ROYAL COLLEGE OF PHYSICIANS OF IRELAND

TOWARDS 2026

A FUTURE DIRECTION FOR IRISH HEALTHCARE

Table of contents

About *Towards 2026*

Towards 2026 is a policy forum established in 2016 by the Royal College of Physicians of Ireland to provide an opportunity for open dialogue between various healthcare stakeholders on the future direction of hospital care[A] in Ireland.

As a professional education and training body, RCPI is responsible for producing clinical leaders across a range of specialties. Addressing the complex challenges endemic in our health system requires strong clinical leadership in which the responsibility of doctors extends beyond individual patients to the entire healthcare system.

Towards 2026 is about understanding the future needs of patients, highlighting the gaps in current healthcare services and clarifying the new role of the doctor in a more responsive and dynamic healthcare system.

This report presents a future direction for hospital care and the role of the doctor in Ireland based on a consultation process with over 100 stakeholders from across the spectrum of the Irish healthcare service including patients, carers, doctors, nurses, health and social care professionals, GPs, and healthcare policy-makers and managers.

A series of meetings and facilitated workshops was held with these key stakeholders from May to October 2016, and the recommendations of this report are based upon these discussions.

Towards 2026 was chaired by Dr Tom Keane, former Director of the National Cancer Control Programme.

Hazel Luskin-Glennon, Towards 2026 Patient and Carer Forum

"Towards 2026 has the potential to be a blueprint for a truly inclusive health service for all citizens. Having the voice of the recipients of services listened to during the entire Towards 2026 process was, for me, hugely significant. The inclusiveness of the process is one of the key messages for me. Too often patients and those caring for them are still being told what is good for them instead of being asked what they need. I was honoured to be invited to participate in the Towards 2026 Patient and Carer Forum."

[A] The main focus of the Towards 2026 forum was acute adult hospital care.

My health service in 2026

Towards 2026 patient and carer forum

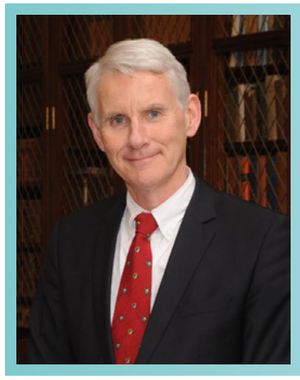
Standing L-R: Thomas Bergin, Hazel Luskin-Glennon, Clare Duffy, Mervyn Taylor, Marie Cregan, Leo Kearns RCPI, Michael Drohan, Brian Hartnett, Mila Whelan, Tom Clifford, Dr Siobhán Kennelly, Katharine O'Leary, Bettina Korn, Alison Harnett, Anna Clarke, Prof Frank Murray RCPI.

Seated L-R: Dr Tom Keane, Elisa Cosgrave, Prof Risteard O'Laoide, Marian Mackle

A message from

Prof Frank Murray

President, Royal College of Physicians of Ireland



Many of the challenges facing the Irish healthcare system are common across the developed world – the increasing demand, rising numbers of people living with chronic diseases, and ageing populations.

As citizens and patients, we need to equip ourselves with the skills and knowledge to take responsibility for our health and, where possible, for our healthcare.

We need to create a healthcare system that supports and responds to the complex needs of communities and individuals, both the patients who receive care and the staff providing that care. And we need to train our doctors in new ways of working: in teams, in the community, in leadership roles, in governance and in entrepreneurship.

The Royal College of Physicians of Ireland has a long and proud tradition of advocating for standards of patient care, to inform and influence national health policy, and to engage in the continuing improvement of health in Ireland.

This College is also a leading advocate for evidence-based legislation, such as the Public Health (Alcohol) Bill and a tax on sugar sweetened drinks and initiatives to support people to be healthier. These legislative measures are essential and we call once again for their implementation.

Led by our esteemed Chair, Dr Tom Keane, Towards 2026 aims to provide a neutral space for patients, clinicians, health and social care professionals, academics, policy-makers and managers to identify their shared desired characteristics of the future hospital and healthcare system.

As part of the Towards 2026 process we sought to understand the needs of the future patient; to describe the acute care services that will best meet their needs; and to re-examine the role of the doctor in this new environment.

There is no perfect formula to create the ideal healthcare system for the future. But it is clear that our health system must revolve around patients' needs to ensure the delivery of high quality healthcare. This report can inform a transition to a patient-centred healthcare system.

We need a plan for the future of our healthcare system and that plan requires full public and political support to ensure it succeeds.

With a political commitment to support long-term change, the Royal College of Physicians of Ireland will support and lead the transition to building a new model of patient care. It will do this through the National Clinical Care Programmes, by supporting public health initiatives, through its postgraduate training of doctors and will play its part in helping to attract and retain high quality doctors in Ireland.

We will also play a significant part in developing clinical leaders who will drive and facilitate this structural shift. We will prioritise leadership in education and training and ensure our training programmes are designed to cultivate the skills doctors require to meet the clinical needs of all Irish patients.

I am confident that by working collaboratively, we will come through the many sectoral, socio-political and economic challenges stronger than before.

We fully support the work of the Oireachtas Committee on the Future of Healthcare which is seeking to set a long-term plan for the health service, and hope that this report will assist them in that endeavour.

We have a huge opportunity to set the course of our healthcare system so that it survives to meet the needs of future generations. There is a strong desire and willingness to make it happen. I trust we can make it happen.

I would like to thank all those who contributed and who are listed at the end of this report, especially Dr Tom Keane.

Foreword

Dr Tom Keane

Chair, Towards 2026

Our duty is to build a system of patient care and develop health services that meet the needs of the entire population. Everyone has a role to play in reaching this goal. There has never been a complete system change; only particular improvements have been made. Our existing system has pockets of excellence, but until we address the many systemic problems caused by a lack of process and transparency, we will remain anchored in the past. There is a danger in thinking through the lens of the current system; that is why we need to set our sights firmly on the future. This process is less about 'fixing' existing hospitals as it is about imagining a different way.

This report focuses on hospitals and how they can become more aligned with changes in the broader system, such as increased care in the community and greater emphasis on prevention. We consulted with patients, doctors and other healthcare professionals, hospital managers, academics, health and social care professionals, clinicians, trainees and policy specialists, and considered the various perspectives put forth during a series of workshops. This report is a synopsis of the rich content gleaned from those experts. The high-level recommendations outlined here represent the strong ideas that emerged from those sessions.

This is not a definitive blueprint for the future health system. Rather, it is a statement of direction for change, which, I hope, will help patients, the public and healthcare professionals to think differently about the health system and to recognise opportunities for improvement. In these challenging times, the need for a bold, ambitious vision for healthcare for everyone in Ireland has never been greater. Some of those challenges, such as tackling the known causes of chronic diseases, cannot be overcome by individuals or health services alone, but require Government and all sectors to play their part.

We know our system can function more effectively and produce better outcomes for people. As a society, we need to consider what type of healthcare system we want, whom it should serve and how it should be paid for. The process of learning to work together towards shared aspirations of a better health system has begun. We must make the very best of this opportunity. We hope this report will provoke discussion and lead to sustained improvement in the healthcare system and the human relationships that underpin it.

I would like to extend my gratitude to all of the patients and carers whose contributions guided our work. My sincere thanks also to the workshop participants, our healthcare leaders, who generously gave their energy and expertise and, most importantly, the time to listen to one another and reach a common understanding. I have been greatly supported in my work by our research and thematic leads, Dr Siobhán Kennelly, Prof Risteárd O'Laoide, Prof Garry Courtney and Prof Charles Normand. Finally, I commend the Royal College of Physicians of Ireland for having the vision to undertake this ambitious but necessary work.

Recommendations

1 Healthcare is about me

A truly patient-centred system

The future health system must put people and patients at its centre in a meaningful way.

This means listening to the patient voice in the planning, design and implementation of services; supporting open and honest public debate on how services are provided; and building a sense of partnership between the people who use services and those who provide them.

> "If older people are afraid of going to hospitals then the services are wrong and they need to change."
> *Patient and carer forum, Towards 2026*

It also means understanding population need and the needs of groups with specific vulnerabilities, and designing services to respond to that need. In the coming years this will mean a particular focus on the needs of an increasing population of older people.

We must champion the fundamental principle that the healthcare system is owned by the patient and is accountable to the people it serves.

See *Page 14*

2 Keeping people well

Stemming the tide of preventable health conditions

Unless action is taken to keep people well, our health system will be overwhelmed by the rise in long-term diseases, such as diabetes. There must be sustained cross-governmental and cross- societal commitment to reduce ill-health through addressing lifestyle trends and inequalities in health outcomes.

See *Page 14*

3 Funding and expectations

Time for public dialogue

Clarity is needed on what can reasonably be expected from the health service, what funding is to be allocated to meet those expectations, and how decisions are made to benefit the greatest number of people in a fair and transparent way.

Fundamentally, we must support the principle that people should be able to access healthcare on the basis of clinical need, not ability to pay. Central to this debate will be the issue of what society is prepared to invest in its health service.

See *Page 16*

4 Using data to plan

Joining the dots between population needs and frontline decisions

Healthcare policies, strategies and plans should use research evidence and relevant data to make clear connections between population needs assessment and frontline planning decisions. Of crucial importance is the alignment of capacity with demand through the use of data and evidence. Much of the current visible dysfunction in the system is a result of demand grossly exceeding capacity.

See *Page 18*

5 Joined up care

Delivering seamless care across various settings

Care pathways should be built around the needs of the patient, not the system. We need to provide care that is joined up from the patient perspective, through the design and implementation of patient-centred, clinically led, evidence-informed integrated models of care. Patient outcome and safety measures, costing and funding models, workforce plans and data and system requirements must all be built in to these integrated models of care. Funding must be allocated to facilitate and incentivise joined up care, and to avoid fragmented care.

See *Page 19*

> "In the future I don't think patients will be as focused on 'the Hospital'. People will accept any alternative if it saves you time"
> *Patient and carer forum, Towards 2026*

6 Hospital without walls

'Hospital' services in the community

Service delivery should be oriented around the service itself rather than buildings and institutions or legacy arrangements. This includes the concept of a 'hospital without walls', where many services delivered in hospitals can and should be delivered in the community, with greater collaboration across hospital, primary care and community care settings. Strengthening capacity in primary and community care will be crucial to achieve this. There should be less focus on the 'place' and more on the 'service.'

See *Page 20*

7 Building for accountability

Responsibility, authority and accountability from the ground up

We need a governance system that applies at every level, from service delivery upwards, and is grounded in the principle that the healthcare system is owned by and accountable to the people. This requires clearly identified responsibility, authority and accountability at all levels of the health service from ward level right up to the Department of Health.

See *Page 22*

8 Supporting healthcare staff

Without people, there is no healthcare system.

Major, sustained emphasis is needed on strengthening and supporting the people who deliver care, and on rebuilding trust and confidence among the workforce. Successful organisations recognise the importance of the people who work for them; they try to recruit the best; ensure they are enabled to perform to their best; are involved appropriately in decision-making; are trusted; and are provided with development opportunities. This is what we should aspire to for our health service.

See *Page 26*

> "Supporting doctors and health professionals in their roles is a patient safety issue."
> *Patient and carer forum, Towards 2026*

9 e-Health now!

e-Health supporting and enabling joined-up care

The individual health identifier and electronic health record must be implemented. The advent of the eHealth Strategy provides an opportunity to adopt a long-term strategy to underpin joined-up care across community, primary care, acute hospitals, and mental health, and to simultaneously enable effective population needs analysis, planning, outcome measurement, and performance accountability at local and national levels.

See *Page 28*

10 Developing healthcare leaders

Great leaders bring about great change

Only strong leadership at local, regional, national and institutional levels can overcome the lack of trust in the system and bring about the kind of change needed to return the health system to its core purpose. It must be recognised that there is a crisis in leadership at all levels, and that there has been a lack of support for leadership development.

Clinical leadership roles and managerial leadership capability should be developed and supported at all levels in the system.

See *Page 29*

11 Shared vision and political consensus

Long term vision, and the political drive and courage to deliver it.

A shared vision and long-term strategic plan with cross-party political support is essential. Frequent changes in direction are fundamentally destabilising and undermining for the health service.

Crucially, it must be recognised that to have a meaningful impact, there must be sustained political commitment to long-term policies and strategies. Cross-party political consensus and longer-term collaborative planning are necessary to support a commitment that spans multiple government terms and composition.

The establishment of the cross-party Oireachtas committee in 2016 is a necessary and practical political development to set a direction for the health service. The challenge to all stakeholders will be to support the output of the committee. The challenge for the committee will be to outline a direction that all stakeholders can commit to.

See *Page 30*

12 Implementing change

A major implementation strategy to deliver change

These recommendations represent an enormous challenge. Failure to successfully implement change has been a recurrent and debilitating feature of the health service for many years. There must be significant, targeted and sustained investment into making these changes happen. This will require a high level expert group that reports to the Oireachtas on progress and that has the mandate and authority to hold all parts of the system to account for making the change happen. Change will not happen without a plan. Neither will it happen without determined and consistent leadership, from the highest level of government.

See *Page 31*

A healthcare system in crisis

Despite two major reports recommending radical and rational reorganisation of Irish hospitals (the 1968 Fitzgerald report[1] and the 2003 Hanly report[2]), and many other policy and strategic reports, the location, structure and services of hospitals in Ireland today still reflect a largely organic and unplanned evolution, although some progress has been made in rationalising services such as cancer and emergency interventional cardiology. Despite the fact that medical care and therapies have changed radically in recent years, the structures to deliver these modern therapies has altered little.

Joined-up healthcare in this context is not possible. In fact, we have by default designed a system where disjointed, fragmented care is inevitable and where reactive, crisis management has become the norm.

> Irish hospitals are charged with what appears to be an impossible task; demand for services exceeds capacity to deliver.

The public healthcare system in Ireland is in a critical state. Excessively long waiting lists, recurrent and worsening trolley waits in emergency departments and ongoing problems in recruiting core medical and nursing staff paint a picture of a health service in deep crisis.

Despite positive health outcomes such as a five-year increase in life expectancy in the last 20 years, and the improvement in outcomes for patients with cancer, it is clear that Irish hospitals are charged with what appears to be an impossible task; the demand for services exceeds capacity to deliver.

Concern exists that much of this demand may relate to the extent to which patients are referred into secondary and tertiary care with problems that would be better resolved in the primary and community care setting, or spend protracted periods in hospitals after they are fit for discharge. With known demographic trends indicating continued growth in demand, hospital services as currently structured simply cannot deliver appropriate care without radical change.

> Many of the solutions to the problems of the hospital lie beyond the hospital itself, and it is clear that building capacity and capability within the primary and community setting is of the utmost importance.

There is a pressing need to redefine the purpose, role and functioning of hospitals and hospital care in the context of a modern healthcare system, while learning from the proposals, and barriers to their implementation, identified by previous reports.

Notwithstanding the many major problems facing the Irish health service, there is an opportunity to radically improve the patient experience and outcomes in Irish hospitals and to define their future role in a cohesive Irish health service. While the focus of this Towards 2026 initiative is primarily the hospital, it is clearly understood that the hospital can only function as an integrated component of the wider healthcare system. Many of the solutions to the problems of the hospital lie beyond the hospital itself, and it is clear that building capacity and capability within the primary and community setting is of the utmost importance.

Failure to recruit and retain healthcare staff

While trolley waits in emergency departments and extra long waiting lists are visible indicators of a system in crisis, what is not so obvious, but potentially much more serious and long-lasting, is the fact that Ireland's health service is finding it very difficult and often impossible to recruit doctors and nurses.

- *In 2016, approximately 20% of approved permanent hospital consultant posts were either vacant or filled on a temporary basis.*[4]
- *In 2016 there were almost 4,000 less Nursing and Midwifery posts in the health service than in 2008*[5]
- *By 2025, the predicted shortage of GPs in Ireland will range from 493 to 1,380 depending on increased levels of access to free GP care.*[6]

Without doctors, nurses and health and social care professionals, we cannot deliver healthcare. Addressing this recruitment crisis must be of the highest priority as we face the next 10 years.

Ireland is not alone in facing these challenges. The same difficulties are faced by health systems across the developed world. Healthcare, one of the greatest of human achievements, is also one of its most complex and is becoming increasingly difficult to manage. A fundamental problem is the challenge of meeting ever-increasing demand with constrained resources. Our goal must not be to finally resolve the problems of the health service, as such an aspiration is unachievable. Rather we should endeavour to create a system that has within itself the capability to continually develop and improve to meet the changing needs of the population, and that sits within a society that has reasonable expectations of the system itself.

A number of policy reports on the future direction of healthcare have been published in the past 15 years, including the 'Hanly Report' - Report of the National Task Force on Medical Staffing (2003)[2], Quality and Fairness Health Strategy (2001)[7], Future Health Strategy (2012)[8] and the Healthy Ireland Framework (2014)[9]. Many of their recommendations remain relevant. As far back as 1968, the Fitzgerald report[1], and the Hospitals Commission reports of the 1930s[10], contain many recommendations that are apposite today.

Many of the key recommendations for delivering integrated care and developing a cross-sectoral approach to health and wellbeing have not been implemented. Since plans for the implementation of Universal Health Insurance (UHI)[11] were shelved in 2015, there is a policy vacuum on the fundamental question of how to fund our health system to ensure its viability into the future. At current levels of funding and demand[12], the public healthcare system is unsustainable and the cracks are clearly visible. In the face of continuing economic uncertainty, more than ever a clear vision for the future model of healthcare is required.

Dearth of policy is not the primary issue; rather, there is a problem of implementation and translation. Too many previous healthcare initiatives have failed, and their failure adds to the complexity of the challenge now faced. The enormity of the crisis that now prevails within the Irish healthcare system is such that we cannot afford another failure to design and implement the radical and fundamental change required.

There have been many positive health outcomes in Ireland which can give us reason for some optimism. The advance of medicine and the application of new technologies and research are on a par with most developed health systems in the world. Our medical education system in Ireland has been effective in the production of a highly skilled workforce, although the benefits of effective education are negated to a large degree by a failure to retain in Ireland graduates across all disciplines.

> Clarity and honesty is needed about the deficiencies in our system, as it is these deficiencies that must be overcome if fundamental improvement is to be achieved.

There are some encouraging developments at all levels of the health service that provide indications that the health service is moving in the right direction in areas such as models of care, quality improvement, training and a renewed focus on staff. The development of the Integrated Care Programmes, while at a very early stage, present another indicator of movement in the right direction.

At the same time, clarity and honesty is needed on the deficiencies in our system, as it is these deficiencies that must be overcome if fundamental improvement is to be achieved.

More of the same will not do. We need a new direction for the Irish health service. The recommendations of this report indicate the direction the system must take to overcome the many barriers to delivery of appropriate, effective and safe care.

Emergency Department Crisis

The crisis that is so obvious in Emergency Departments is a microcosm of the deep problems that exist right across the health service.

The ED crisis is not due to, or solvable in the ED. The Emergency Department has become the default place of last resort within the health service. When nothing else is available or accessible, people will go to the ED. Therefore while the problem manifests as an 'ED problem', generally speaking the problem is usually caused elsewhere and needs to be solved elsewhere.

Resolving the ED crisis is essential, not just because of the immense and utterly unacceptable suffering caused to so many patients and their families, and the safety issues that arise from such extreme overcrowding, but also because of the destabilising impact it has on the rest of the health service.

Figure 1: Trolley crisis January 2017

As this report was being finalised in January 2017, the latest instance of crisis was making the news: on January 4th, 2017, the number of patients on trolleys waiting for admission hit an all-time high of 612.[13]

612* **PATIENTS ON TROLLEYS IN HOSPITAL EMERGENCY DEPARTMENTS — ALL TIME HIGH**

These are people assessed by healthcare staff as being sufficiently ill to require admission to hospital for further treatment.

Not included in the 612:
- — People waiting in ambulances
- — People waiting to be assessed

WE'VE BEEN HERE BEFORE

Over 10 years ago, the then Minister for Health described the trolley crisis in ED as 'a national emergency' and determined to resolve the problem within 12 months.

Each year, the same crisis occurs, and each year the crisis is managed in the same way, and emergency funding allocated, until the peak passes, and the major crisis becomes a smaller crisis that doesn't hit the headlines, until inevitably the cycle begins again.

From 2006-2015, over-65 population increased by 29.5%, while acute inpatient hospital beds decreased by 13%.[24, 25]

The result is:

- — **Suffering and distress for patients and families.**
- — **Safety risks for patients and staff**
- — **Extreme stress and frustration for doctors, nurses, health and social care professionals and administrators**

Things we need to understand and approach differently:

- There is insufficient bed capacity to meet demand in both hospitals and nursing homes
- The problem manifests in ED but the solution may be elsewhere
- Inadequate capacity in primary, community and outpatients services increases demand in ED
- An unacceptable experience for patients and staff has been culturally normalised

A more coherent approach:

- Joined up, long term planning for emergency care at national and regional level
- Dynamic management of unscheduled patient flow at local level
- Integrated pathways for unscheduled care across community, primary, mental health and acute care
- Data, including demographic data, to properly plan. Underpinned by systems
- A will to face up to reorganisation of hospitals so that they can provide the emergency service that people require

Crisis management will not and cannot resolve the fundamental problem. If underlying causes are not understood and dealt with, it is inevitable that the crisis will return and be worse each time.

* INMO Trolley Watch/Ward Watch Figures below for February 10th 2017

Towards 2026 – The vision

1 "Healthcare is about me"

The future health system must put people and patients at its centre in a meaningful way. This means listening to the patient voice in planning, design and implementation of services; supporting open and honest public debate around how services are provided; and building a sense of partnership between the people who use services and those who provide them.

We must champion the fundamental principle that the healthcare system is owned by the patient and is accountable to the people it serves.

People want high 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. They want to be able to access systems of peer support for patients, carers and families.

When considering population perspectives, 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 the 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.

2 Keeping people well

There must be sustained cross-governmental and cross-societal commitment to reduce ill-health through addressing lifestyle trends and inequalities in health outcomes.

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

If ill-health due to tobacco, alcohol, obesity and physical inactivity is not reduced, the health service will be unable to cope with the inevitable rise in demand. This will require that health promotion is placed as a core responsibility of all sections of government and society, and not laid at the door of the health service alone.

Individuals play an important role in maintaining their own health; the health service should be built upon the philosophy that it is there to facilitate them to do so.

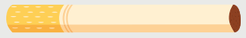
Evidence shows that poverty is a strong determinant in health outcomes.[9] No health policy or strategy will be truly effective without a strong and determined effort to reduce poverty and social inequalities, including inequitable access to essential health services based on ability to pay rather than medical need.

Priority Prevention Measures

- *Public Health Alcohol Bill*
- *Introduction of tax on sugar sweetened drinks*

Figure 2: Preventable health conditions in Ireland

160,221 hospital bed-days used for alcohol related illness in 2012[14]



27,540 inpatient admissions each year due to smoking.[15]

Physical inactivity is responsible for 9% of coronary heart disease; 11% of type 2 diabetes; 15% of breast cancers and 16% of colon cancers[16]

56% increase in the number of obese men and 70% increase in obese women between 2007-2015[17]

Reaffirming the purpose of the health service

The core purpose of the health service, and the main reason most people aspire to work in the sector, is to provide appropriate care to the people of this country when and where they need it.

Unfortunately, for many who work in the health service, it appears that over the past few years, financial control has been the overriding and indeed primary objective of the health service. While prudent financial management is critical to the effective functioning of the health service, to many there is a strong sense that the focus on patient care as the primary purpose has been lost at a system level. While it can be argued that the national financial crisis of 2007/2008 required an intense financial focus, it is essential to understand that such an approach has significantly damaged the healthcare system[18], and has had significant negative consequences.

In order to seriously embark on a re-engagement of people across the nation and within the health service, we must begin with a declaration that the core and primary purpose of the health service is to provide the care that people need, within the context of what is reasonable to expect from the health service, and what society is prepared to pay for the service. All those who work in the service, and those at governmental and political level who create the financial and policy framework within which the health service operates, must commit to this.

Some of the most difficult public and media narratives about the health service relate to inequalities in access to care and demand/capacity mismatch. These concerns, which perpetuate a sense of injustice, raise fears in relation to equity, queue-jumping and prioritisation based on ability to pay rather than on medical need. People who must rely on the health system should be confident that their access to essential services is based on medical need rather than their ability to afford private healthcare.

3 Funding and expectations

Clarity is needed about what is reasonable to expect from the health service, what funding is to be allocated to meet those expectations, and what decisions need to be made to benefit the greatest number of people in a fair and transparent way. Central to this debate will be the issue of what society is prepared to invest in its health service

As a nation we accept that we continue to face into uncertain economic times. We also accept that the healthcare economics are trending towards ever-increasing demand and cost, most likely on an unsustainable scale.

There must be radical change to the philosophy and methods we use to fund our health service. Clear alignment, based on transparency and fairness, must be established between the funding allocation and what the health service is expected to deliver for that funding.

Addressing the issue of funding is a fundamental challenge. Many health systems are facing an existential crisis in relation to increasing demand, costs, and an ever-increasing funding deficit. Dr Don Berwick, founder of the Institute for Healthcare Improvement, has spoken about the potential of healthcare systems to bankrupt nations if current demographic, disease, cost, and waste trends continue. It is therefore all the more essential to ensure that the resources allocated to the health service by the Government are used to the greatest benefit.[19]

This is a responsibility that all share, including doctors. Dr Berwick has referred to the ethical responsibility of doctors to ensure that available resources are allocated to the greatest benefit of patients, and that the allocation of funding is not simply a matter for others to decide.[20 21]

Equity must play a significant role in funding decisions – both in terms of ensuring equity of access for patients, but also equity in terms of resource allocation across the country. We must consider all resources available, both public and private, and how best use may be made of these resources for the benefit of patients. All change must be transparent to ensure the greatest benefit accrues to the greatest number of people. Difficulties experienced by specific groups in accessing services, for example in remote or less-populated areas, must be considered.

Fundamentally, the funding allocation must be aligned with population need at both local and national level. This can only happen if we have the accurate data and processes necessary to accurately define population need; to prioritise need; to design and implement integrated models of care; and to allocate funding in ways that are aligned to need and models of care. This requires a rigour and transparency that does not yet exist. It also requires fundamental changes to the way the health service does its business.

These objectives will be attainable only with transparent and meaningful financial data available to national and local decision-makers, who must apply an ethical framework to ensure resources are used for the greatest impact.

A funding crisis

There has been unsatisfactory debate and much uncertainty regarding the funding of the Irish health service. However, the prevailing narrative is that the system has never had such a high level of funding, and that it is well funded compared to other OECD countries.

Depending on which OECD comparators are used, funding may appear relatively high, but if it is, we do not appear to be deriving the benefits. Measures such as the length of time people have to wait to be seen by a specialist; or the numbers and time spent waiting on a trolley in emergency departments; or access to diagnostics in community and primary care clearly indicate that other systems may be deriving greater benefit from their expenditure than is the case in Ireland. For example, despite the increase in funding in the last two budgets, the average annual number of people on trolleys has risen from 230 in 2013 to 326 in 2016.[17]

> There is a risk that an exclusive focus on a limited set of particular outcomes will give a biased view of a health system that does actually achieve against a range of other important indicators, one of which, for example, includes a progressive lengthening of the expected life span of the Irish citizen during these last decades.

The subtext here is that the Irish health service cannot expect more funding because it is 'well-funded'. This may very well be the case when financial data are viewed at an aggregate level, and without reference to patient outcomes and experience. However, given that the majority of funding is allocated on a historical basis, a much more sophisticated analysis is needed if there is to be a meaningful discussion on the redistribution and strategic allocation of funding.

During the financial crisis, Ireland was one of the few OECD countries where there was an absolute reduction in expenditure on health. However, this was achieved through relatively simple measures applied crudely across the health service, some of which may have had the perverse impact of actually increasing costs, e.g. of expensive agency staff to fill critical staffing gaps.[22]

There was also no provision for demographic change in this period. Since 2009, there has been a 10% increase in demand for acute hospital services based on demographic pressures, and a 24% reduction in hospital funding[17]. It is not possible to discuss meaningfully an appropriate level of funding for the health service without an explicit alignment of funding to expectation, need, demand and outcome.

The health service also faces a serious crisis in relation to capital funding. Almost all available capital funding for the health service for the next number of years has already been allocated to a small number of major capital-intensive, highly visible and worthwhile projects such as the National Children's Hospital. Working and clinical conditions in both community and hospitals are very much suboptimal in many cases, there is an urgent need to implement an electronic health record, and to replace ageing equipment and infrastructure in a planned and orderly fashion. This problem is exacerbated by the fact that a burst of capital spending in 2006-2008 has resulted in a spike in replacement requirements now.

It is incorrect to say that the healthcare problem in Ireland is solely due to insufficient funding, and that additional resources will resolve everything. It is equally incorrect to characterise the health service as a well-funded 'black hole' where any further investment will be wasted. All stakeholders must face up to the responsibilities they bear in creating this situation, and determine to make the real changes that will help improve the alignment between expenditure, patient need and health outcomes.

In the absence of effective joined-up models of care, joined-up real-time information, the ability to collect and make use of 'big data', and the lack of joined-up governance, we do not have the tools to properly cost health provision, to accurately assess population need, evaluate resource allocation, make strategic and prioritised decisions, or translate this into plans and performance across the system at local and national levels.

4 Using data to plan

Healthcare policies, strategies and plans should use research evidence and relevant data to make clear connections between population needs assessment and frontline planning decisions.

Of crucial importance is the alignment of demand with capacity through the use of data and evidence.

We need to ensure we can accurately estimate population need, and design and implement costed models of care to meet that need with funding allocation aligned with the agreed models of care. The health sector must continue to develop expertise in the systematisation of access to and the appropriate analysis of healthcare-related data to help inform decision-making processes.

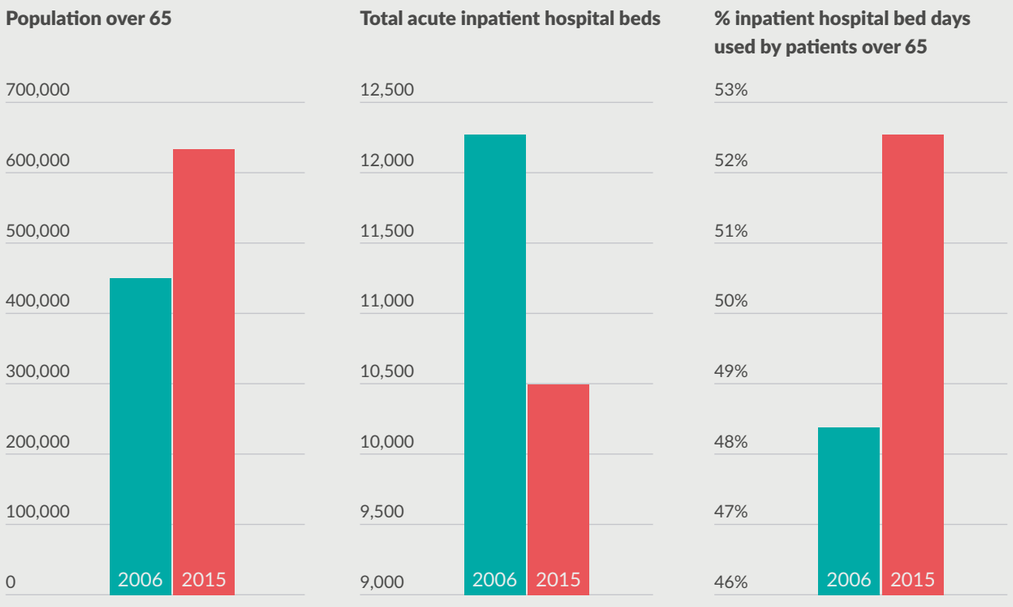
Much of the current visible dysfunction in the system is a result of demand grossly exceeding capacity. This failure to align capacity and demand has contributed significantly to the current critical state of the public healthcare system. Unacceptably long waiting lists, recurrent and intractable trolley waits in emergency departments, and serious and worsening problems in recruiting core medical and nursing staff are just some indicators of how vulnerable the system is currently.

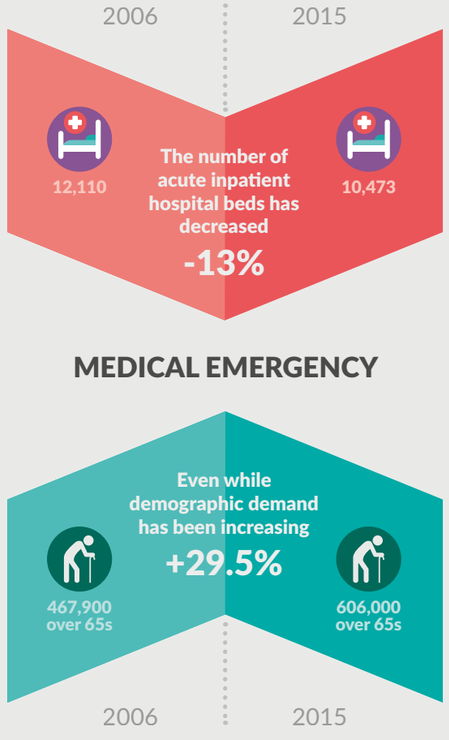
Demographic and health projections show a continuous upward trend in demand for services. The number of adults aged 65 and over will increase by up to 21% by 2022, while in the same period the population of those aged 85 and over will increase by almost 4%. It is also notable that over 600,000 people at the last census reported at least one disability. [17]

The scale of the surge in demand that this foretells can be appreciated when one considers that in 2015, adults aged 65 and over, who represented just 13% of the population, used 52% of total hospital in-patient bed days *(See figure 3)*.[24] [25] Current demand is not being met and, notwithstanding increases for health announced in the 2017 budget, there is no plan outlining how this level of future demand can be addressed.

Figure 3:
Mismatch between capacity and demand

The number of hospital beds per 1000 population in Ireland is among the lowest in the OECD [23]





Source: Health in Ireland – Key trends[24, 25]

5 Joined-up care

Care pathways should be built around the needs of the patient, not the system. We need to provide care that is joined up from the patient perspective, through design and implementation of patient-centred, clinically led, data-informed integrated models of care. Patient outcome and safety measures, costing and funding models, workforce plans and data and system requirements must all be built in.

Care that is 'joined up' and coordinated from the patient's perspective is what people want. However, for many historical reasons, including the impact of legacy funding mechanisms, ad-hoc service development, siloed policy, poor or absent strategic planning, local political imperatives, medical politics[26] and fragmented governance, care has been oriented around the entities, places, processes and structures of the system, rather than the needs of the person requiring care services.

To be serious about reaffirming the purpose of the health service and the care that people need, the system needs to provide care that is built around patient needs and that is joined up from the perspective of the patient, regardless of where in the system that care is delivered, or by whom.

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 an evolving spirit of collaboration and knowledge-sharing.

> The system needs to provide care that is built around patient needs and that is joined up from the perspective of the patient, regardless of where in the system that care is delivered, or by whom.

Community and hospital budgets that are aligned across the integrated models of care will be essential to address the overall needs of a shared population base. Otherwise the respective community and hospital skill mixes, and the domain of prevention/health maintenance (such as

Healthy Ireland) will remain divergent, and genuine shared care will be difficult to attain.

While the implementation of team-based, joined-up care across settings is critical, absolute clarity as to who ultimately bears clinical responsibility at each stage is equally important.

All of this will require a radical change to the way care is designed and delivered. With the advent of the National Clinical Programmes, for the first time, there is initial development of models of care and pathways that are oriented towards understanding the needs of the person and not the system. Building on this base, models of care that are integrated across community, primary, acute, social and mental health care can now be developed, and a number are at an early stage of development.

However, joined-up, safe and effective care cannot be provided to patients unless there is deliberate design of integrated models of care, with alignment of funding models, workforce plans, clarity in ownership of tasks and responsibilities, performance measures and data, and systems to enable implementation of those models.

6 Hospital without walls

Healthcare delivery should be oriented around the service itself rather than buildings and institutions or legacy arrangements. This includes the concept of a 'hospital without walls', where many services delivered in hospitals can and should be delivered in the community, with greater collaboration across hospital, primary care and community care settings.

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 system 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 sector 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. There should be less focus on the 'place' and more on the 'service.' The vision of the hospital in 2026 is of a 'hospital without walls'. This represents a shift away from the concept of a hospital as simply a 'place', to the idea of a hospital as a package of acute, specialist and emergency services available to a population.

People must be able to 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.

Strengthening capacity in primary and community care will be crucial to achieve this. Equally important will be the appropriate mapping of hospital services for complex, specialised care and 24-hour emergency care. Some services will continue to require aggregation in a specific place. Although much care can and should be devolved locally, this can only work if relevant secondary and tertiary services are also supported. Critical mass and adequate clinical throughput with specialised infrastructure will be necessary to ensure retention of skills, safety and quality in the delivery of those secondary and tertiary services.

Figure 4: Patient flow

To effectively manage the flow of patients through ED and to resolve the longstanding trolley crisis, we must understand that this 'flow' begins long before the ED and continues long after.

Services provided within the community to enable people to live at home and manage conditions themselves with support in the community if necessary	GP's enabled with resources and diagnostics to minimise referrals to acute services to those who need them	Expertise and resources within ED to effectively manage those presenting and to discharge and admit appropriately	Sufficient acute hospital beds with all related resources, therapies and diagnostics, to meet demand.	Community services and capacity to enable patients to move from acute bed to a more appropriate rehabilitation, nursing home or home setting	Mental health services to meet demand in the community and other settings.

Patient flow is local. Aggregating data to national level is interesting and supports national planning, but will not help to manage the flow of patients through a specific ED.

It is essential to have governance arrangements that allow for transparency, oversight, integration and management of patient flow across community, primary and acute services.

A capacity deficit at any point along the flow will usually manifest as a problem in the ED, which is often the place of last resort.

The system must be able to adapt to address capacity and demand issues at any point along the patient flow. For this we need to:

Manage flow continuously › Have authority to make decisions across the flow › Use real-time data to know what's happening › Plan for contingencies › Use science relating to management of flow from other industries/healthcare systems

If the patient flow pathway is…

Mapped out › Demand predicted › Resources lined up in community, primary care › Diagnostics available in community and acute settings at the time required › Patients discharged as soon as acute care completed › Rehabilitation and nursing home beds available › Home supports allocated

then the incidence of people waiting on trolleys will be minimised.

This also requires…

Agreement with staff to move resources to where they are needed › Working patterns changed to meet demand › May require agreements with private providers to meet spikes in demand › Dynamic management of patient flow applied with authority across the continuum of home, community, primary and acute care › Skilled clinicians and managers working together with responsibility for managing patient flow across boundaries in real time, at a local level

Funding › **Workforce** › **Performance Measurement** › **Systems and Data**

are all critical enablers of this systemic approach

If a systemic approach is taken, we should expect all local services to be able to deal with episodic spikes in demand, but no system can deal with sustained and gross mismatch between demand and capacity

7 Building for accountability

We need a governance system that applies at every level, from service delivery upwards, and is grounded in the principle that the healthcare system is owned by and accountable to the people. It must identify responsibility clearly at every level, provide authority and capability as required, and be held to account for doing so. Service delivery must be aligned with national frameworks and policy.

It is essential that robust and intelligent models of clinical governance are in place and aligned across service domains. They should also be integrated across non-clinical domains such as human resources, finance, and information technology and fully embedded within the governance of the relevant service organisation.

Effective governance must be built from the ground up and not, as so often happens, from the top down. It must begin with the service to be provided to patients, as defined in models of care; and in the context of the outcomes, quality, performance and financial frameworks which these models define and require. Clinical governance should be a core concern of the board and CEO of a healthcare organisation. It should align seamlessly across primary, secondary and tertiary care.

Governance must become an integral part of clinical and healthcare training and practice to facilitate greater understanding among healthcare professionals, patients and healthcare managers. Governance frameworks must apply at every level of the health service, including at Department of Health and governmental level, and must be rigorously applied.

Good governance ensures that an organisation is set up optimally to achieve its purpose; that all who work in that organisation understand their personal and team responsibility; have all relevant competencies and authorities necessary to fulfil those responsibilities; and are appropriately and consistently held to account for that.

While structures are important and can enable or impede good governance, resolving the governance crisis is not primarily an issue of structure. Changing structures without addressing the fundamental system issues is akin to adding extra storeys to a building while leaving the foundations unchanged. It may give the impression of progress and activity in the short term but ultimately it is profoundly unsafe and, under pressure, will fail.

Much of the dysfunction within the health system flows from poor or unclear, or non-existent governance. We have previously discussed the negative impact of fragmented governance across the flow of patients through the ED. Without addressing in a meaningful and radical way the problems of governance within the health service, including clinical governance, no real progress will be made in terms of improving the health service.

RCPI therefore welcomes the changes that are happening, albeit slowly, to devolve responsibility and authority to service delivery organisations such as Community Health Organisations and Hospital Groups while at the same time reimagining the function of the national centre of the health service to develop much more relevant and strategic national functions such as population needs assessment; service design and commissioning-type activities.

It is essential that this 'national centre' be coherent and aligned not just within the HSE, but also within the Department of Health and other relevant government departments, including the Department of Public Expenditure and Reform. It is not possible to deliver clear direction and an integrated approach to the wider health service if there isn't alignment between the policy function of the Government and the health delivery system itself.

This is a rare and important opportunity to build governance systems from the ground up.

Governance – the foundation stone

Governance is the framework of processes, systems and structures that enable the health service to deliver on its core purpose and its key goals. Clinical governance defines the culture, values, processes and procedures required to achieve sustained quality of care in healthcare organisations. It involves moving towards a culture where safe, high-quality, patient-centred care is ensured by all those involved in the patient journey. This is significantly more complex in the not-for-profit health sectors, and in hospitals in particular, than in the corporate world, as described in Belgian[28] and Irish[29] research.

All patient experience, patient outcomes, quality, safety and cost derive from the point at which care is delivered to the patient. Yet an extreme form of centralised command-and-control governance has evolved in the Irish health system. This has been largely driven by the desire to have a single point of accountability for the health service, which is neither achievable nor optimal. It destroys the sense of ownership and decision-making at local level that is essential to enable high-quality and effective care to be planned, organised and provided. It also diverts focus away from critical matters that require national leadership and attention, such as strategic planning for the entire health service, population needs assessment, service design and performance accountability.

Not only has governance been overly centralised, it has also been fragmented and siloed – not just in relation to service areas such as acute, primary care, social care and mental health, but also in respect of critical enablers of the system such as workforce, finance and information and communication technology (ICT). This fragmentation has fatally undermined the ability of the system to act in a co-ordinated way at local, regional and national levels, yet there is almost no instance of care that does not require a joined-up approach.

No successful organisation would approach the task of service planning and delivery in this way. The problem here is not amenable to exhortations for people to work harder or smarter, but rather that at a fundamental level the health service has evolved a governance system that makes it impossible for the health service to function in an effective and safe way, and for those who work within it to effectively carry out their duties. Those responsible for delivering service have been disempowered; and those responsible for setting and assuring strategic direction have been equally disempowered. In the words of W. Edwards Deming, 'a bad system will beat a good person every time'.[30]

We have today a system that can do little more than deal with the latest crisis, possessing little ability to address the underlying causes, with the result that the same problems and crises recur repeatedly, and when they do, they are dealt with in the same manner while a different result is expected. It must be acknowledged that there are fundamental problems within our healthcare system which can only be addressed in a fundamental way.

Accountability, not blame

In this dysfunctional governance model, while there is much talk about accountability, what is often actually created is a blame culture, where in reality there can be little accountability. Accountability is only meaningful if the person or entity being held accountable has been provided with:

1. Clarity about what they are responsible for;
2. The authority and resources they require to fulfil that responsibility; and
3. Clarity about how they are to be held to account and by whom.

It is essential that no person or entity with authority to make a decision that has a material impact on the functioning of the health service lies outside an accountability framework. If authority is assumed, then accountability must go with it. Often a person or entity may be held to account for a responsibility where they were denied the authority or resources they need to meet that responsibility. This creates a blame culture. Equally damaging, and less often spoken about, is where an individual wields authority without being held accountable themselves for any adverse outcomes of their decisions; but others are. This leads to dysfunctionality, and fundamentally undermines any sense of real accountability, and indeed trust.

Given that the purpose of the health service is to provide care, accountability must start at the point at which care is delivered. Any accountability framework that does not begin at this level – in the ward, or emergency or outpatients' department, or laboratory, or in primary care – is ultimately irrelevant to the core purpose of the health service, and will fail. Building from this level, accountability must then be aligned through the layers of the health system, right through to the Minister for Health and to the Government.

Sadly, what the Irish health service has evolved is a governance system that is applied from the top down, not from the ground up, and where at every level, including at national levels of the Department of Health and the HSE, appropriate responsibility is not aligned with authority, nor with accountability. Most damaging, governance is not aligned with the service to be provided to patients, leading to a fragmented approach to planning and delivering care, which for patients ultimately results in an experience of disjointed and sometimes unsafe care.

While we can all understand and support the concept of providing care that is centred around the needs of the patient whether at home, in the community, in primary care, or in hospital, the system has been set up to work in almost total opposition to that concept, in terms of how the service is governed, managed, funded and measured. This is why nothing less than fundamental, systemic change is needed.

> "You are responsible and accountable for things over which you have no control".[31]

Hospital Groups and Community Healthcare Organisations

Are Hospital Groups and Community Healthcare Organisations a good idea and will they work?

In principle the concept of devolving responsibility, authority and accountability for the delivery of services as close to the patient as possible is not only good, but essential.

A weakness of the envisaged structures is that they are not clearly aligned to the population they serve across community and acute services. Neither is it yet clear how integrated care will be governed and managed across the boundaries that will exist.

A major mistake is to focus exclusively on the 'structures' being created. New structures are almost certain to have no discernible impact, and more changes to structures is likely only to cause more confusion and delay. What will make a difference is how new patient-oriented ways of delivering integrated care can be implemented.

The focus for both Hospital Groups and CHOs should be on how they are setting up the processes and aligning resources to be able to deliver joined-up coordinated care to the population they serve.

Whether Hospital Groups will become independent Hospital Trusts, is an issue for the Government to address, but it is highly unlikely that Ireland has the scale to warrant such an approach.

The Government has a responsibility to set the direction of travel in this regard – ideally towards population-based, integrated healthcare services, but should understand that this will take considerable time, and will not be created through structure but through changed ways of working at local, regional and national level.

Another point to note is that the while the Higgins Report[27] envisages autonomous hospital trusts, this has not yet been implemented, and it is unclear whether this goal is achievable. The future statutory basis for hospital groups must be clarified. The lack of clarity on this issue has been a destabilising factor within the health service. It is also important that these new service delivery organisations be oriented around providing services to a defined population; and that governance arrangements and processes between them are such that an integrated, patient-centred approach to service delivery by those organisations is both enabled and mandated. Otherwise our existing siloed approach to service delivery will endure.

In this context it is critical that service delivery organisations are established in such a way that they are both accountable to the local population they serve, and accountable at a regional or national level in relation to performance against frameworks and standards.

8 Supporting healthcare staff

Major, sustained emphasis is needed on strengthening and supporting the people who deliver care, and on rebuilding trust and confidence among the workforce.

Successful organisations recognise the importance of the people who work for them; they try to recruit the best; ensure they are enabled to perform to their best; are involved appropriately in decision-making; are trusted; and are provided with development opportunities. This is what we should aspire to for our health service.

Without people, there is no healthcare system. Clinical teams cannot function without high-calibre administrators and managers who manage the logistics and support for the team. Doctors cannot deliver high-quality care to patients without highly skilled and professional nurses and health and social care professionals. Hospitals cannot function without highly able financial managers; nor can they function without the dedication of porters, cleaners, catering staff and the many others who contribute to the day-to-day life of the hospital. High-calibre CEOs have a profound influence on the effectiveness and efficiencies of a hospital. Hospitals cannot provide quality care to patients without high-quality GPs delivering excellent primary care. In such a complex system, multiple talents are needed for the system to perform, and we should acknowledge and support the essential roles played by all these staff.

There is also a responsibility on staff to play their role in leading and supporting change. Many of those working in the service, far from resisting progress, are eager and willing to promote change that results in better care and improved morale.[32]

Workforce planning that is based on healthcare demand will ensure that the workforce capacity is sufficient and appropriately skilled to meet future needs 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 their roles and responsibilities with appropriate equipment, training, structured and flexible career pathways, a safe, comfortable and effective physical working environment, and a prevailing culture in which all staff are valued.

It is encouraging to note that the HSE's People Strategy[33] recognises the central importance of high-quality, motivated staff to the delivery of care, and seeks to change the experience of people working in the health service. This is an indicator that a new approach to people is being led from the very top of the health service, and is very much to be welcomed and supported. We should be optimistic that the vast majority of staff across the health service will respond positively to a new philosophy and approach, if they trust that this new direction will be meaningfully supported and sustained at all levels of leadership, within the HSE, the Department of Health and other relevant government departments.

Crisis of staff retention and morale

> 1 in 5 medical trainees intend to either definitely not, or probably not practise medicine in Ireland in the foreseeable future.

At a time when the world is facing into a global shortage of high-quality clinical staff, Ireland's strategy towards the people who work in the health service is unclear. Over the past number of years, it appears to have been one of alienation. We know from a Medical Council survey that 1 in 5 medical trainees intend to either definitely not, or probably not practice medicine in Ireland in the foreseeable future.[34]

> "Emigration is a matter of self-preservation. The working conditions …are killing us slowly'[35]

There is a crisis of morale within the health service, and a crisis of retention and recruitment among many critical clinical and management staff. While there is no doubt that pay has become a crucial issue with many staff, and that Ireland is now competing with international health services for the best medical and nursing staff, the problem is also fundamentally linked to a perceived lack of respect for staff, and indeed the sense that workers are increasingly regarded as a commodity, which was particularly and most damagingly exacerbated during the financial crisis[18]. Engagement with staff has been unnecessarily and damagingly adversarial.

> Health professionals who have emigrated have reported that improved working conditions in the destination country appeared to provide respondents with the opportunity to rediscover the joy of practising their profession without having to contend with a difficult work environment

This situation must be recovered. Staff want to play their part in a functional healthcare system where sustained focus is on delivering optimal patient care. Achieving some sense of professional fulfilment in a health system that is in almost continuous crisis mode is extremely difficult, if not impossible. Health professionals who have emigrated have reported that improved working conditions in the destination country appeared to provide respondents with the opportunity to rediscover the joy of practising their profession without having to contend with a difficult work environment.[35]

> "We are not afraid of hard work but the daily demand is such that you don't even get to avail of simple human needs like lunch or the bathroom because of staff shortages."[31]

The almost constant negative public and media narrative about the health service in Ireland has also had a negative impact. Despite the millions of positive interactions and good patient outcomes each year, to many staff in the health service it appears that the primary public narrative is one of failure. This creates a damaging context for people in which to work. While the system must take its share of responsibility for creating this environment, at a societal level it must be recognised that the health service is a human system, subject to human frailty and the limits of technology and systems. In the best systems in the world errors do happen. In a system with fundamental flaws in governance, errors will certainly occur. Our emphasis should be on minimising error and its impact through appropriate systems.

9 eHealth

The individual health identifier and electronic health record must be implemented. The advent of the eHealth Strategy provides an opportunity to adopt a long-term strategy to underpin joined-up care across community, primary care, acute hospitals, and mental health; and to simultaneously enable effective population needs analysis, prioritisation, planning, outcome measurement, and performance accountability at local and national levels.

Moving to a single national patient identifier and electronic health record is a prerequisite to the success of any development of integrated care. Sustained investment in eHealth promises profound potential benefits, and can no longer be ignored. Ireland has an opportunity here to leverage its historical underdevelopment in this area by learning from what has not worked well internationally and ensuring we design a system based on these lessons.

Healthcare is a complex system, and the need for Information and Communications Technology (ICT) systems and data to support and enable effective and joined-up models of care is clear.

It is not possible to deliver safe, quality and effective care to patients when important patient data in the secondary and tertiary care settings is contained in multiple, often paper-based documents; and where the transition of a patient from one care setting to another is by way of paper files. However, persistent lack of strategy and underinvestment over the last number of years has led to a fragmented and not fit-for-purpose approach to ICT.

While there is a multiplicity of IT systems within the health service, there is very little interoperability between them. Almost all are in the acute sector while community systems are largely absent.

> It is not possible to deliver safe, quality and effective care to patients when important patient data in the secondary and tertiary care settings is contained in multiple, often paper-based documents.

Without significant, strategic and long-term investment in eHealth, the vision of caring for people in the community, as close to home as possible, will remain a pipe dream.

The published eHealth strategy for Ireland provides a direction for us to take in this regard.[36]

The need for e-health - the physician's perspective

"We're using lever arch files and post-it notes. Patient files are missing vital pieces of information such as referral letters. We cannot implement the care we are striving for in this outdated environment"

- Consultant in an Irish Hospital

10 Developing healthcare leaders

Clinical leadership roles and managerial capability should be developed and supported at all points in the system

Only strong leadership at local, regional, national and institutional levels can overcome the lack of trust in the system and bring about the kind of change needed to return the health system to its core purpose and deliver on it. It must be recognised that there is a crisis in leadership at all levels, and that there has been lack of support for leadership development.

Clinicians should be represented in all governance structures and an environment should be created whereby leadership and governance roles are seen as desirable and attractive. This is of particular importance for doctors, as historically their involvement in leadership and management roles has been limited.

Among clinicians, management and leadership should be seen as career tracks that are as valid as education, research and clinical excellence. 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.

11 Shared vision and political consensus

A shared vision and long-term strategic plan with cross-party political support is essential. Frequent changes in direction are fundamentally destabilising and undermining for the health service.

There must be sustained political and inter-professional commitment to long-term policies and strategies. Cross-political consensus is necessary to support a commitment that spans multiple government terms and composition.

As a consequence of dysfunctional governance, the extreme austerity experienced by the health service in recent years[18], and the inexorable rise in demand for health services[38] there has been a default towards crisis management, and a distinct lack of strategic planning at national and local levels. The only outcome of such an approach is continued self-perpetuating crisis and underperformance.

For example, since the foundation of the HSE in 2005, there have been five Ministers of Health, each with a particular policy focus. During this time we have seen the formation of the HSE as the accountable body; the abolition of the board of the HSE as the accountable body; the creation of national directorates; integrated service areas; regional operational areas; hospital groups and community healthcare organisations. Policies regarding co-location of public and private hospitals and a programme of universal health insurance have come and gone.

The lack of a clear direction for the health system with general and sustained all-stakeholder support is extraordinarily debilitating for the service. It is the responsibility of the Government and politicians to provide policy frameworks and to enable those frameworks to be implemented, through legislation and funding

The appropriate role of politics in the health service must be considered. The HSE was set up with a sense that it would allow for 'removing politics from health'. This was never realistic as health will always be a political issue given that politicians represent and are accountable to the people, who are ultimately the owners and users of the health system. However, the manner in which politics engages with the health system needs to change.

> The manner in which politics engages with the health system needs to change.

It is the responsibility of the political system to establish effective and robust governance arrangements for the health system; to lead the public debate on what is reasonable to expect from the system; to define what funding is to be allocated to meet those expectations; to set out the high-level measures to which the system is held locally and nationally accountable on behalf of the population; and to put in place the policy and legislative requirements to enable the health service deliver on its responsibilities.

Political leadership for change

The Oireachtas and the Government must become guardians of the transformation of the health service

While healthcare will always be a political issue, no meaningful improvement will be delivered unless there is a sustained agreement across the political divide on a future path for the health service. The Government needs to provide a 10 to 15 year undertaking and direction for the health service matched by investment to create a new patient-centred system of healthcare in Ireland.

The Oireachtas and the Government must become guardians of the transformation of the health service, and provide the necessary policy and legislative framework to enable the improvement plan. The establishment of the cross-party Oireachtas committee in 2016 is a necessary and practical political development to set a direction for the health service. The challenge to all stakeholders will be to support the output of the committee. The challenge for the committee will be to outline a direction that all stakeholders can commit to. Even with this cross-party support it is essential that the Government establish a high level expert group that reports to the Oireachtas on progress and that has the mandate and authority to hold all parts of the system to account for making the change happen. In the absence of such a body, there is no possibility of meaningful change emerging from within the health system.

12 Implementing change

Failure to successfully implement change has been a recurrent and debilitating feature of the health service for many years. There must be significant, targeted and sustained investment into making these changes happen.

There is no shortage of strategic reports and policy documents describing our aspirations for the health service. But there is a problem with implementation. The Quality and Fairness Health Strategy (2001) called for a shift of care into the community. A decade and a half later, we are still pursuing the same target. This is unacceptable. The health service in Ireland is on a precipice and crisis management will not draw us back from the edge. Those in leadership positions at all levels of the health service and in Government have a clear duty to inform the public and to effectively advocate and lead change on behalf of the people.

Learning from past experience is crucial. One of the few recent examples of successful implementation of radical change was the National Cancer Programme. Lessons learned were on the importance of political and clinical leadership; the development of a long-term vision and plan; change based on evidence, appropriate authority and resources; and continuous communication with all stakeholders.

Change is not possible without a vision that resonates with those who need to make it happen. But neither is it possible without a concrete plan with objectives, milestones, management, expertise and resources.

Policy alone is not a plan. Legislation is not a plan. A co-ordinated, programmatic approach with cross-sectoral engagement is essential.

> The focus must shift from short-term, recurring crisis management to strategic change management

Change is difficult and requires a sustained and consistent approach. It will fail if the plan isn't good enough; it will also fail if the plan itself is open to frequent change of direction, or if the execution of the plan is not reliably informed by timely analysis of real-time data. The focus must shift from short-term, recurring crisis management to strategic change management. Simply and naively asserting that 'change is needed' is not change. Unless the pursuit of real change becomes the primary focus, it will not happen. If the primary focus remains crisis management, this will always win out against implementing real and constructive change as it has done for the past few years.

Change that focuses on symptoms and not on underlying causes will fail. The focus must be on changing how the system is governed and operates, its ways of working, culture, capabilities and processes. To make effective changes in these areas, there must first be an understanding as to why the system is failing. Structural change must come after this. Structural change alone is not change.

Change requires transparency, honesty and adherence to commitments and to the values and spirit of the plan. Lack of trust is a major barrier that only leadership of great vision and integrity can overcome.

Making change happen requires investment. Without additional resources it will be impossible for change to occur on any meaningful scale. Any assumption that significant improvement can be achieved without specific investment to make change happen is not feasible. There must be deliberate, targeted and sustained investment in making change happen. Long-term investment is needed to enable changes over time.

> Making change happen requires investment. Without additional resources it will be impossible for change to occur on any meaningful scale.

From our discussions in Towards 2026, there is a real sense that change is not only necessary, but that it is achievable.

There is support for fundamental, meaningful change from those working in the health service and those receiving care. There will be a need to mobilise public support for change, and many stakeholders are willing to help in this regard. In the same way that the future of healthcare services relies on effective collaboration and partnership between multiple stakeholders, a radical plan for our future healthcare system will also depend on this collaboration and partnership.

To put the recommendations of this report into action, a major implementation strategy is required encompassing policy implementation within and outside the health sector.

All stakeholders must be involved in making change happen and should have a clearly defined role in the implementation of this vision. Without their active involvement, change will be impossible. In particular, the voice of patients and carers must be prominent in the process.

Meaningful change is impossible without strong leadership at all levels of the health service and the Government. All those in leadership positions must reflect on their vision and capacity to do the job required. The ultimate governance of this change must reach the top level of the Government and the Oireachtas.

This will require an implementation group that is mandated and given the authority and resources necessary to drive and support change throughout all aspects and levels of the health service.

Finally, there must be an understanding and acceptance that this journey will never end. All stakeholders must forever seek to improve the health of the nation and the healthcare service provided to the people of the nation. The challenge is to build a system that, within itself, has the capacity, capability and drive to continue to improve.

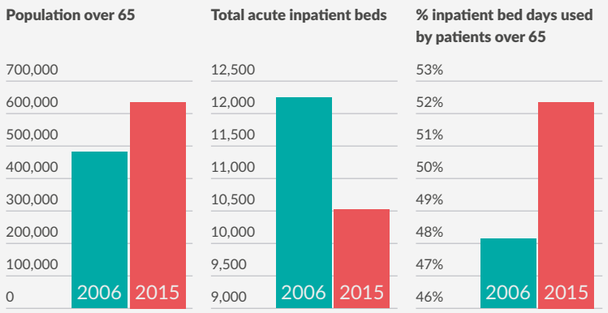
References

1. Department of Health. Outline of the future hospital system report of the consultative council on general hospital services (Fitzgerald Report). Dublin 1968
2. Department of Health. Report of the National Task Force on Medical Staffing (Hanly Report). 2003
3. Future Hospital Commission. Future hospital: caring for medical patients – A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians; 2013. Available from: https://www.rcplondon.ac.uk/projects/outputs/future-hospital- commission
4. Irish Hospital Consultants Association. We are no longer able to recruit and retain the best. The Consultant. IHCA Autumn 2016
5. Irish Nurses and Midwives Organisations. Press Release – INMO Calls For Immediate Action On Pay And Nursing/Midwifery Shortages. 06.10.16 https://www.inmo.ie/Home/Index/217/12777
6. Health Service Executive. Medical Workforce Planning – Future demand for General Practitioners. HSE- NDTP 2015.
7. Department of Health. Quality and Fairness – A health system for you. Dublin 2001
8. Department of Health. Future Health: A Strategic Framework for Reform of the Health Service 2012-2015. Dublin 2012.
9. Department of Health and Children. Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2015. Dublin: DoHC; 2012.
10. Department of Local Government and Public Health. The Hospitals Commission General Reports 1933-38. Available from http://www.lenus.ie
11. Department of Health. The Path to Universal Healthcare: White Paper on Universal Health Insurance'. Dublin, Ireland: Department of Health; 2014.
12. Health Services Executive. HSE National Service Plan for 2016. Dublin; 2015. Available from: http://www.hse.ie/ eng/services/publications/serviceplans/nsp16.pdf
13. INMO. Trolley Watch/Ward Watch for February 10th 2017. www.inmo.ie
14. Health Research Board. Alcohol in Ireland: consumption, harm and cost. Available from http://www.hrb.ie/uploads/media/Alcohol_in_Ireland_consumption_harm_and_cost.pdf
15. HIQA. Health technology assessment (HTA) of smoking cessation interventions. HIQA 2017
16. Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT; Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. Lancet. 2012 Jul 21;380(9838):219-29.
17. Smyth B. Planning for Health 2017 HSE Planning for Health: Trends and Priorities to inform Health Service Planning 2017. Dublin: HSE; 2016.
18. Thomas S, Burke S, Barry S. The Irish health-care system and austerity: sharing the pain. The Lancet. 2014 May 3;383(9928):1545-6.
19. Berwick DM, Hackbarth AD. Eliminating Waste in US Health Care. Journal of the American Medical Association. 2012 Apr 11;307(14):1513-1516.
20. Elliott S. Fisher, M.D., M.P.H., Donald M. Berwick, M.D., M.P.P., and Karen Davis, Ph.D. Achieving Health Care Reform — How Physicians Can Help. N Engl J Med 2009; 360:2495-2497, Available at: http://www.nejm.org/doi/ full/10.1056/nejmp0903923#t=article
21. Medical Council. Guide to Professional Conduct and Ethics for Registered Medical Practitioners Eight Edition. Dublin: Medical Council; 2016
22. Evetovits, Tamas, Figueras, Josep, Jowett, Matthew, Mladovsky, Philipa, Nolan, Anne, Normand, Charles and Thomson, Sarah (2012) Health system responses to financial pressures in Ireland: policy options in an international context. Thomson, Sarah, Jowett, Matthew and Mladovsky, Philipa (eds.) Department of Health, Dublin.
23. Eurostat. Healthcare resource statistics – beds. Available from http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_resource_statistics_-_beds. [accessed 15/03/17]
24. Department of Health. Health in Ireland – Key Trends 2015.
25. Department of Health. Health in Ireland – Key Trends 2016.
26. Barrington R. Health, Medicine and Politics in Ireland. Dublin, Institute of Public Administration, 1987
27. Department of Health. The establishment of hospital groups as a transition to independent hospital trusts – a report to the Minister for Health ("The Higgins Report"). Dublin, Ireland: Department of Health; 2014
28. Eeckloo K, Van Herck G, Van Hulle C, Vleugels A. From corporate governance to hospital governance. Authority, transparency and accountability of Belgian non-profit hospitals' board and management. Health Policy. 2004 Apr;68(1):1-15.
29. Murphy C, O'Donohoe S. Hospital Governance: An Insight from the South East of Ireland. In: Irish Accounting & Finance Association Conference. DCU, Ireland. 11–12 May, 2006 (Unpublished). Available from: http://repository.wit. ie/267/2/Cath_paper_IAFA_conf.pdf
30. Attributed to W. Edwards Deming – ref unknown.
31. Hayes B, Fitzgerald D, Doherty S, et al Quality care, public perception and quick-fix service management: a Delphi study on stressors of hospital doctors in Ireland BMJ Open 2015;5:e009564. doi: 10.1136/bmjopen-2015-009564.
32. Ipsos MRBI/HSE. Have Your Say: The Health Services Employee Survey 2014. Dublin: HSE; 2014, p9
33. HSE (2015). Health Services People Strategy 2015-2018. Leaders in People Services. http://www.hse.ie/eng/staff/Resources/hrstrategiesreports/peoplestrategy.pdf
34. Medical Council 2016. Your Training Counts. Spotlight on trainee career and retention intentions
35. Humphries et al. Emigration is a matter of self-preservation. The working conditions… are killing us slowly': qualitative insights into health professional emigration from Ireland Human Resources for Health (2015) 13:35
36. eHealth strategy for Ireland. HSE Available from http://www.ehealthireland.ie/Knowledge-Information-Plan/ eHealth-Strategy-for-Ireland.pdf
38. Shelley E. The Importance of Demographic Trends [PowerPoint Presentation] 2016 May 24
39. The Scottish Government. National Health and Wellbeing Outcomes Framework. Edinburgh: The Scottish Government; 2015. Available at: http://www.gov.scot/Resource/0047/00470219.pdf

Figure 5: **Towards 2026**

2016

Mismatch between capacity and demand



Source: Health in Ireland – Key trends (2016 and 2016)

Preventable Health Conditions in Ireland

160,221 hospital bed-days used for alcohol related illness in 2012

27,450 inpatient admissions per year due to smoking

Physical inactivity is responsible for 9% of coronary heart disease; 11% of type 2 diabetes; 15% of breast cancers and 16% of colon cancers

56% increase in the number of obese men and 70% increase in obese women between 2007-2015

Trolley Crisis

2011 The Minister for Health stated "never again" would trolley numbers get so high

2014 Emergency department taskforce convened

Jan 2017 **612** Patients on trolleys (all time high)

- 1 in 5 medical trainees intend to either definitely not, or probably not practice medicine in Ireland in the foreseeable future.
- In 2016, approximately 20% of approved permanent hospital consultant posts were either vacant or filled on a temporary basis.
- In 2016 there were almost 4,000 less Nursing and Midwifery posts, in the health service, than in 2008 (INMO).
- By 2025, the predicted shortage of GPs in Ireland will range from 493 to 1,380 depending on increased levels of access to free GP care. (HSE).

Our recommendations

1. Healthcare is about me
2. Keeping people well
3. Funding and expectations
4. Using data to plan
5. Joined-up care
6. Hospital without walls
7. Building for accountability
8. Supporting healthcare staff
9. eHealth
10. Developing healthcare leaders
11. Shared vision and political consensus
12. Implementing change

2026

- Patients supported to live at home
- A healthcare system that is always improving
- People have confidence in their healthcare system
- Nobody waits for a bed on a trolley for more than 4 hours
- Happy healthcare staff
- Joined-up care is the norm
- When you need specialist care, it's world class
- Most care in community and primary care
- Less people smoking, lower alcohol consumption, less people overweight, more people physically active
- No waiting for specialist care

"I didn't think it could come so far so quickly. What a change!"

"I feel listened to. I matter"

"The patient journey is convenient, efficient, caring and safe"

"I am not afraid of going to hospital"

"Easy accessible, safe quality care"

Towards 2026 – Participants

Chair, Towards 2026
Dr Tom Keane,

Thematic Leads, Towards 2026
Dr Siobhán Kennelly, Consultant Geriatrician and National Clinical Advisor and Group Lead Social Care

Dr Garry Courtney, Consultant Physician and Gastroenterologist & Clinical Director, St. Luke's Hospital, Kilkenny

Prof Risteard O'Laoide, Consultant Radiologist

Prof Charles Normand, Edward Kennedy Professor of Health Policy & Management, Trinity College Dublin

Participants, Towards 2026
Siobhán Creaton, Head of Public Affairs, RCPI

***Dr John Barragry,** Consultant Endocrinologist and Member of the Irish Medical Council

Dr Sarah Barry, Research Fellow, Trinity College Dublin

Mr Thomas Bergin, Patient nominated by the Irish Heart Foundation

***Prof Peter Boylan,** Consultant Obstetrician and Gynaecologist at the National Maternity Hospital and Chair of Institute of Obstetricians and Gynaecologists

Ms Mary Brosnan, Director of Midwifery & Nursing, National Maternity Hospital

***Mr David Byrne,** SC, Co-Chair of the European Alliance for Personalised Medicine (EAPM), Former EU Health Commissioner, Member of RCPI Council

Dr Declan Byrne, Consultant Physician in Geriatric and General Medicine, St James's Hospital

Mr Tony Canavan, CHO Chief Officer

***Dr Áine Carroll,** National Director, Clinical Strategy and Programmes Division

***Dr Geoff Chadwick,** Consultant Respiratory and General Physician, St. Columcille's Hospital

Dr Anna Clarke, Health Promotion Manager with the Diabetes Federation of Ireland

Mr Tom Clifford, Carer and former co-chair of Limerick Regional Hospital Patient Forum nominated by Family Carers Ireland

Ms Heather Coetzee, Speech and Language Therapy Manager, Mater Misericordiae University Hospital

Ms Aileen Colley, CHO Chief Officer

Tracey Conroy, Assistant Secretary, Acute Hospitals Division, Department of Health

Ms Eliza Cosgrave, Development Officer, Irish Hospice Foundation

Ms Marie Cregan, Lecturer in University College Cork and Patient Advocate

***Dr Philip Crowley,** National Director, Quality Improvement Division, HSE

Dr Gerry Cummins, ICGP President

Ms Carol de Wilde, Principal Medical Social Worker, St Columcille's Hospital

***Dr John Donohoe,** Past-President of the Royal College of Physicians of Ireland

Ms Trina Doran, Executive Business Manager, South/South West Hospitals Group

Mr Michael Drohan, COPD Support Ireland

Ms Mary Duff, Registered nurse and midwife, Board of Medical Council of Ireland

Ms Karen Egan, Patient Advocate

Dr Una Fallon, Public Health Medicine

Dr Martin Fellenz, Associate Professor in Business Studies (Business & Administrative Studies), TCD

Maebh Ní Fhallúin, Policy Specialist RCPI (Towards 2026)

Dr John Fitzsimons, Consultant Paediatrician and Clinical Director for Quality Improvement

***Dr Catherine Fleming,** Consultant in Infectious Diseases, Galway University Hospital

Ms Rhona Gaynor, Department of Health

Dr Karena Hanley, ICGP National Director of Specialist Training in General Practice

Dr David Hanlon, National Clinical Advisor and Group Lead Primary Care

Ms Eilish Hardiman, CEO Children's Hospital Group

Ms Alison Harnett, National Federation of Voluntary Bodies

Mr Brian Hartnett, Patient

Dr Blánaid Hayes, Consultant Occupational Physician

Ms Ita Hegarty (representing Mr Ollie Plunkett, National Outpatient Lead, HSE)

Mairéad Heffron , Policy Specialist RCPI

Dr Colm Henry, National Clinical Advisor and Group Lead for Acute Hospitals

***Prof Hilary Hoey,** Director of Professional Competence, RCPI

***Dr Mary Holohan,** Consultant Obstetrician and Gynaecologist, Rotunda Maternity Hospital

Dr Tony Holohan, Chief Medical Officer, Department of Health and Children

***Prof Mary Horgan,** Dean of the Council of Deans & UCC School of Medicine

***Prof Hilary Humphreys,** Dean, Faculty of Pathology

Prof Alan Irwine, Professor of Dermatology (Clinical Medicine), Trinity College Dublin

Dr Howard Johnson, Clinical Lead, Knowledge Management (incorporating Health Intelligence), HSE

***Prof Elizabeth Keane,** Dean of the Faculty of Public Health Medicine

Prof Frank Keane, Past President of the Royal College of Surgeons Ireland and Clinical Lead, National Clinical Programme for Surgery

Leo Kearns, CEO RCPI

Ciara Kirke, Pharmacist and Clinical Lead, Medication Safety Programme, Quality Improvement Directorate

Dr Peter Lachman, ISQua CEO

Ms Jill Long, President of the ISCP & Chairperson of HSCPA (previously) PBAI

Ms Hazel Luskin Glennon, Patient Advocate and Carer

Mr Matthew Lynch, Royal College of Surgeons in Ireland School of Pharmacy

Ms Marian Mackle, Patient Nominee, Irish Heart Foundatio

***Dr James Mahon (HST),** Collegiate Members Committee, RCPI

Dr Ann Manley, SpR Representative, Faculty of Occupational Medicine

Ms Rosarii Mannion, National Director of Human Resources, HSE

Dr Gerard Mansfield, ICGP National Director of Specialist Training

Dr Sara McAleese, National Doctors Training and Planning Unit, HSE

Mr Damien McCallion, HSE Area Manager, Sligo/Leitrim/West Cavan (National Director for National Ambulance Service)

Dr Gerry McCarthy, Clinical Lead, Emergency Medicine, Cork University Hospital

Dr Julie McCarthy, Lead Clinical Director, Histopathology

Prof Eilis McGovern, Director National Doctors Training and Planning, HSE

***Dr T. Joseph McKenna,** Former President of RCPI

Dr Mary McMahon, Consultant Occupational Health Physician

Dr Michelle Monahan, Radiographer

Dr Carmel Moore, Trainee representative, Paediatrics

Prof Frank Murray, President RCPI

Roisin Neary, Corporate Affairs Executive RCPI

Ms Colette Nugent (representing Mr Ollie Plunkett, National Outpatient Lead, HSE)

Prof Alf Nicholson, Consultant Paediatrician

Prof Charles Normand, Edward Kennedy Professor of Health Policy & Management, Trinity College Dublin

Mr Simon Nugent, Chief Executive, Private Hospitals Association

Dr Sorca O'Brien, Trainee

Ms Olive O'Connor, Founder of Medistori.com and Irish Patients Association Representative

Dr Paul O'Hara (BST), Collegiate Members Committee, RCPI

Mr Brendan O'Hara, Programme Manager at All Ireland Institute of Hospice and Palliative Care

***Prof Conor O'Keane,** Consultant Histopathologist, Mater Misericordiae University Hospital

Dr Stephanie O'Keefe, National Director of Health and Wellbeing, HSE

** indicates member of RCPI council*

Towards 2026 – Participants

Mr Pat O'Mahony, Deputy Secretary General, Department of Health

***Prof Des O'Neill,** Consultant Geriatrician, Tallaght Hospital

Prof Anthony O'Regan, Consultant Respiratory Physician

Dr Orlaith O'Reilly, National Clinical Advisor and Group Programme Lead, Health & Wellbeing Division

Dr Susan O'Reilly CEO, Dublin-Midlands Hospitals Group

Dr Brendan O'Shea, General Practitioner and Clinical Assistant Professor in Primary Care, School of Medicine, Trinity College Dublin

Dr Diarmuid O'Shea, Registrar RCPI

Prof Donal O'Shea, Co-Chair, RCPI Policy Group on Obesity

Prof Ellen O'Sullivan, Consultant Anaesthetist, St James's Hospital

Leah O'Toole, Head of Corporate Affairs RCPI

Dr Naomi Petty-Saphon, Trainee representative

***Dr Donal Reddan,** Consultant Nephrologist and Clinical Director for Medicine, SAOLTA

***Patricia Rickard Clarke,** Solicitor & RCPI Council Member

Dr Eve Robinson, Trainee Representative, Faculty of Public Health Medicine

Mr Joe Ryan, Acting Head of System Reform Group

Dr Karen Ryan, Consultant in Palliative Medicine

Dr Emer Ryan, Faculty of Paediatrics Specialist Registrar

Dr Rupak Sarkar, Trainee representative IOG

Dr Tony Shannon, CCIO Leeds NHS and Founder of Frectal Ltd

Dr Keshav Sharma, Forum Trainee Subcommittee

Prof Emer Shelley, Consultant in Public Health Medicine and RCSI Lecturer

Dr Diarmuid Smith, Consultant Endocrinologist

Dr Breda Smyth, Consultant in Public Health Medicine, HSE West

Dr Yvonne Smyth, Trainee representative

Mr Eddie Staddon, Business Manager – National Doctors Training & Planning (NDTP)

Mr Mervyn Taylor, Manager of SAGE (Third Age)

Dr David Vaughan, Director of Quality and Patient Safety at Children's Hospitals Group

Dr Catherine Wall, Consultant Nephrologist

Ms Mila Whelan, National Advocacy Unit, Quality and Patient Safety Directorate, HSE

Dr Barry White, Consultant Haematologist, St James's Hospital and former National Director for National Clinical Programmes

Prof Freddie Wood, President, Medical Council

Mr Liam Woods, Interim National Director, Acute Services

Dr Margo Wrigley, Consultant Psychiatrist, National Clinical Advisor and Clinical Programme Group Lead – Mental Health

Mary Wynne, Interim Nursing and Midwifery Services Director, HSE Clinical Strategy and Programmes Division

Many thanks to MCO Projects for facilitation of the Towards 2026 workshops, to Walker Communications Limited for report design and to the RCPI policy and public affairs staff for their contributions towards this report.

** indicates member of RCPI council*

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Royal College of Physicians of Ireland,
Frederick House,
19 South Frederick Street,
Dublin 2, Ireland
Phone: +353 1 863 9700
Fax: +353 1 672 4707

twitter.com/RCPI_news
facebook.com/RoyalCollegePhysiciansIreland
youtube.com/WatchRCPI

www.rcpi.ie