of the ABF Programme.	• Ensure recognition at national level that ABF will require resources and that approval for staff and appropriate funding is provided.
Non-compliance with 'trading rules' e.g. undertaking activity above contracted limits.	**F**	**Major**	**Possible**	• Hospital will not be paid for such activity and will suffer a financial crisis.	• Careful monitoring of activity volumes as part of the Performance Assurance Process.

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Operational Risks

Risk	Cat.	Impact	Likelihood	Consequences	Mitigation Plan
Providers contest HPO 'prices' in response to deficits.	**O**	**Minor**	**Possible**	• Potential undermining of HPO prices.	• Publication of costing manuals, publication of appropriate datasets and modelling, and costing etc. which will create clarity around price-setting and validate the credibility of the process.
Providers shift costs away from areas funded under ABF.	**O**	**Major**	**Possible**	• Inaccurate price-setting by the HPO.	• Regular review of costing manuals. • Strong financial audit function.
Inappropriate early discharge or under treatment.	**O**	**Minor**	**Possible**	• Poor patient outcomes. • Risk to patient safety and possible re-admission to care system.	• Strong clinical audit function.
'Cherry-picking' of low cost clients in hospitals or community services.	**O**	**Minor**	**Possible**	• Reduction in appropriate services available to patients and clients.	• Commissioning function to monitor profiled activity against actual activity.
Fraudulent reclassification of hospital patients so that they are assigned to a higher DRG, e.g. by falsely adding secondary diagnoses.	**O**	**Minor**	**Possible**	• Provider fraudulently obtaining funding which could be used for other patient or client care.	• Appropriate legislation to make such behavior an offence. • Visibility of a strong clinical audit function. • Financial and other sanctions made clear to the delivery system.
Provision of services which lead to a reclassification of the patient/client into a higher payment category, delivery of unnecessary services or the treatment of a patient in a more expensive setting in order to attract a higher payment rate, i.e. all forms of supplier induced demand.	**O**	**Minor**	**Possible**	• Unnecessary use of public funds. • Reduction in the amount of care available for other patients/clients.	• Strong clinical audit. • Ensure monthly performance data is being reviewed from a quality perspective by clinical managers. • Strict activity limits in hospital Performance Contracts. • Structured consultation and continuous updating of the system. • Financial sanctions.

Governance, Regulation and Compliance Risks

Risk	Cat.	Impact	Likelihood	Consequences	Mitigation Plan
A shift in Government and /or healthcare policy over the course of the ABF Plan.	**G**	**Major**	**Possible**	• The policy context for ABF would change and the Programme would not have the support of key stakeholders.	• Continue to educate stakeholders on the benefits of ABF and ensure that any movements in policy are fully informed by these benefits.
Breaches of Data Protection legislation or data security.	**G**	**Major**	**Possible**	• Major public disquiet and loss of confidence in the HPO.	• Ensure staff are properly trained in data protection and that data security is continually reviewed. • Maintain regular interaction with Data Protection Commissioner. • Ensure HIQA guidelines are followed in relation to data.
Lack of "Senior behavioural commitment".	**G**	**Major**	**Possible**	• ABF does not get sufficient senior management attention due to conflicting demands.	• Continue to brief senior management on the development of the Programme, escalating issues as required and maintaining a high profile.

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