ROYAL COLLEGE OF PHYSICIANS OF IRELAND

TOWARDS 2026

A FUTURE DIRECTION FOR IRISH HEALTHCARE

SUPPLEMENTAL REPORT - APRIL 2017

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The main Towards 2026 report described the major deficits and challenges in the current health system, and included key recommendations to address those deficits and challenges at a system level. This supplemental report describes in more detail the kind of health system we should be aspiring towards in 2026.

Section A
Process, Scope and Assumptions

PROCESS

RCPI held a series of facilitated workshops with patients and healthcare experts to discuss a number of predefined critical questions on the themes of patients, hospitals and doctors in 2026.

The process began in May 2016 with an initial meeting of patients and carers to discuss their future healthcare requirements. The output of this meeting was used to guide the work of the policy forum which included a series of three workshops, each attended by approximately 50 people comprising RCPI members and Fellows, trainees, academics, nursing staff, managers and health and social care professionals comprising a broad multidisciplinary spectrum of background and experience, inclusive of both primary and secondary care. The workshops explored the future needs of patients, provision of hospital services to meet those needs, future development of services, and the role of doctors and all health and social care professionals in delivering those services. A consensus meeting was held in October 2016 to offer all participants the opportunity to review the key findings.

May 2016 — **First Patient and Carer Forum Meeting**

June -Sept 2016 — **3 Facilitated workshops on the themes 'Patients', 'Hospitals' and Doctors**

Oct 2016 — **Second Patient and Carer Meeting**

Oct 2016 — **Consensus Meeting**

Mar 2017 — **Publication of Final Report**

SCOPE AND ASSUMPTIONS

The task/remit of this forum was to develop an aspirational document describing the shared, desired characteristics of a future system of hospital care. It is hoped that some of what is identified as 'needed' would be implemented. Recommendations are pathways towards achieving this desired state and are as applicable today as they are in 2026. The scope of the forum's work was:

- *To consider future patient and population needs.*
- *To focus on acute adult hospital care.*
- *To explore what the hospital, as a critical element of the healthcare system, will look like in 2026, in the face of other health, social, economic and political changes.*
- *To consider what changes are required in the hospital setting in response to changes taking place outside the hospital setting.*
- *To consider what needs to happen outside the hospital setting without going into detail on broader system design.*
- *To look at the interfaces in and out of hospital.*
- *To explore the role of the doctor and future training requirements.*
- *This work did not include prescribing or designing models of care.*

Certain assumptions underpinned the workshop discussions:

- *The only purpose of the hospital is to serve the patient.*
- *There will be development of primary and community care services.*
- *Models of care will be developed that reflect integration across the continuum and deliver care closer to the patient's home.*
- *eHhealth will be central to the delivery of all future models of care.*
- *People are living longer; in advanced age they are more likely to need hospital care.*

Section B

Characteristics and Components of a Future Health System

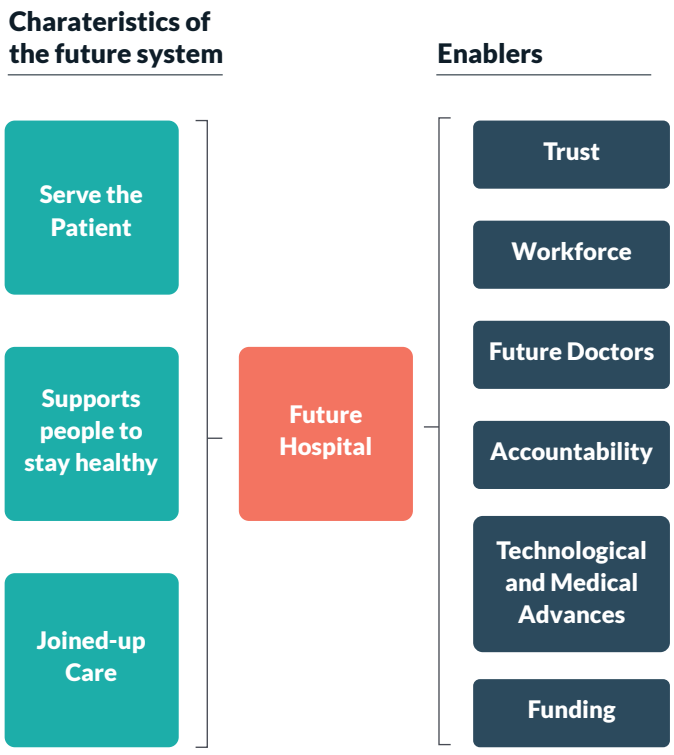
This section (illustrated by the diagram below) outlines key considerations arising from the Towards 2026 discussions which, taken together, describe **overarching characteristics** of a health system and **future hospital** that:

- *Serves the patient.*
- *Supports people to stay healthy*
- *Provides joined-up care*

Characteristics are also described and grouped in terms of various enablers that are necessary to realise this vision.

- *Trust*
- *Workforce*
- *Future Doctors*
- *Accountability*
- *Technological and Medical advances*
- *Funding*

The points captured below are the basis from which the Towards 2026 high level recommendations have been developed. (See main report)



1. KEY CHARACTERISTICS OF THE FUTURE SYSTEM

1.1 SERVE THE PATIENT

A fundamental characteristic of the future health system and future hospital will be that it is focused on serving the patient. This means the patient's voice will be a fundamental component in planning and implementation, and that peer support and a spirit of partnership will be central to the patient-doctor relationship.

People want quality care and to feel a sense of partnership with the people delivering their care. They want their voice to be heard in planning, design and implementation of the services that they and their families will use.

When considering population perspectives, serving the patient means it is necessary to acknowledge the increased number of older people who will be served by the hospital and the health system and to ensure appropriate consideration is given to their health needs. To address this and to effectively meet the needs of an older demographic, we will need to deliver more services in hospitals, in community clinic settings, in communities and in homes. It also means designing services that reflect needs of patients with specific vulnerabilities such as those with disabilities.

Our reflections during 'Towards 2026' clearly indicate that more effective use of leading technologies, and shifting from a predominantly paper-driven administrative system in our hospitals to a universal electronic system with appropriate use of smart data management, will assist in successfully and equitably rising to this challenge.

1.1.1 Design services that reflect the needs of the population

- *Holistic models of care are needed that promote good health and prevention and emphasise timely access to comprehensive assessment, early rehabilitation and co-ordinated care across the system. Particular emphasis should be placed on care for older persons and those with chronic or lifelong conditions.*
- *Future hospital and service design should reflect the needs of patients with specific*

vulnerabilities including those with disabilities, cognitive impairment or dementia, and frailty.

- *The central role of the family carer in the support of vulnerable patients will be reflected in all aspects of healthcare planning.*

1.1.2 Patient voice

- *People, patients and carers should be actively involved in healthcare services planning from the early stages through to implementation. Healthcare services should be co-designed with patients and based on the best evidence of population need.*
- *Individual patients and patient advocacy groups should be resourced to provide peer education to new and long-term patients.*
- *Patient experts should be trained to allow them to analyse, critique and improve the system.*
- *While the for-profit private insured health sector is appropriately sensitive to the perceived needs of private patients, the whole system's sensitivity to the needs of the public patient must be urgently reviewed. The voice of older, impoverished individuals with complex comorbidities, whose care is delivered almost exclusively on the public system, and encompasses the poorest level of access to hospital service, needs to be heard and reflected in the public discussion regarding healthcare transformation and system development.*

1.1.3 Patient-doctor relationship

Note: A spirit of partnership with patients will be important in any patient-healthcare professional relationship. RCPI, as a postgraduate medical training college, is particularly interested in the patient-doctor relationship.

- *Doctors should lead the way in shifting the emphasis from 'dependent patient' to an active patient-doctor partnership approach. Doctors should speak the language of their patients, informing patients of their options and motivating and facilitating them to take an active role in their own healthcare where possible. (See also section on Future Doctors)*
- *The healthcare professional with key responsibility for the patient should, in partnership with the patient, determine clear roles, goals and progress indicators, with respect to the particular needs of the patient. This will help to to clarify what the doctor can and cannot do for the patient and what the patient is responsible for themselves.*
- *Doctors, individually and collectively through professional bodies, should foster a culture of mutual respect and empathy with patients, the public, with each other and with allied disciplines; build partnerships that recognise the expertise of patients; and seek to understand and carefully address the expectations of patients and their families through active listening.*
- *Patients should be provided with the tools, especially health literacy, to support them to make decisions about their health, manage their own care and access evidence-based advice and treatment when necessary.*
- *Health care professionals should take practical steps to enable the seamless diffusion of health care information and data to patients where safe and appropriate to do so. In practical terms this means the sharing of clinical data, enhanced access to electronic medical records and sharing of this electronic medical records with the individuals to whom care is being provided. It also may mean exploring relevant new technologies or innovations such as audio recording and sharing of complex and important consultations.*
- *For the benefit of people/patients and healthcare professionals and to encourage acceptability of open disclosure among health professionals, a supportive (towards patients, families and health professionals) and blame-free environment that cultivates honest and open disclosure and learning from errors is required. This is particularly important in the context of an error or adverse event.*

There should also be awareness that responses that characterise adverse events as primarily an individual responsibility often hide the reality that many errors or adverse events involving patients are system failures and not necessarily individual errors.

- *Open disclosure should be supported through appropriate legal, institutional and regulatory support structures.*

1.2 SUPPORTING PEOPLE TO STAY HEALTHY

Keeping people well and avoiding ill-health as far as possible by modifying lifestyle and reducing health harms will have a sustained and significant focus into the future.

Health will be a core responsibility in all sectors of government and society, not only the health sector.

No health policy or strategy will be truly effective without strong and determined efforts to reduce the levels of poverty and social inequalities in this country, including inequitable access to essential health services based on ability to pay rather than medical need.

1.2.1 Focus on prevention

- *A strong foundation of primary care is required, in accordance with the Department of Health's Strategy on Primary Care. This includes the translation of relevant evidence regarding optimising and building capacity in primary care in terms of adequate numbers of GPs, practice nurses, public health nurses, community pharmacists and health and social care professionals.*
- *Learning opportunities for healthy living should be incorporated into all levels of the education system, and appropriate opportunities taken to reinforce these with public and workplace-based messaging.*
- *People and communities should be empowered to make healthy choices through the creation of healthy environments. This will require strong health-oriented public policies designed to specifically address social and health inequalities.*
- *Prevention should be prioritised in policy decisions across all sectors, government departments, local government and in all healthcare activities. Policy levers and media should be used to protect and maintain good physical and mental health through the promotion of healthy diet and physical activity and by informing people about modifiable risk factors such as drinking, smoking, obesity and lack of exercise.*
- *Evidence-based screening and vaccination programmes should be central components of a prevention-focused health system.*

1.2.2 Services provision and access

- *Everyone should have access to healthcare, including rapid ambulatory care, seven days a week.*
- *Current individual rights and entitlements regarding access and opportunities for healthcare should be clarified. Legislation may be required for appropriate needs-based access to and provision of health and social care services (emergency and elective) for all.*
- *Appropriate physical access to healthcare services and facilities for people who are frail or have a disability are essential.*
- *A transparent mechanism is required for demonstrating prioritisation of patient care (e.g. by medical need, the quality-adjusted life year measure (QALY), etc.).*
- *Healthcare services should address the multicultural needs of professionals and patients.*
- *Patients should have clear personalised care plans, regularly reviewed and modified where necessary in conjunction with a health professional to whom they are well known and with whom they can develop a long-term relationship based on access and personal care. Patients should have an identified point of contact and be given ongoing support by a team of health professionals with multidisciplinary skills.*

- *Clear and acceptable processes are needed for palliative and end-of-life care in the appropriate setting and in accordance with the patient's wishes.*

1.2.3 Education and access to information

- *All information relevant to healthcare services including eligibility, waiting lists and emergency department waiting times should be publicly available in a centralised, user-friendly format.*
- *Patients and lay people should be enabled (this may include training/education) to fully participate in governance structures to represent public and patient interests.*
- *People/patients of all ages need to be educated on the risks, uncertainties and complexities within healthcare.*
- *People/patients, their carers and families require a supportive information environment with clear signposts to relevant evidence-based health information, particularly around cost-effective preventive interventions.*
- *Self-management of health should be promoted through health literacy education and providing people/patients with easy access to:*
  - *Medical information including a full copy of their medical record in an electronic, comprehensible format.*
  - *Peer-reviewed, easy to understand health information via quality-assured websites and other knowledge-sharing technologies.*
  - *Technologies and training to help them monitor their own conditions.*

1.3 JOINED-UP CARE

The future system will provide care that is joined up from the perspective of the patient, with models of care based on population need and with clear definitions of functions across hospital, community and primary care services. Models of care will have costing and funding models built in, and will have workforce planning; quality outcomes and performance measures; and ICT system and data requirements as an integral part of their design.

All healthcare providers will need to be involved in the delivery of co-ordinated, continuous care packages across settings and disciplines to meet patients' needs. This form of people-centred care will require a high level of organisation, co-operation and time for communication. Healthcare professionals and providers will need to support each other and demonstrate a spirit of collaboration and knowledge-sharing. The role of the general practitioner as co-ordinating clinician and gatekeeping clinician to secondary-care needs to be reviewed and considered.

1.3.1 A health system designed for joined-up care

- *A strategy is required to devolve authority and responsibility for care from national to regional and local levels in a way that enables joined-up care.*
- *Joined-up care is dependent on cross-sectoral input that reflects the needs of populations, such as environment, housing and education. All strategic developments should reflect government policy that embeds this way of working. (Scotland is a good example of how this was achieved and remained independent of changes in the political system.)*
- *Strategy decisions at national level should be based on robust local and regional level population-needs assessment.*
- *Community and hospital care services distributed across a population or geographic area should be linked to create networks of excellence.*
- *The relationship between community healthcare organisations (CHOs) and hospital groups should be based on models of care and be developed according to the aims of a long-term strategy for health services.*
- *Integrated governance structures for community and hospital care should be established. While the face and infrastructure of healthcare provision will change on an ongoing basis, the core principles of bidirectional linkages and co-ordinated/*

joined-up care need to be embedded.

- *Every network of excellence should have a catchment community, required for standardising hospital services, population level planning and performance measurement.*
- *Communities should be determined on the basis of a number of factors including demography and population, clinical/patient need, disease prevalence, deprivation, available expertise, and geography (e.g. rural vs urban). They should be clearly defined but retain a degree of flexibility.*
- *All healthcare services should be planned in accordance with a defined model of care.*

1.3.2 Models of care

- *New holistic and integrated models of care should be developed, evaluated and standardised.*
- *Hospital, community and primary care services should have clear definitions of function based on models of care and local population needs.*
- *Guidelines and, where possible, protocols for the delivery of care should be developed based on the model of care.*
- *Models of care and individual patient care plans should include clear and accepted markers regarding a) level of complexity and b) level of emergency (i.e. planned or unplanned) to determine when and where a patient goes to hospital.*
- *All patients should have individual care plans.*
- *Individual care and support packages should be delivered by multidisciplinary and interdisciplinary teams where required, across community care, social care, rehabilitation services and hospitals. Special care and designated responsibility will be needed to ensure smooth patient transfers where necessary.*
- *Responsibility for the patient should be clearly assigned at each stage of the care pathway and the patient should be kept informed as an active participant in the process of transfer of care.*
- *All healthcare staff will require appropriate time for patient consultations to enable consensual decision-making.*
- *Integrated models of care as envisaged will be dependent on implementation of e-health.*

1.3.3 Interdisciplinary working

- *Where required, multidisciplinary (MDTs) and interdisciplinary teams (IDTs) working within networks of excellence should be planned and resourced. These teams will deliver care to people with complex needs, including younger and older people with acute illness and/or multi-morbidities, older people with frailty or dementia and people with mental health issues with co-morbid physical illness. A case management approach working across primary and community, acute and social care will be required to ensure early identification and treatment of problems.*
- *Teams will need strong, qualified and clearly identified leaders, a role that may be undertaken by doctors or other team members. All members of teams will require ongoing mentoring and training including access to leadership training programmes to support leadership development.*
- *Teams will be dynamic in size, depending on the specific needs of individual patients and should be given scope to innovate.*
- *The governance structures of these teams should be agreed by the team and may vary between teams.*
- *Trust, respect and open communication will be required between team members (e.g. the primary care team or teams across healthcare settings) to ensure adequate care is delivered by the most appropriate person in the most appropriate setting and thereby avoid unnecessary hospital attendance.*

2 FUTURE HOSPITAL

Hospital care today incorporates a complex mix of services, some of which should be consolidated within the hospital and some delivered in the community. Hospitals cannot be a one-stop-shop for all care services but rather are one component of the healthcare subsystem consisting of a network of providers working closely together to deliver joined-up care for patients. Throughout this exercise there was the recurrent observation that our secondary and tertiary care sectors are congested with work which should be carried out in the primary sector, which, unless addressed, will fatally compromise the ability of the secondary and tertiary care sectors to deliver.

'Hospital' as a building is no longer an appropriate concept. The vision of the hospital in 2026 is of a 'hospital without walls'. This represents a shift in thinking away from the concept of hospital as simply a place to the idea of hospital as a package of acute, specialist and emergency services available to a population, to communities, and especially to individuals with complex medical issues requiring timely and reliable specialist expertise and sophisticated therapies that should be available in the hospital setting.

Fundamentally, people will access care in the most appropriate care setting, including specialist opinion, some of which may be delivered outside the traditional acute hospital setting, perhaps using telemedicine or by electronically engaging with the general practitioner.

Some services will continue to require aggregation in a specific place. A necessary feature to ensure safety and quality in delivery of those tertiary services will be critical mass of throughput, expertise, staffing and facilities.

2.1 CHARACTERISTICS OF THE FUTURE HOSPITAL

- Hospital-based complex care should be delivered as part of the continuum of care which begins with people and patients in the community. Such hospital-based services are not to the exclusion, replacement or reduction of community-based complex care services.
- People should be able to access holistic medical assessment and treatment in the most appropriate care setting dictated by the acuity and complexity of need. This should include access to specialist opinion, the provision of which could be delivered outside of the traditional acute hospital setting, in alternative care settings in the community supported by appropriate diagnostics, treatment and rehabilitation pathways and in line with agreed models of care.
- The hospital should be understood within the context of a healthcare system managing acute and complex care across a number of interfaces through community and acute hospitals.
- All patients with complex needs should have timely access to senior doctors, meaning either general practitioners or specialists.
- Where possible, care should be provided within the community by general practice and primary and community care teams, supported by timely access to diagnostics and health and social care professionals.
- Where appropriate, hospital-based complex care should be delivered by multidisciplinary teams with timely access to diagnostics.
- Appropriate diagnostic testing should be provided as close as possible to the patient.
- Hospital-based healthcare professionals other than doctors should continue to develop expanded roles based on levels of competency, and tasks should be delegated to them accordingly. (More detail on expanded roles in Section 3.2.2)

2.2. FINANCING THE HOSPITAL OF THE FUTURE

- Funding must be based on outcomes across the continuum of care, not on discrete activities at points in time or space; and based on patient-expressed preferences as much as possible.
- Hospitals and all other healthcare settings should be financed and equipped to harness advances in medicine and technology where there is a strong evidence base. Future developments in healthcare and healthcare delivery may include personalised care based on genomic data analytics, telemedicine and use of social media, patient apps, artificial intelligence (AI), robotics, nanotechnology, therapeutic technology and new drugs and stem-cell treatment.

- Funding for ICT technologies that underpin effective joined-up care, reporting of diagnostics, governance, data sharing, data protection/security, communication and new work practices such as telemedicine should be prioritised, enabling relationships between general practitioners and specialists, as well as between patients and members of healthcare teams.
- Capital spending should be provided for hospitals to ensure that they are built and adapted in a timely way according to the best evidence on current and future population needs and hospital architecture and design. Universal design guidelines should be followed, assuring appropriate provision for vulnerable groups including frail, older people and the disabled.
- Equipment must be standardised as much as possible across the health system; functional integration of equipment must be a priority.
- Existing healthcare settings should be assessed to determine whether they are fit for purpose.

2.3. CONFIGURATION OF CARE

- Configuration of care and structures to deliver care should align with the models of care described in section 1.3.2.
- There is a need to move away from thinking of a 'centre of excellence' to thinking of a 'network of excellence' which includes a hospital alongside community, primary care, social and rehabilitation services, accessible to and serving the needs of a defined population. Within this network some functions will be centralised based on critical mass of throughput, but multiple elements comprise the 'network of excellence'.
- Detailed models of care as described in section 1.3.2 should be adopted by healthcare providers within each network of excellence.
- Community services and hospitals should be highly integrated through strong, bidirectional professional, financial relationships between community and hospital-based staff.
- Although much care can and should be devolved to community and primary care, this can only work if secondary and tertiary services are also supported. A necessary feature to ensure safety and quality in delivery of those services will be critical mass of throughput, expertise, staffing and facilities.
- The principles of critical mass must be driven by objective data and not by political or institutional agendas. We have good and practical experience in this regard in the Irish health system in the reorganisation of cancer services, where active consolidation of specialist cancer services was

aggressively and purposively conducted with marked improvement in whole population outcomes for the main cancers. This experience should be extended.

3. ENABLERS

The vision of a future system and hospital as described above requires a number of enablers to make it a reality. The enablers are described below.

3.1 TRUST

Trust between stakeholders in healthcare is an essential enabler of quality care. It will be developed by a new focus on a partnership approach in healthcare, by continuous open and informed dialogue between all stakeholders on major public health issues. Trust will also be strengthened through the adoption of a national framework for prioritisation of funding, central to which will be a set of clear principles to underpin decisions on government health spending.

Critically, an open and honest societal discussion is needed about how we should fund our health service and what decisions we need to make in order to benefit the greatest number of people and the greatest need in a fair and transparent way, mindful of the challenge of combatting stigma and prejudices associated with certain conditions. While this debate must be led primarily at political level, clinicians must play a leading role. For example, even as demand increases due to demographic pressures, there is the parallel emergence of an expectation of precision medicine, when in fact there is little evidence that this is a realisable concept in the context of the health systems we currently struggle with.

3.1.1 Partnership approach

Healthcare professionals have traditionally worked autonomously, often in professional silos. A significant cultural shift is required to create a truly collaborative workforce and working environment that benefits the whole population. Recognising and encouraging the embodiment of core values such as honesty, compassion, integrity and empathy in all healthcare professions is important, as is expressing those values in all interactions with fellow professionals and the public. A partnership approach is required in healthcare training and in the workplace to foster open communication, mutual understanding and respectful relationships between:

- *People/patients, carers, families, advocates and healthcare professionals (to support patients to take a proactive role in co-managing their own health and healthcare).*
- *All healthcare professionals (to develop interdisciplinary working and collaborative work practices).*
- *Healthcare service providers (for integrated networks of services to function effectively).*
- *All healthcare stakeholders (to develop strong health policies).*

3.1.2 Shared dialogue

Public literacy and discourse on health needs to improve to enable patients to take more control over their health and healthcare and to encourage greater participation in health advocacy and governance. Continuous open and informed dialogue is required between healthcare professionals, the public and policy-makers on major public health issues including:

- *How the public healthcare system is funded and the extent of funding, and how that money is spent.*
- *What expectations doctors and patients have of healthcare services.*
- *How the state should deal with healthcare demand.*
- *What doctors and medicine can and cannot deliver.*
- *What patients are able/unable to undertake.*
- *How services should be organised and used by people/patients.*
- *How end-of-life care should be delivered.*
- *Accountability and how a 'blame' culture can be avoided.*
- *The role of private healthcare insurance.*

Informed dialogue can be facilitated or impeded by the media. The impact of poorly informed or sensationalised media discussion on the development of optimal healthcare policies and the subsequent negative impact on patient care must be openly discussed and evaluated.

3.1.3 Healthcare spending – principles and values

- *Government expenditure on healthcare should align with and support patients' journeys through the health system.*
- *In the face of exponential growth in the demand for healthcare services, a national framework for prioritisation of funding is required along with multiannual budgets to implement that framework.*
- *A number of principles were identified which should underpin decision-making around government health spending:*
  - *Prevention-focused.*
  - *Decisions based on best evidence of population need.*
  - *Participatory, inclusive and power-sharing.*
  - *Ethics-based.*
  - *Promoting equality and social justice (greater supports for disadvantaged).*
  - *Universal and equitable in terms of access.*
  - *Transparent (especially around funding decisions).*
  - *Informed (public, media, policy-makers).*
  - *Efficient and equitable (value for money).*
  - *Long-term focused.*
  - *Delivery of most appropriate care in the most appropriate environment.*
- *The mix of public and private funding of the Irish health system needs to be discussed, agreed, or rejected by society and its politicians.*

3.1.4 Clinical leadership

- *Clinicians should be represented in all governance structures and an environment should be created whereby leadership and governance roles are seen as desirable. (See also Section 3.4. on Accountability).*
- *Roles should be created for clinician-managers, and clinical leadership education and training should be provided throughout clinicians' professional careers, starting at undergraduate level. Coaching and mentoring support should be provided for those appointed to clinical leadership roles.*
- *Clinicians should play a leadership role in guiding and informing public discussion and policy-making on major issues relating to public health (such as prioritisation of funding and the transition to a preventive healthcare model) through advocacy and collaboration with other stakeholders.*
- *The advocacy role of clinicians should include leading improvement in their work environment through identifying and promoting examples of good practice, ensuring the voice of frontline staff is heard, and advocating on behalf of patients.*
- *Clinicians should develop work practices that will improve health literacy in the general population through patient consultations and broader educational initiatives including, for example brief interventions.*

3.2 WORKFORCE

Workforce planning based on understanding and linking of healthcare demand will ensure that the workforce capacity is sufficient and appropriately skilled to meet future needs. New and expanded roles, based on international models of best practice, will be a feature of the healthcare workforce in the future, requiring new professional contracts with new definitions of roles and responsibilities.

Retention of the best staff will be improved when they are supported to fulfil these roles and responsibilities with appropriate equipment, training, structured and

flexible career pathways, and a safe, comfortable and effective physical working environment in which all staff are valued.

3.2.1. Capacity

- *Sufficient human resource capacity should be provided to meet healthcare demand based on detailed workforce planning and assessment of need, including epidemiological analysis.*
- *Integrated workforce planning should be in place to ensure sufficient numbers of staff are working in the most appropriate settings (i.e. wherever the best place is for the patient).*
- *Based on appropriate workforce planning and population need assessments, consideration must be given to the number of training places across all disciplines to ensure there is an adequate, qualified workforce to meet population need.*
- *GP training places should be increased to meet demand for primary care services.*
- *A strategy to ensure sufficient human resource capacity to meet future healthcare demand has to address the issue of retaining staff here – and particularly the current issue of post-training retention. This requires innovative short-term measures to encourage trainees to work in Ireland post-training, as well as consideration of issues such as attractiveness of posts, flexible working conditions, and a positive work environment and culture.*
- *The need to incentivise posts in certain areas or hospitals should be considered.*
- *Workforce planning needs to be aligned with models of care, (and the roles defined within those models of care) and population needs analysis.*

3.2.2 New and expanded roles

- *Work practices for all health professionals will need to radically change, and to be mapped according to the needs of patients. The demands of the new workplace should be met through developing expanded roles using international and national models of best practice, and providing all health professionals with appropriate skill-sets.*
- *Professional contracts should be modified to reflect new roles and responsibilities involved in the integrated models of care.*
- *The need to expand the roles of health and social care professionals must be examined, and changes in this regard supported.*
- *The role of the doctor should evolve as other new roles emerge. Appropriate responsibilities should be assumed by the most appropriate healthcare professional.*
- *GPs should be enabled and resourced to effectively handle increasingly complex cases such as patients with multiple chronic diseases, and to meet increasing demand.*
- *There is a particular need to focus on the development of a healthcare workforce that meets the needs of an ageing population as well as people with complex needs across all care settings.*
- *Tasks should diffuse down to the lowest levels of cost and complexity on a system-wide basis.*
- *There must be a focus in health workforce planning on developing a next generation of health service managers who can provide strong leadership and direction for services, staff and systems within the health services.*

3.2.3 Supports for health care professionals (HCPs)

- *All healthcare professionals should have lifelong/career-long training and educational opportunities to allow them to continuously acquire new skills, particularly in the light of evolving models of care, new technology and changing societal need.*
- *Mentoring, coaching and support should be provided to healthcare professionals throughout their careers.*
- *Supports are needed to ensure and improve staff wellbeing and morale. The health sector's*

greatest asset is its people, and this should be reflected in all policies that affect them and their working environment. Workplaces should foster a philosophy of 'joy in work' and healthcare systems should take the lead in improving their own employee health and wellbeing.

- *The built environment should support safe, comfortable and effective working (e.g. on-call rooms, sleeping accommodation, and recreational and educational areas).*
- *All healthcare professionals should be adequately inducted and supported to work in newly reformed services.*
- *All healthcare professionals should have access to and be trained in the use of equipment and technology that is fit-for-purpose and that is maintained and updated in light of technological advances.*
- *Career pathways and structures should allow flexibility at different stages of the career path. This includes flexible working-time arrangements and opportunities for development of a variety of career paths, including pursuit of multiple areas of interest and development of skills across a range of fields, including opportunities for career development in research and medical education.*

3.3 FUTURE DOCTORS

The future doctor will be expected to demonstrate values, skills and competencies that support the delivery of evidence-based medicine within the context of a patient-doctor relationship based on a sense of true partnership. Greater interdisciplinary collaboration and working across different settings will also be required.

In addition to clinical competence, which is fundamental, doctors will need to have systems knowledge and understanding of how care can be provided in a systemised, joined-up way. For example, costing, outcome measures and policy all affect how care is delivered, and should form part of the doctor's core competencies. Management and leadership should be seen as career tracks that are as valid as education, research and clinical excellence.

Training curricula should be developed accordingly to prepare medical trainees for these future roles. A key feature of training in the future will be cross-skilling between settings and early exposure to interdisciplinary working. Life-long learning for all medical personnel will also be a very desirable goal both in keeping up to date with current thinking and treatments but also to keep them enthused for the profession they chose.

***Note:** Planning for a quality healthcare system that responds appropriately to the needs of the population requires consideration of the competencies, skills and training needed by a range of healthcare professionals. RCPI, as a postgraduate medical training college, needs specifically to consider the skills competencies and training required to equip doctors to work effectively for this future healthcare system. RCPI is thus focused on the medical specialities under its training remit, but many of the points here may be applicable to all doctors.*

3.3.1 Values

- *Doctors should be caring, compassionate, empathic, ethical, resilient, respectful, open and transparent, committed, and show integrity.*
- *The importance, function and value of prevention and primary care should be explained and promoted to doctors, health and social care professionals and patients.*

- *To develop a dynamic learning system, doctors should be open to knowledge-sharing and to continuously improving individual and collaborative work practices.*
- *Developing competencies should be part of a wider culture of quality improvement.*
- *The development of reflective practice is very important, including sensitivity to conflicts of interest, financial and non-financial, which may impinge on the integrity of the health and hospital systems.*

3.3.2 Core skills and competencies

- *Clinical competence will continue to be fundamental to the role of the doctor in the future.*
- *Doctors will require an ability to critically appraise the evidence base and skills to disseminate that information.*
- *Doctors need to have strong interpersonal skills. Communications skills are essential, including through electronic means, advocacy and media communication skills.*
- *Integrated care and the development of interdisciplinary working means a greater proportion of the doctor's role and time will involve collaboration, partnership and teamwork. The doctor needs to be confident as a team leader. A good understanding of roles across health and social care as well as a sound knowledge of the structures of health services will be required by all health professionals.*
- *Doctors will need to have systems knowledge and understanding of how care can be provided in a systemised, joined-up way. For example, an understanding of costings, outcome measures, and policy all affect how care is delivered, and should form part of the doctor's core competencies.*
- *Doctors should be cognisant of the cost and value of different types of care to patients and to healthcare providers, and should be able to use that knowledge to make rational decisions around appropriateness of care.*
- *Doctors require ICT literacy and e-health technologies to deliver better care. This includes skills in data analytics and informatics to co-design and develop ICT infrastructure and tools to support eHealth.*
- *Doctors need skills to analyse and interpret population level data and inform decision-making around funding and services design.*
- *Doctors need to understand genomics and the roles of personalised medicine and screening.*
- *Many doctors may be required to work in multiple settings in the community and in hospitals.*
- *In order for doctors to become effective in these elements of their career, they will require protected time away from interaction with patients. This must be recognised and reflected in working arrangements and personnel planning, so that they are available for multidisciplinary collaboration, research, delivering and engaging in educational activities, and engaging with the management process.*

3.3.3 Leadership positions

- *Doctors who seek leadership roles will require skills and training in strategy, innovation, quality improvement, health services, communications and health economics.*
- *Some doctors will need skills in operations management.*
- *Roles and opportunities for doctors in research and education should continue to be supported.*

3.3.4 The training experience

- *Training is fundamental and should take place in various settings, in hospitals and in the community, with a degree of cross-skilling between both. This should begin at undergraduate level, where training should reflect models of care, but should extend into basic and advanced specialty training across specialities, and between primary and secondary care.*

- *There must be dedicated/protected time for training for both trainer and trainee, as this is a key function of a hospital. This must be recognised by all stakeholders.*
- *The ratio of trainers to trainees should be increased.*
- *Training must be quality-assured.*
- *Training pathways and structures should allow flexibility to meet evolving trainee needs, including recognition of existing qualifications and experience, flexible work arrangements and out-of-programme options for preparation for non-clinical aspects of careers (including fast-track training and transfer between specialities).*
- *Trainee assessment should include outcome-based reflection, and peer, supervisor and self-appraisal.*
- *Trainees should have the opportunity to spend time in community and primary care practice and with ambulatory care centres with GPs, particularly within specialties that are developing a community focus.*

3.3.5 Training curricula

- *Medical training curricula should be fluid, dynamic and responsive to change. There should be close engagement between services and training bodies so that experience in services can influence the curriculum.*
- *Medical training should continue to set standards and be embedded into service planning and provision.*
- *Teamwork and co-operation should be strengthened through early (as students) exposure to interdisciplinary working and shared learning opportunities. Education and training bodies should provide joint or inter-professional training and should facilitate interaction between professions.*
- *Education and training bodies should provide training in clinical leadership*
- *Training should reflect new technologies in medicine, ICT and diagnostics and healthcare models, and some doctors should be equipped to lead those advances.*
- *Training should incorporate new evidence in medicine and population health, and provide trainees with the skills to critically appraise new research.*
- *Skills and competencies that come under the 'professionalism' heading should be taught at all levels of education and training.*
- *Trainees should have input into the development of curricula (e.g. providing feedback on training modules).*
- *The public/patient voice should be included in trainee curricula.*
- *Different training streams should be provided to meet population healthcare needs – ICT, research, systems planning, advocacy, financial management, etc.*
- *Doctors should be trained to deliver consultations online for specific areas but not as an alternative to person-to-person consultation.*
- *Trainees should have grounding in gerontology and chronic disease to meet the needs of an ageing population, and continuous professional development should address the issues involved in dealing with an ageing population.*
- *Training and professional development is needed around quality improvement and safety (patient and system safety).*
- *Research will be an important component of postgraduate and lifelong training*

3.4 ACCOUNTABILITY

Accountability can be achieved through an appropriate governance framework for healthcare delivery. The purpose of the governance framework will be to ensure patients receive the care they need. The framework should enable delivery of this care at each level of the system, clarifying who is responsible for what, providing authority and capabilities for delivery on responsibilities, using meaningful measures to determine whether desired outcomes are being achieved, and acting on these measures in a timely and effective way.

Instituting a no-blame culture is a challenge for healthcare systems around the world: every safe industry has transgressions that are firing offences, and it is challenging to balance a no-blame culture with accountability.

3.4.1 Characteristics of the governance framework

- *National standards of care, appropriately resourced for implementation, should be agreed with patients, the public and health professionals. These should be couched in practical rather than purely aspirational terms.*
- *A clear accountability framework should be developed, reflecting the new roles and responsibilities of healthcare providers (including models of care and multidisciplinary teams).*
- *Effective and confidential enquiry, complaint, and feedback structures and processes should be established, including clear communications processes for dealing rapidly with serious adverse events.*
- *Governance structures should include multidisciplinary representation at all levels including patients and frontline staff, and should operate across the primary/secondary care interface.*
- *The governance frameworks should enable patient risk assessment and management, open disclosure and a culture of learning both from adverse events and when things go well.*
- *The governance framework should support a system-wide culture of continuous quality improvement (CQI).*
- *Management structures for networks of excellence should enable the governance framework.*
- *The framework should include consideration of shared care and care transfer (e.g. from GP to specialist and vice versa).*

3.4.2 Healthcare professionals and governance

- *A greater understanding of governance is required among healthcare professionals and patients. Clinicians and other healthcare professionals have an important role to play in governance structures and should be supported in that role.*
- *Governance structures should ensure system and individual accountability through matching responsibilities with equivalent levels of authority throughout the system.*
- *A culture of shared responsibility is needed to support and encourage staff to fully understand and assume responsibility for their individual roles.*
- *Roles and responsibilities should be clearly defined, and healthcare professionals enabled through appropriate training, equipment and resources, with a reporting system for each aspect of care.*
- *Involvement in governance by healthcare professionals should be recognised, facilitated and actively encouraged, including through the allocation of protected time.*
- *Healthcare providers should be given resources to develop structures that support good governance, such as audit, risk registers, risk committees, complaints management, performance measurement, quality improvement, and ICT.*
- *Governance should be an integral part of clinical and healthcare training and practice.*
- *Collaboration is needed with regulators to help provide and reinforce good governance and to avoid mixed messaging*

3.4.3 Performance data and measurement

- *Performance data and measurement should be meaningful to patients, healthcare professionals and boards of management. Measurement should include safety and quality, and should be focused as much as possible on patient outcomes, and not process.*
- *An example of modern health informatics in the Irish setting with detailed feedback to clinical teams is the National Quality Assurance Intelligence System (NQAIS) family of applications, developed jointly by the Royal Colleges and HSE Health Intelligence and ICT.*

- *Patient satisfaction surveys and other agreed mechanisms for integrating and understanding patient expectation and experience should be used.*
- *Governance structures should ensure results are acted upon in a timely way that benefits patients, healthcare professionals and healthcare providers.*
- *Healthcare professionals at management level should be trained to incorporate audit, and to use performance data management tools.*
- *There should be a system under the clinical governance structure for assuring practice standards. Failure to meet practice standards would trigger a well-defined process to protect patients with remediation where possible.*
- *Peer review and appraisal should form part of performance measurement processes.*

3.5 TECHNOLOGICAL AND MEDICAL ADVANCES

Healthcare policies should use research evidence and data to make clear connections between population-level needs assessment and frontline planning decisions. Policies should set out realistic, achievable goals, and should be resourced and implemented in a timely way steered objectively utilising shared real-time, automated de-identified data collection, derived from all relevant clinical services.

Prevention of ill-health, rapid deployment of information technology commensurate with most other sectors in the Irish economy, and a focus on health inequalities should be prioritised within policy development and implementation. There are substantial gains to be realised from investing in these areas.

3.5.1 Policy development

- *A shared vision and long-term strategic plan for healthcare services is essential.*
- *Political consensus on both the immediate and longer-term development of the healthcare system should be achieved to allow for adequate planning and investment.*
- *All health system policies and strategies should set out realistic and achievable goals for healthcare services with clear, identified lines of accountability.*
- *As far as possible, goals should be communicated in both practical and aspirational terms, and not restricted to the latter.*
- *Health policies should be resourced and implemented in an effective and timely way, to address the current gap/disconnect between policy and implementation.*
- *Policies should only be adopted on condition of scheduled reviews with public and stakeholder feedback on progress.*
- *Information and education should be made available to the public on how decisions are made.*
- *Healthcare professionals should lead and influence in the public debate on healthcare policy.*

3.5.2 Research, data collection and analysis

- *Performance data and information should be collected, analysed and made available to facilitate rigorous population-based health planning.*
- *There should be clear connectivity between learning from the frontline and planning decisions. Health and healthcare system planning should be based on population-level needs assessment and focused primarily on prevention and health promotion, with appropriate focus on inequalities.*
- *An evidence base for effective preventive measures to support policy decisions should be developed.*
- *Links should be created between academic research and policy development to strengthen population health planning based on accurate predictions of future capacity needs.*
- *Government policy should prioritise funding of population-based research to facilitate these aims.*

3.5.3 ICT, advances in medicine and other technologies

- *Advances in ICT should be harnessed to develop tools that support patients and healthcare providers in the provision of joined-up care.*
- *The national eHealth strategy should continue to be funded and implemented. eHealth including individual health identifier is a critical enabler of person centred and evidence-based care across settings.*
- *Where cost-effective and beneficial, new medicines and technologies should be provided in a timely manner and through a transparent funding system to improve population outcomes.*

3.6 HEALTH SYSTEM FUNDING

- Sustained investment consistent with the plan outlined in this document should be provided and backed by legislation. Funding should be allocated in a way that incentivises the achievement of the desired outcomes, in particular joined-up care and prevention/early intervention.
- A detailed long-term strategy and implementation plan for change and transition in health services should be costed and adequately resourced, financially and otherwise.
- A long-term capital plan is required for hospitals and communities that includes investment in new equipment and ongoing replacement and maintenance.
- Multiannual budgeting for health is required.
- Appropriate funding for social services and supports is required.

Section C

Evidence and Examples of Good Practice

During the Towards 2026 workshops, participants were asked to provide national and international examples of good practice from their personal experience and from the literature on a range of themes. This appendix is a summary of evidence and references collated. This list is more anecdotal than scientific but includes some useful examples of positive developments that may signal a way forward for our healthcare system.

1. *Integrated Care.*
2. *Prevention*
3. *Goverance*
4. *Clinical Leadership*
5. *The Role of Primary Care*
6. *Co-designing health services*
7. *Open Disclosure and Professionalism*
8. *Expanded roles and advanced practice within the health and social care professions*
9. *Ambulatory Emergency Care*
10. *Multidisciplinary Medical Assessment*

1. INTEGRATED CARE

Scotland offers a good model of devolved authority and integrated health and social care backed by legislation.

Under new legislation which came into effect in 2016, the Scottish NHS and local council care services have been brought together to create local partnerships to manage almost £8 billion of health and social care resources[i]. The National Health and Wellbeing Outcomes Framework is the strategic framework for the planning and delivery of integrated health and social care services. It ensures Health Boards, Local Authorities and Integration Authorities are clear about their shared priorities and provides a mechanism by which Scottish Ministers can bring together the performance management mechanisms for health and social care. These reforms are intended to address the issues of delayed discharge and unplanned admissions in the over 75s by ensuring joint responsibility between health and social care for moving patients between hospital and care settings in as seamless a way as possible. They also ensure all health and social care professionals work together to support patients in the community and avoid unnecessary readmission to hospital.[ii]

Southcentral Foundation's 'Nuka System of Care' in Alaska is held up as an exemplary model of integrated care which was achieved through intentional whole health system redesign.

Southcentral is a state-funded health system (a large proportion of its resources come from taxation) serving more than 60,000 Alaska Native and American Indian people. The health care system was created and is entirely managed and owned by Alaska Native people to achieve their own identified health goals of physical, mental, emotional and spiritual wellness. In response to strong local advocacy for a voice in health programme planning and service delivery, Congress passed a federal law in the 1970's in favour of self-determination which meant that Alaska Native people were no longer mere recipients of health services but had ownership of decision-making and administration. What followed was a transformation from a heavily bureaucratic system with long waiting times, low staff morale and a lack of innovation to a participative, holistic and efficient service that is now regarded as one of the most successful examples of health system redesign in the United States and internationally. Case-studies show how this was a 'customer-driven' transformation of healthcare delivery, philosophy and values rather than a response to top-down performance management, competition or financial incentives.[iii]

The **Integrated Care Programme for Older Persons (ICPOP)**, with the **National Clinical Programme for Older Persons** is leading the way for integrated care in Ireland. It has developed a 10-step Integrated Care Framework which may be adapted by other integrated care programmes.[iv]

Links on cost-effectiveness of integrated healthcare

http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/eurohealth/Eurohealth_volume_19_issue_2.pdf

http://www.euro.who.int/__data/assets/pdf_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf

2. PREVENTION

The WHO's Alma Ata Declaration on Primary Health Care (1978) states that health protection is essential to sustained economic and social development and contributes to a better quality of life; that it involves all related sectors and aspects of national and community development, including health, food, industry, education, housing, public works, communications; and demands the coordinated efforts of all those and other sectors. Recent trends reinforce the case for prevention: the Organisation for Economic Co-operation and Development (OECD) predicts that without reorienting health services towards prevention and primary care, the cost of healthcare in the region will double by 2050, potentially overwhelming systems.[v]

A wide range of preventive approaches have been shown to be cost-effective in both the short and longer term, including interventions that address environmental and social determinants of health, build resilience and promote healthy behaviours. **The WHO's evidence-based "best buy" interventions for chronic diseases**, deemed to be highly cost-effective, meaning they generate better outcomes than the next best alternative use of resources, include tobacco and alcohol legislation and increasing physical activity.[vi] It recommends interventions such as promoting walking and cycling, green spaces, safer transport and housing interventions which are shown to have early returns on investment, with additional social and environmental benefits. A UK study on the cost-effectiveness of public health interventions (n. 200 including smoking and alcohol prevention and physical activity), produced to inform NICE guidelines, showed that the vast majority are highly cost-effective and in most cases well below the NICE threshold of £20,000 per Quality-Adjusted Life Year (QALY).[vii]

There is increasing evidence that a **tax on sugar sweetened beverages** which has been introduced in a number of US cities, could reduce healthcare expenditure and increase healthy life expectancy particularly if tax revenue is ring-fenced for health promotion and subsidising healthier options.[viii] Research suggests that **Minimum Unit Pricing (MUP)** in Ireland would be effective in reducing alcohol consumption, alcohol-related harms (including alcohol-related deaths, hospitalisations, crimes and workplace absences) and the costs associated with those harms.[ix] Less than 2% of Ireland's health budget for 2016 was allocated for health and wellbeing[x] indicating scope for increases in investment in cost-effective public health and prevention measures.

3. GOVERNANCE

Inquiries by HIQA and the HSE into safety, quality and standards of services at various hospitals after serious adverse incidents in recent years have highlighted many examples of poor governance. In its Report of the Quality and Safety Clinical Governance Development Initiative [xi], the HSE states that "the integration of corporate and clinical governance is of utmost importance for all health system changes." There are signs that the HSE and some healthcare providers are moving in the right direction in terms of establishing robust and participative governance structures. **'Board on board'** is a joint initiative between the Quality Improvement Division in the HSE and the Mater Misericordiae University Hospital to equip the Board of the Mater with practical tools and skills to assume greater responsibility for, and strengthen its impact on, the hospital's quality performance.[xii] A set of interventions has been developed and trialled with the result that Board members have a better understanding of quality clinical care indicators; scheduling of quality of care discussions in the routine Board agenda have been extended; and a mechanism for assessing the quality of frontline clinical care at the hospital has been developed. These measures will help Board Members to act to hold the hospital accountable on the quality of clinical care delivered.

The **HSE's** 'Community Healthcare Organisations – *Report and Recommendations of the Integrated Service Area Review Group' (2014)*[xiii] provides a **framework for new governance and organisational structures to improve service delivery at local level.** It examines international models of good clinical governance in Scotland, England, Australia, New Zealand and in the area of mental health in Canada and

identifies key features which could be introduced in Ireland. Unfortunately the issue of formal governance of both CHOs and hospital groups and the overall HSE, remains to be clarified.

4. CLINICAL LEADERSHIP

There is a growing body of literature on the **key role of clinical leadership in highly ranked healthcare organisations** which are shown to have more effective management practices[xiv] and better patient outcomes[xv]. Strong clinical leadership includes having a sufficient number of clinically qualified managers and clinical participation in board level management. A review of physician leadership in three of the US's largest integrated healthcare delivery systems[xvi] advocates for a true partnership approach between physicians and professional administrators where both parties share the same goals and objectives. The review also recommends that all leaders have a clear understanding of system challenges, a realistic view of the national healthcare reality, and a coherent, proactive, and rigorous implementation plan.

A study by the King's Fund looked at **clinical leadership in the context of broader healthcare system change**[xvii], stating that knowledge about health system improvement needs to be integrated with clinical expertise. It showed that many organisations had difficulties developing skills for improving care and creating environments in which doctors 'own' improvement. Implementing changes means recruiting and developing clinical leaders, providing appropriate leadership training at every level and embedding it in medical school[xviii]. The King's Fund study identified a number of examples of strong clinical practice:

1. At **Intermountain Healthcare (US)** where doctors working as medical directors take key leadership roles in each clinical programme and work with frontline clinical staff to identify issues in the implementation of clinical process management, set clinical goals, and hold clinical teams accountable for performance.
2. At **Jönköping County Council (Sweden)** where doctors play key roles in the redesign of services and the integration of care across the continuum in paediatrics and older persons' health services.
3. At **Birmingham East and North Primary Care Trust and Heart of England Foundation Trust** where doctors hold major leadership roles in the trusts and have responsibility for funding allocation.

It has been highlighted that the expanded paradigm of physician leadership can only be achieved within integrated systems of care resourced to improve outcomes at a population level.[xvi] An interesting example of innovation in healthcare delivery that can be led by clinicians is the **Innovation Advisors Programme run by the US Centre for Medicare & Medicaid Innovation** in which trained leaders test new delivery models in their organizations and communities.[xix]

The Joint HSE/Colleges National Clinical Programmes are a strong example of innovation using clinical leadership in the Irish health system.

5. THE ROLE OF PRIMARY CARE

There is growing evidence that health systems with a strong primary care level appear to be better able to control costs and have better health outcomes.[xx] Recent evidence shows an association between strong primary care and better population health, lower rates of unnecessary hospitalisations and relatively lower socioeconomic inequality.[xxi]

It is increasingly recognised that primary care systems should play a key role in systematic prevention and chronic disease management though this has not yet been realised in most countries. In countries with strong primary care, one of the most consistent policy characteristics is the governments' attempts to distribute resources equitably[xxii] thereby reducing health inequalities. Compared with other European countries, Ireland scores poorly on **primary care governance and economic conditions for primary care** (i.e. health expenditure spent on primary care and financial conditions for access to care for patients), while countries which score well include the Netherlands, Spain and the United Kingdom. [xxii] Ireland is one of only three European countries without quality assurance evidence-based clinical guidelines for GPs.

6. CO-DESIGNING HEALTH SERVICES

Let's Talk About [xxiii] is a cross-border initiative undertaken by the All Ireland Institute of Hospice and Palliative Care (AIIHPC) involving users, carers and communities in the development and delivery of palliative care. Survey respondents were asked to share stories of personal experience of living with or having a life-limiting condition. These narratives will be used to inform palliative care practice and policy development across the island of Ireland and to ultimately improve the experience of palliative and end-of-life care.

A promising example of how patients can be fully involved in healthcare services planning is **Experience-based Co-design (EBCD)**[xxiv] which was introduced into the NHS in 2005 and has since been adapted to different types of healthcare services at local and national level. Drawing inspiration from disciplines including architecture and software engineering, this design theory aims to improve patient experience and staff wellbeing and address issues of quality and safety by bringing users and providers together in a face-to- face collaborative venture. The focus is on co-designing experiences rather than systems or processes with users involved at every step from need analysis to implementation and evaluation. [xxv]

The **Institute for Healthcare Improvement's (IHI) Triple Aim approach**[xxvi] takes a slightly different approach to co-design. Triple Aim is a set of strategic organising principles for organisations and systems to simultaneously improve individual care, improve population health and reduce per capita costs of healthcare. It starts with a focus on 'quality' as defined by individuals, families and care-givers, and then uses those perspectives as a source of insight for populations.

7. OPEN DISCLOSURE AND PROFESSIONALISM

Ireland has a very high level of medical litigation compared to other European countries.[xxvii] There is insufficient evidence to fully explain this, however, our 'stressed' health system and absence of open disclosure have likely played a role. Recent evidence from the US shows that medical error is the third leading cause of death[xxviii] while the first study of **adverse events in Ireland** reports similar rates to other countries.[xxix] A lack of public understanding about the dangers associated with healthcare have contributed to an adversarial approach when medical error arises which serves neither patients nor doctors well.

Plans to introduce mandatory open disclosure in Ireland were stalled in early 2016 due to fears of litigation, loss of reputation and loss of work among medical practitioners. Countries who have open disclosure programmes in place include Australia, Canada, US and UK. The **HSE's Evaluation of the National Open Disclosure Pilot**[xxx] references the most recent review of the Australian Open Disclosure Standard which suggests that disclosure is more effective as an ethical practice that prioritises organisational and individual learning from error than solely as an organisational risk management strategy[xxxi] It also found that open disclosure has created significant benefits for the health system and patients by fostering cultures of openness and trust.

The Medical Council has recently published the eighth edition of its **Guide to Professional Conduct and Ethics for Registered Medical Practitioners**[xxxii] which identifies three 'pillars of professionalism' – partnership, practice and performance. **CanMEDS**[xxxiii], which is recognised as the most widely accepted and applied physician competency framework in the world, provides a comprehensive definition of the competencies needed for all domains of medical practice. It is not expected that a single doctor will have all of the competencies outlined, however, it does underscore the evolving nature of the doctor's role.

8. EXPANDED ROLES AND ADVANCED PRACTICE WITHIN THE HEALTH AND SOCIAL CARE PROFESSIONS

***Information submitted to Towards 2026 by the Health and Social Care Professions Alliance**

The Health and Social Care Professions Alliance represents 11 health and social care professions in Ireland.[xxxiv] Health and Social Care Professionals (HSCPs) employed by the HSE in 2015 totalled 13 639, constituting 14% of the workforce. It is estimated that there are upwards of 30,000 HSCPs working in Ireland currently. This group of professionals provide a valuable resource in the current and future healthcare context in Ireland. Each HSCP has the skills to assess, diagnose, treat and discharge within each individual profession's scope.

There are numerous documents outlining the roles of HSCP advanced practitioners internationally, particularly from the United Kingdom[xxxv], Canada[xxxvi], Australia and North America. Most of these reports are applicable across many professions and cover broad areas such as independent prescribing rights, first contact practitioners and HSCP-

led clinics/tasks. The Nuffield Trust in the UK recently published a report on reshaping the workforce through extended roles and advanced practice roles for nursing and health and social care professionals.[xxxvii] This reinforces a recommendation by HIQA, arising from its investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital/National Children's Hospital (AMNCH)[xxxviii], that current and future potential for expanded roles for nursing and allied health professionals be reviewed. In September 2016 the HSE published a Development Framework Supporting Nursing Practice Skills and Competencies in Acute Medical Assessment Units (AMAUs) and Medical Assessment Units (MAUs)[xxxix]

9. AMBULATORY EMERGENCY CARE

The Royal College of Physicians (RCP) London published **a toolkit for ambulatory emergency** care (AEC) in 2014[xi]. AEC is described as a 'streamlined way of managing patients presenting to hospital who would traditionally be admitted' and is being gradually developed and implemented by clinical teams across England in response to the widespread problem of emergency department (ED) overcrowding. Once suitable patients are identified among those presenting to hospital for admission, AEC means they are rapidly assessed in order to be diagnosed and treated on the same day. The toolkit highlights that in order to implement AEC effectively, a whole-system approach is required where primary care and community and ambulance services work with the acute site to develop patient pathways. Clinical teams have reported converting 20–30% of emergency admissions to AEC thereby reducing the numbers requiring full admission. Learnings from this approach include the important role of advanced nurse practitioners who are autonomously managing approximately 30% of AEC clinical scenarios (where the nurse has acquired the appropriate further education and training to undertake this role). Also, the range of patients presenting to AEC indicate a requirement for clinicians with good generalist skills. It is anticipated that emerging technologies for physiological monitoring and drug delivery will offer more options for treating patients through an AEC approach.

10. MULTIDISCIPLINARY MEDICAL ASSESSMENT

The successful implementation of the electronic health record (EHR) and delivery of integrated care will depend on the development of a common language or standardisation of relevant clinical data across care settings and professions.[xii] InterRAI is a single assessment tool (SAT) designed to enable different professionals to identify and respond to the complex care needs of patients (e.g. of older people with multimorbidities across care settings). **InterRAI** has been piloted by the Department of Health and the HSE to enable multiple agencies to work together to provide effective, co-ordinated, cost-effective quality care for older people with complex health and social needs. Following a successful evaluation, InterRAI, is in the early stages of implementation with a focus on older people with more complex needs.[xiii]

OTHER EVIDENCE / EXAMPLES OF GOOD PRACTICE:

Theme	Example of Good Practice / Evidence
Partnership Model to enable joined up care	Carlow Kilkenny Model
Centralisation of services for specific diseases	Cancer Services Reconfiguration
Quality Improvement	Evidence-based Practice for Improving Quality (EPIQ), Dr Shoo Lee, Canada - http://www.epiq.ca/ (Dr Lee presented at the HRB30 Conference in Dublin Castle on 30th Nov 2016). The HSE and RCPI have developed a one-year diploma in a joint partnership to build quality improvement capacity and capability in the Irish healthcare system.
Health Information and Patient Safety Legislation	Health Information and Patient Safety Bill 2015 http://health.gov.ie/wp-content/uploads/2015/11/Revised-General-Scheme-HIPS-Bill.pdf
Regulation of private healthcare providers	New bill introduced in Scotland - http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare.aspx
Doctor-Patient communication	Evidence-based training of health professionals on how to communicate with families.[xiii]
Assisted Decision Making	Assisted Decision Making: The Decision Making (Capacity) Act 2015, is particularly important for individuals with intellectual disability or mental illness. Certain parts of the act have been signed into law, however, others are still outstanding. The Assisted Decision-Making (Capacity) Act 2015 provides a statutory framework for individuals to make legally-binding agreements to be assisted and supported in making decisions about their welfare and their property and affairs.[xiv]
Interdisciplinary teams	In France a national plan has been successful in increasing the number of group practices and multidisciplinary “maisons de santé” in primary care. The plan has also counteracted threatening shortages in underserved areas.[xxii]
Population level planning	HSE Health Intelligence Unit & Health Atlas
Enabling Communities	In the UK in 2013, public health functions and staff were transferred from the NHS to a new body called Public Health England and to local authorities. These significant reforms involved local Councils taking a leading role in health improvement and health protection as well as providing public health advice to NHS commissioners. As part of this process, specialist public health staff were transferred into local government.[xiv]

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Section D
Glossary

Adverse events
An undesired patient outcome that may or may not be the result of an error.

Big data
High-volume, high-velocity and/or high-variety information assets that demand cost-effective, innovative forms of information processing that enable enhanced insight, decision-making, and process automation.

Capacity
1) Decision-making: the ability of healthcare recipients to make their own healthcare decisions, especially where decisions to consent to or refuse treatment are concerned.
2) Healthcare resources: human resources (staff) and facility infrastructure (hospital beds, residential care facilities, etc.).

Clinical audit
A clinically led, quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria, and to act to improve care when standards are not met.

Clinical governance
A system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical Leadership
All clinicians can contribute to leadership where and when their expertise and qualities are relevant and appropriate. Not everyone is necessarily a leader, but everyone can contribute to the leadership process. This model of leadership is often described as shared or distributed leadership.

Community and primary care
All of the healthcare services provided in the community outside the hospital setting, including GPs, primary care centres, public health nurses and a range of other services.

Compliance
The adherence of a particular organisation to statutes or mandates from regulatory agencies -- governing agencies or bodies— or to an official mandate or obligatory standard.

Community healthcare organisation (CHO)
Nine community healthcare organisations have been set up to govern and manage the delivery of community healthcare services at local level. They will enable and support integrated care within the community services, between the community and acute hospital services, and with wider public service organisations (e.g. local authorities, child and family agencies, education and local voluntary organisations, etc.)

Configuration of care
The way health care services are arranged, generally varying between regions.

Corporate governance
The systems and procedures by which organisations direct and control their functions and relate to their stakeholders in order to manage their business, achieve their objectives and meet the necessary standards of accountability, integrity and propriety. It is a key element in improving efficiency and accountability, as well as in enhancing openness and transparency. To this end, the HSE has adopted a corporate governance regime in accordance with best practice.

Doctors
All medical doctors including GPs, non-consultant hospital doctors (NCHDs), consultants and trainees.

Governance
In this document, 'governance' refers to corporate and clinical governance together.

Health and social care professionals
Health professionals from a range of disciplines, mostly non-clinical, registered under CORU , Ireland's multiprofession health regulator.

Healthcare professionals
All doctors, nurses, midwives and health and social care professionals.

Healthy environments
A healthy community environment encompasses aspects of human health, disease, and injury that are determined or influenced by factors in the physical and social environment.

Hospital
Healthcare institutions with inpatient facilities and organised medical and other professional staff that delivers medical, nursing and related services 24 hours per day, seven days per week. Hospitals range from primary level to secondary and tertiary level, depending on the number of specialties, the number of highly specialised staff, the level of technical equipment and the number of beds.

Hospital group
Hospital groups are a configuration of hospital services with their own governance and management structures. Seven hospital groups have been established, each with a primary academic partner: (i) RCSI Hospitals (Dublin North East); (ii)

Dublin Midlands; (iii) Ireland East; (iv) South/South West; (v) Saolta University Healthcare Group (West/Northwest); (vi) UL Hospital Group (Midwest) and (vii) Children's Hospital Group.

Integrated care programmes (ICPs)

The HSE's integrated care programmes aim to deliver seamless person-centred health and social care services. Five ICPs will be introduced by the HSE over the coming two to five years, focusing on areas identified as the most challenging in the health and social care systems: patient flow, older persons, prevention and management of chronic disease, children and maternity. Each ICP will develop a framework for the management and delivery of health and social care services and an implementation plan.

Integration

Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called 'integrated care.'

Interdisciplinary team

Team members who work together with associated referral and consultation processes in a collaborative way. Related to interdisciplinary teaching and interdisciplinary care. The term 'multidisciplinary' is sometimes used interchangeably with 'interdisciplinary'; however, multidisciplinary refers to a team composed of multiple disciplines working separately in a particular care process.

Joined-up care

This term can be used interchangeably with 'co-ordinated care' or 'integrated care'. It refers to an organising principle for care delivery that 'puts the patient perspective at its heart, reshaping traditional "silo" working and enabling the planned and efficient delivery of care within and beyond the health system'.

National, regional and local levels of authority

All groups with a footprint in healthcare management and provision including the cabinet, government departments, local government and administration, the Health Service Executive, hospital groups, community healthcare organisations and others.

Models of Care

Clinical algorithms being developed by the National Clinical Programmes (NCPs) to bring service provision into line with evidence-based practice and international standards of care. The new models of care also aim to standardise care across networks (national, regional and community services).

National standards of care

The Health Information and Quality Authority's National Standards for Safer Better Healthcare (2012) aim to provide the building blocks for a standards-driven health service through creating a common understanding of quality and safety. The standards are intended to give healthcare providers a structure to systematically and continuously improve the safety and quality of services delivered.

Network of excellence

A subsystem of interconnected community and hospital care services distributed across a geographic area, serving a defined catchment area and population. In this document, networks of excellence include four core components: hospital services, community care services, social care services and rehabilitation services. The term 'network of excellence' emerged from discussions on the inadequacy of the term 'centre of excellence', which does not reflect the new integrated and decentralised configuration of services.

Older people

Most developed world countries have accepted the chronological age of 65 years as a definition of 'older person'. This is associated with the age at which one can begin to receive pension benefits. There is no United Nations standard numerical criterion, but the UN-agreed cut-off is 60+ years to refer to the older population. Clinical services in Ireland generally work on the basis of 65 years.

Open disclosure

An open, consistent approach to communicating with patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.

Patient

A person receiving healthcare (other frequently used terms include service user and client).

People/patients

Everyone. Those who manage their own health and those receiving healthcare from a health service provider.

Section D
Glossary

Personalised medicine
A medical model using characterisation of individuals' phenotypes and genotypes (e.g. molecular profiling, medical imaging, lifestyle data) for tailoring the right therapeutic strategy for a particular person at the right time, and/or to determine the predisposition to disease and/or to deliver timely and targeted prevention.

Policy levers
Mechanisms used for health policy implementation, e.g. regulation, finance, payment, education.

Political consensus
Cross-party agreement.

Population need (population approach)
Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. A population health approach focuses on improving the health status of the population. Action is directed at the health of an entire population, or sub-population, rather than individuals.

Professionalism
One of eight domains of professional good practice defined by the Medical Council. It requires medical practitioners to demonstrate a commitment to fulfilling professional responsibilities by adhering to the standards specified in the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

Public healthcare system
The public healthcare system in Ireland is funded through general taxation and managed by the Health Service Executive. Anyone ordinarily resident in Ireland has eligibility to public health services.

Quality-adjusted life year (QALY)
A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to one year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a scale of 0 to 1). It is often measured in terms of the person's ability to carry out the activities of daily life, and freedom from pain and mental disturbance.

Quality improvement (QI)
The combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, commissioners, providers and educators -- to make the changes that will lead to better patient outcomes , better experience of care and continued development and supporting of staff in delivering quality care.

RCPI trainees
Individuals undergoing post-graduate medical training in RCPI. This term is used where recommendations relate specifically to post-graduate training.

Specialist
Medical specialists are doctors who have completed advanced education and clinical training in a specific area of medicine (their specialty area) and who are eligible to be registered on the specialist division at the Irish Medical Council. They include specialists who work in the secondary and tertiary care settings (e.g. cardiologists, vascular surgeons), together with those who work in the primary care setting (general practitioners) or in the domain of population-based medicine (public health).

Stakeholders
Everyone is a stakeholder.

Tertiary services
Specialised consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has personnel and facilities for special investigation and treatment. (Secondary medical care is the medical care provided by a physician who acts as a consultant at the request of the primary physician.)

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