1. Statement of Strategic Objective for the HSE:

1.1 The **HSE Corporate Plan** (2021-2024) includes a number of references to the need for the HSE to make the best use of the resources available to it:

- Chairman's foreword – *"…..and improving financial controls"*
- CEO's foreword – "….drive value for money"
- Enabler 2- Data and Information – *"….consolidate information and provide insights to decision making"*
- Section 3 Becoming a high performing organisation – *"…..we must ensure that….our funding is always wisely spent and on the right things….with clear financial and performance accountability"*
- Improving Financial Control (p.21) – *"….we will continue to work towards improving our financial planning and management to demonstrate greater financial control and to meet budget expectations"*
- Section 3 - What will we do p.22 Action 7 – *"We will implement a single modern IFMS across the Irish health services, including all voluntary organisations funded under s.38 of the Health Act s.38 funded organisations and larger organisations funded under s.39."*

IFMS (Integrated Financial Management System) is the national project which is delivering a single national finance and procurement system for the publicly funded health and social care service. IFMS is being delivered utilising the latest version of SAP (SAP Hanna) enterprise software. This is business change programme being supported by technology. In addition to SAP, the HSE has procured IBM to be the systems integrator partner.

1.2 **The object (purpose) of the HSE** is described in the Health Act 2004 as follows: "… to use the resources available to it in the most beneficial, effective, and efficient manner to improve, promote and protect the health and welfare of the public.

1.3 **Quality** - The Institute of Medicine (IOM), (1991) seminal report: "Crossing the Quality Chasm: A new health system for the 21st century". This report, speaking over 30 years ago about the US healthcare system, described it as poorly organised, overly complex, riven by multiple hand-off points that slow it down and reduce safety, also having cumbersome processes, resource waste and a version of what we today would call "the post code lottery" in terms of variable service coverage and availability. Unfortunately this report is still very much relevant to many healthcare systems in the western world including parts of the Irish system as acknowledged by the recent Sláintecare report. The "Crossing the Quality Chasm" **report outlines 6 Aims for Improvement.**

I. **Safe Care** (Do no harm)

II. Effective Care (Evidence based care and only if likely to benefit the patient)

III. Patient Centred Care (takes account of patient preferences and values)

IV. Efficient Care (avoids waste, including of time)

V. **Timely Care** (reduces waits and harmful delays)

VI. Equitable care (quality constant regardless of socio economic status, gender, geographic location etc.)

These six aims for improvement are in effect descriptors, in the view of the IOM, as to what would be the characteristics of a high **quality** healthcare system.

1.4 Value – These 6 aims can also be readily mapped to what the Department of Public Expenditure and Reform (DPER) has previously described as Value (for Money) i.e. economy, efficiency and effectiveness).

I. **Effectiveness** = Whether the outputs deliver the required objectives in both the short term i.e. safety & quality indicators, and the medium to long term i.e. outcome measures
II. **Efficiency** – Whether the lowest practical ratio of inputs to outputs has been achieved without compromising the quality of outputs / outcomes?
III. **Economy** - Whether the lowest practical price per unit of each input has been achieved without compromising quality of outputs / outcomes? (economy is a subset of efficiency)

In summary, the terms quality and value can be used somewhat interchangeably and, whichever is preferred, the HSE has a clear strategic objective to improve its ability to drive and demonstrate value / quality in how it makes use of all of the assets / resources available to it at any given point in time. Given this context, it is clear that improving our financial reporting, including through implementing the fundamental building block that is IFMS, is of strategic importance to the HSE.

2. Current Status Update:

For the purposes of this paper, financial reporting is defined as follows: The production and capture of data, it's conversion into information, the conversion of that information into insight and the use of that insight to inform decisions leading to necessary actions to manage and improve services. These actions may relate to any financial aspect of the overall commissioning cycle including forecasting, planning, resource allocation, budgeting or performance management

The Health Service has able and dedicated financial staff, who with input from non-financial colleagues, have generally provided the best financial reporting and decision support that they can to our services despite the systems and other constraints they operate within. The quality of some of that decision support and the improvements made in recent years, including in relation to the fair deal system and hospital activity based funding, are significant achievements given the extent of the constraints. Other good practice in place at local or regional may simply not be readily visible at national level.

There are currently 4 regional systems within the HSE and multiple different systems within the section 38 and 39 agencies. These systems and their underlying processes operate on disparate systems, are not designed, or defined, in a standard way and are not operated in a standard way. The implications are that our financial data lacks comparability, becomes available at different points in time and can be prone to errors and time consuming reconciliations or other forms of checking.

As a result, an inordinate amount of scarce accounting staff time and energy is spent trying to bring together disparate financial data into a coherent set of very basic financial information. This leaves limited capacity and time to focus on the generation of insight.

However, in order to make progress, it is necessary to stand back from these islands of excellence and make as objective a diagnosis as possible of the general state of financial reporting across the wider health system:

Data - Our financial data i.e. our raw numbers are an output from our transaction and accounting processes.

Information – The process by which we bring data together and convert it into information via analysis (trending, variance analysis, forecasting etc.) is also not standard or operating to particular guidelines. It is not supported by standard tools utilised in a consistent way.

Insight – Insight is gained when financial information, and related non-financial information, is linked and subjected to detailed analysis, by experienced staff that have a reasonable understanding of how the services operate. This aspect suffers from the lack of a clearly mandated set of specific objectives that each preparer of a financial report is working towards as well as the general limitations set out under the information and data headings. It is also hampered by a general lack of integrated information systems, particularly within the community sector.

Decision making – Our current financial reporting does not optimally enable, nor is it sufficiently focused on, prompting decisions and actions. At best, there is significant variability in the extent and standard of any decisions and actions that are routinely flagged in the financial reports that are exchanged between the different levels of the health system. This is a logical implication of the lack of assessment and reporting on economy, efficiency and, ultimately, effectiveness.

Ultimately where we know that a service scores reasonably well across all 3 measures of economy, efficiency and effectiveness, then the most practical actions to be flagged, where resource limits are under pressure, are either secure more funding, including reprioritising within existing overall funding, or consider capping the level of service provided.

Following on from and underlying the above, some more detailed characteristics of the current state position in relation to financial reporting can be summarised under the following headings:

I. Not timely or sustainable – need to move to 5 working day close and report
II. Overly focused on “simple breakeven” – breakeven is an essential hygiene factor but not sufficient in itself
III. Overly focused on inputs, with limited output based reporting
IV. Suffers from a general absence of price / volume analysis for both inputs and outputs
V. Overly retrospective in focus – need more and better forecasting supported by standard tools and models
VI. Generally not sufficiently focused on the wider control environment, cash / working capital etc.
VII. Generally not sufficiently focused on Value i.e. Economy, Efficiency and Effectiveness including the quality aspects of same

The issues above, when taken together, significantly hamper the capacity of our dedicated financial staff to support high quality planning for, and performance management of, our health and social services. The overall "system" (our financial people, financial processes and financial technology) is stretched to meet a very basic monthly reporting cycle. When that cycle coincides with the October to February time period when additional year end and year start workload is at its height, the "system" becomes overloaded to the detriment of our staff and the services they are seeking to support.

The current status update above has been extracted from ***Chapter 5: Reporting Strategy*** within the ***Irish Health Service Financial Management Framework,*** which underpins the IFMS project.

Despite some important progress, including in relation to weekly COVID flash reporting, forecasting and cash / working capital reporting, over the 2-3 years since it was written, this assessment of financial reporting within the health service remains largely valid today, and will do until IFMS is implemented.

3. The key issues arising:

Some of the key challenges in successfully implementing the IFMS programme include:

3.1 Scale and complexity of necessary change

The IFMS programme is a very significant and long-term (2014-2027) financial transformation effort that will ultimately involve 25,000-30,000 users across over 50 legal entities. The current highly dispersed purchasing process (orders, requisitions, goods received etc.) spread across thousands of non-professional buyers represents the single biggest overall process change.

Without standard processes, operated in a consistent way across all health and social care services, it will not be practical to achieve the benefits of better financial information and a stronger control environment. The health service needs more than just a defined set of standard processes. These processes must also be **operated** in a way that is consistent, efficient and sustainable over the longer term. This includes data consistency and ensuring common approaches to coding and classification of activities and costs via the adoption of a single chart of accounts within a single overall enterprise structure. This has significant implications for where we locate the various elements of each major process.

Making the change from the current disparate local processes to a set of nationally standardised best practice processes operated in a consistent way is a major part of the challenge that the health service must overcome if it wants to achieve the benefits of improved financial information and a stronger control environment.

All of this clearly points to the need to optimise the effective use of local self-service, automated workflows and the expansion of the previous HSE Health Business Services (Finance and procurement) into a national shared financial and procurement shared services provider. This is in line with government policy for the development of the Public Service.

3.2 Voluntary Organisation Adoption

The voluntary sector is recognised as a key stakeholder in the Finance Reform Programme and is represented across all levels of project governance and project delivery. The HSE recognises that the deployment of IFMS will involve significant change for voluntary organisations and has been engaged with the voluntary sector.

This has been at individual organisation level and through the various representative bodies (e.g. Voluntary Healthcare Forum, National Federation of Voluntary Service Providers, The Wheel National Association of Community and Voluntary Organisations, Charities and Social Enterprises, etc.) since the inception of the project to develop a collaborative approach.

The Boards of some voluntary organisations have expressed concerns about perceived impact of IFMS on their independence and autonomy whereas other voluntary organisations have expressed the desire to adopt IFMS as early as possible.

Work is ongoing to develop a legal framework which will codify the reciprocal accountabilities and provide the necessary assurances to boards around independence and autonomy. When this is available in initial draft form, significant engagement with the voluntary system will be arranged.

3.3 Dependencies on other systems

IFMS project has significant dependencies on the development and continued rollout of other systems, most importantly:

A) **HR and Payroll** – 70% to 90% of most health and social care service costs are staff related and ensuring labour hours and individual position data is available to support financial analysis and reporting in IFMS is critical to the realisation of the benefits expected from IFMS. This predominately involves close working between the IFMS and NIRSP (Implementing SAP HR & Payroll) teams. In relation to capturing the cost of agency staff hours, there remain high level governance decisions to be made once the current options appraisal process around agency hour capture and reporting have been considered by both project teams.

B) **Other Non- Pay input systems** – Non-pay relates to the purchase of goods or services. A key principle of IFMS, as set out within the Financial Management Framework (FMF), is that 100% of all non-pay costs should be linked to unique material or service codes. This is to enable input based reporting including the differentiation of cost movements as between the impact of changes in unit price versus changes in the number of units purchased or the mix of same.

IFMS is currently managing a number of dependencies in this regard including in relation to the National Estates Information System (NEIS) and the expected Hospital Pharmacy System both which are currently being deployed.

C) **Outputs – Linking Financial and Non-Financial Data** – While the information at 1 and 2 above will facilitate input based reporting including the determination of whether “economy” is being achieved, it is necessary to link financial and non-financial data to determine whether “efficiency” or “effectiveness” are being achieved.

There are significant digital deficits across the HSE and voluntary landscape in terms of systems to support service operation, including clinical systems deficits, particularly within the Community services area. IFMS and the costing projects it will support will work with the significant volume of currently available non-financial data and be ready to make use of improvements in the availability of such data as and when they occur.

D) Investment in the wider Health System Finance Organisation - There has never been an exercise to assess the current finance and procurement workforce in its entirety across the HSE corporate centre, HSE service areas and the voluntary sector, in order to determine what was the optimum number, location, skill set and grading of such staff.

This exercise is being carried out as part of the implementation of IFMS i.e. assuming we have in place a single national finance and procurement system, benefiting from nationally standardised best practice processes, what is needed to staff a fit for purpose finance and procurement organisation across the public health and social care system. The output of this exercise, even allowing for the benefit of streamlined processes, is likely to require an investment over a number of years.

4. The assurance process for the Board:

Deployment of IFMS in HSE, S.38 and larger S.39 organisations is a key enabler of Sláintecare, is mandated by the Finance Reform Board (Governing body involving HSE (CEO), DOH (Sec Gen) and DPER), and has been expressed as a Ministerial Priority in the HSE National Service Plan(s) in the context of Slaintecare and the implementation of RHAs.. The shared services model underpinning IFMS is consistent with the Government mandate to expand and accelerate shared services in the Irish Public Service.

The governance of IFMS includes:

1. **Finance Reform Programme Board** – Chaired by HSE CEO, with membership including DOH, DPER and EMT members including CFO – for high level escalation and overarching directional support.

2. **Finance Reform Steering Committee** – Chaired by HSE CFO, with membership including DOH, senior leaders at HSE Centre, senior CHO leaders and HSE Hospital Group and senior leaders from the community and Voluntary sectors across s.38 and s.39. – Oversight and key decision making.

3. **Design and Change Authorities** – Including key stakeholders across HSE, s.38 and s.39

4. **Process Councils** - Four Councils are in place to support design, implementation and post go-live maintenance across the purchase to pay, order to cash, core finance and financial planning and analysis process areas. Membership includes key stakeholder representatives across HSE, s.38 and s.39.

Digital Government Oversight Unit (DGOU) - IFMS is also subject to scrutiny by the DGOU within the Office of the Government CIO (part of DPER), including periodic engagement with the DGOU appointed Peer Review Group.

HSE Board - IFMS provides quarterly updates to the Performance and Delivery Committee of the Board and is subject to periodic engagement with the Audit and Risk Committee of the Board (on agenda for November ARC).

Financial Management Framework and Key Design Principles: The Chief Financial Officer has created a Financial Management Framework document that has been approved by the FRP Steering Committee. The purpose of this framework is largely to act as a communication and change management tool. It sets out core principles, addresses key conceptual challenges, clarifies roles and responsibilities and enables key decisions where necessary.

The framework is intended to be in alignment with, rather than a substitute for, all of the material in the Finance Reform Programme (FRP of which IFMS is a core element) Business Case or other foundational documents.

The framework, as the living document, is intended to take precedence over the foundational documents in cases where there is any potential misalignment. The key design principles set out in the Framework are taken from the original approved business case in respect of IFMS:

1. A single Integrated Financial Management System supporting Finance and Procurement.

2. Governance, compliance and accountability are central to the design and delivery model.

3. A best practice shared service model including standardised processes and controls is integral to the successful delivery of IFMS.

4. System is managed and delivered from the centre with the responsibility for the correct recording of transactions remaining with the service organisations

5. System is configured to SAP best practice where customisation will be the exception.

6. Optimum end user experience promoting the self-service model where information is keyed once by the actual service user or their administrative support.

7. Workflow will be deployed as a matter of principle to facilitate and automate business processes where the right work is brought in the right sequence at the right time to the right people.

8. Optimise the use of the software functionality available.

9. A standard data model is in place for all data that supports a standard approach to the availability and use of all data.

Utilisation of best in class software and Systems Integrator Partner: The HSE is utilising SAP Hanna Software, which is one of three Enterprise Resource Planning (ERP) software vendors, according to Gartner in 2022. The HSE also selected IBM as our Systems Integration Partner, IBM have a long established relationship with the HSE in the deployment of SAP solutions within the HSE. They are also a partner in the SAP HR national solution and will host the solution in the IBM private cloud. In addition, the HSE has a strong project team drawn from multiple finance and procurement areas and combined with an experienced eHealth team.

Benefits Realisation Strategy: One of the requirements of the new Systems Integrator (IBM) is to draft a benefits realisation strategy for approval by IFMS governance. It is intended that feedback on the draft strategy will be sought from the P&D committee of the board prior to its finalisation.

5. The key performance indicators (KPI's) / targets

1. Complete Design Review and Validation Stage – 12th Oct 2022
2. Complete National Template Build and Test – 31st Mar 2023
3. 1st Implementation Group (East, Tusla, PCRS) Go-Live – 30th June 2023
4. 100% HSE spend and 80% overall health spend on IFMS – 30th Jun 2025
5. 98% overall health spend on IFMS by end 2027
6. 5 Working Day-close monthly close and report for services on IFMS
7. 10 Working Day quarterly detailed forecast for services on IFMS
8. HSE & S.38 positions, WTEs and individual labour hours available within IFMS including for detailed price / volume analysis and forecasting.
9. Up to 100% of non-pay costs within IFMS to be based on unique material or service costs to facilitate detailed price / volume analysis
10. Minimum customisation of SAP with significant strengthening of the control environment via fidelity to SAP best practice processes and related controls.
11. Adherence to key design principles referred to above.
12. Other KPI's / targets to be finalised within Benefits Realisation Strategy referred to above

6. The implications for other strategic priorities / service plan

The success of the programme requires continued engagement with the voluntary sector and also public support at DOH, Ministerial and where necessary Government level for the mandate of IFMS, to include the requirement for its adoption by all organisations within scope, including the voluntary sector. This support is essential if we are to deliver on the benefits expected from IFMS within the current planned timelines.

The current National Financial Regulations do not mandate the devolution of budgets to any particular level within the HSE or the wider health sector. When they were first written (2004/2005) this was largely due to the lack of a single integrated financial management system for the HSE. IFMS will address this deficit and it is suggested that this should be coupled with a concerted effort to devolve budgets progressively over time down as far as individual front line team level e.g. to each community based mental health team and each ward based team within our hospitals.

The Health Sector will always need additional investment and government have shown strong support in recent years in providing that additional investment.

It follows that the HSE centre needs to actively help our Community Healthcare Organisations and Hospital Groups to, in turn, help our front line teams to do best they can with the assets / resources that they have available to them at any point in time, regardless of and separate to any additional resources that may be on their way or sought.

IFMS will be a major enabler of the changes outlined above. Similarly HSE will need to continue to invest, amongst other things, in its Integrated Information Service (IIS) and Health Identifiers teams, as alongside but separate to overall ICT investment, in order to enable the best use to be made of whatever non-financial data is available including facilitating the linking of same with IFMS financial data.

7. Approach to stakeholder management

As has been indicated above, the IFMS approach up to now has involved significant work to identify and then engage with stakeholders, including by ensuring they are represented at all levels of the governance of the project. As part of our overall Process Governance Model, which is set out within the Financial Management Framework, a network of 350-400 regional and local process operators (RPOs and LPOs) has been created across the 4 main process areas comprising senior representatives of organisations, including voluntary organisations, across the publicly funded health and social care system. These RPOs and LPOSs have been invited to the various series of workshops that have been a core part of the key stages of the project.

As we now move towards the first implementations in the middle of 2023, plans are being finalised to further enhance the change management effort including stakeholder engagement and communications. We have already begun to resource local change and deployment teams and this will be further accelerated in the months to come along with an updated change strategy which will be ready shortly.

At a practical level, IFMS has always encouraged efforts to “upfront” as much of the change as possible, rather than waiting for the new system, including encouraging services to make changes in their legacy systems where this was practical. The adoption during COVID of ARIBA SNAP, a simplified form of the SAP ARIBA e-Purchasing platform, was an example of this from which very valuable lessons that will assist in the ultimate change process have been learned. In keeping with this approach a number of key pre-implementation projects are continuing to progress in parallel to the main IFMS design review and validation. These are indicated in the summary table below.

Key Projects	Purpose/Scope
Stabilisation SAP in CHI @Temple Street:	• The project will deploy the finance and procurement system used elsewhere in CHI (Stabilisation SAP ECC6.0), in CHI@Temple Street. • The operation of a single enterprise-wide SAP system for CHI offers significant operational benefits in terms of process consolidation and standardisation, transparency and controls, as well as more efficient reporting and improved analytical capability. • The effort associated with the replacement of the existing Temple Street legacy system now will reduce the scope, complexity and costs for the transition of CHI to IFMS in due course.
IFMS Data Readiness:	• Provide important information about the extent of data readiness • Will enable much of the necessary cleansing, quality assessment and standardisation work, originally scheduled as a Deployment Stage activity, to be completed in advance of IFMS deployments.
Ariba SNAP Implementation:	• A key opportunity for the project to front load the change management effort as this will be the first experience of IFMS that many new self-service users will have. • Assist with the transition to the self-service requisitioning model under IFMS as the Ariba SNAP users will ultimately be using an identical user interface and functionality under IFMS Ariba. • An opportunity to raise awareness of IFMS generally and increase stakeholder engagement with the project.
Enterprise Structure for CHOs, Acutes and Tusla; preparation for RHA structures:	• An Enterprise Structure for IFMS was signed off in January 2020. However, the enterprise reporting solution is evolving to reflect reporting requirements and organisation structure developments and changes. • The project team are engaging with key stakeholders from CHOs and Acutes in validating the current enterprise reporting solution with a view

8. Conclusion

The successful development and implementation of a single integrated financial and procurement system for the publicly funded health and social care system is a key strategic enabler for our services. It will facilitate better financial reporting which is intended to support decisions and actions around the better management and improvement of the services we deliver to those that rely upon them. There a range of challenges to this implementation that we will need support to overcome so that the significant immediate benefits of IFMS can be realised. Over the medium to longer term, particularly as other operational and clinical systems gaps are addressed, IFMS will be able to play its part in transforming how we drive and demonstrate value and quality in the system. This work is key to maintaining and appropriately growing necessary investment in the public health and social care system.