IRISH HEALTH SERVICE – FINANCIAL MANAGEMENT FRAMEWORK

CONTEXT – INTRODUCTION OF AN INTEGRATED FINANCIAL MANAGEMENT SYSTEM (IFMS) TO SUPPORT IRISH HEALTHCARE

CONSULTATION PAPER – January 2020

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1. Introduction

1.1 Background

The report *"DEFINING FINANCIAL MANAGEMENT - A Finance Operating Model for Health in Ireland, 30th August 2013",* generally referred to as "The FOM" was commissioned by the HSE in 2012. The FOM stated that *"the current financial management framework does not support the Chief Financial Officer's (CFO) responsibilities and accountabilities"*. It also stated that *"The CFO will define the financial management framework which is mandated across the health system. This will define the process, governance and controls required to demonstrate effective financial management practice".*

The FOM is one of the foundational documents[1] underpinning the overall Finance Reform Programme (FRP). The national integrated finance and procurement system (IFMS) is being developed as part of that program. The job description for the "new" role of HSE CFO, first filled in 2013, also referenced the requirement for the CFO to develop a financial management framework.

The health service is now moving towards the design and implementation phase of the IFMS which will be built on the very modern SAP S/4HANA platform procured in 2017. This brings a number of requirements including the need to adopt a set of national standard finance and procurement processes in order to secure the benefits of this significant investment. This will bring opportunities and challenges and it is in that context that this Financial Management Framework (the Framework) is now being developed. This development is intended to be a collaborative exercise that provides an opportunity for as many managers, clinicians and staff, who wish to do so, to participate.

1.2 Purpose & Governance of the Financial Management Framework

The purpose of this framework is largely to act as a communication and change management tool. It will seek to set out core principles, address key conceptual challenges, clarify roles and responsibilities and enable key decisions where necessary. It is intended to underpin a wide engagement across the health system in relation to the key issues that will determine the success or otherwise of the implementation of the IFMS. The IFMS will in turn significantly influence the success or otherwise of the overall FRP. This engagement is intended to share information with, and solicit input from, relevant administrative, managerial and clinical staff at all levels across the statutory and voluntary health and social care system.

The text of the framework will be updated, amended and expanded as the outputs from the engagement process become available and as the process to get ready for IFMS continues. The current text has already been significantly amended and expanded based on feedback received to-date as part of the initial stages of engagement.

Formal governance in relation to the text of the framework and the IFMS itself is via a steering committee that the CFO chairs. This is a national decision making group that has senior representatives from the statutory and voluntary system at local, regional and national "centre" levels. It will consider the output from the engagement process and advise the CFO as to appropriate updates to the framework.

1.3 Primacy of the Financial Management Framework

The framework is intended to be in alignment with, rather than a substitute for, all of the material in the FRP Business Case or other foundational documents. The framework, as the living document, is intended to take precedence over the foundational documents in cases where there is any potential misalignment.

[1] Other foundational documents include the FRP Business Case and the IFMS ICT Business Case.

In practice this will require the IFMS team to review the framework, as it develops, against the foundational documents and advise the CFO and the steering committee accordingly. Where necessary to bring it into alignment with the framework, a change to some element of one of the foundational documents will be approved through the formal change control process. This process involves the Finance Reform Steering Committee and ultimately the Finance Reform Board chaired by the Director General.

1.4 Realistic Ambition

Looked at in overall terms our current financial management technology and processes are not fit for purpose despite many examples of localised good practice or general improvements in spite of the many constraints. The benefits for staff, services and ultimately patients from a well implemented national financial and procurement system across the Irish health service are considerable.

However, it is important that we do not underestimate the scale of the change management challenge required to successfully implement a single national financial and procurement system across the Irish health and social care system. This is why wide engagement with the system and strong collaboration as colleagues with largely shared goals is so important despite the time and other challenges this will bring.

Notwithstanding these challenges there is an essential requirement for us to be “realistically ambitious" in what we set out to achieve and part of the purpose of the framework is to capture that ambition. It is not appropriate, for example, that our design principles around national processes would be based on the “lowest common denominator” of what represents the least change from today. Being realistically ambitious means we need to set out for IFMS and its national processes what we think will represent good and best practice. It needs to represent a good return for the investment of our collective time and energy over the next 5 years as well as for the significant investment of taxpayers’ funds.

Our default ambition will be to seek to implement all of what we set out as best practices in this framework, **in advance** of or during the implementation of IFMS as it is “rolled” out to different service areas. At the detailed design or implementation planning stages it may be determined that some aspects of best practice cannot be fully delivered by the time IFMS is “rolled out” to some area. In such cases the requirement will be to set and agree a clear process and timeline by which this “delayed” aspect of best practice is fully delivered rather than deferring it until “some future time”.

This can be divided into at least two categories. The first category is processes that exist routinely today but are of poor quality in many areas. An example is the operational purchasing process where there may be limited proper use of purchase requisitions and purchase orders. This leads to poor public procurement compliance and limited availability of data to inform the sourcing of better contracts. In such instances the general approach is to encourage local services to begin to tackle poor current practices now within their legacy systems to the greatest extent practical. It is expected that these core and routine processes will be largely fully implemented by the time IFMS is rolled out to a particular service area.

The second category is processes that are not yet routinely in place or well developed. An example is costing of community services. This includes better financial reporting and costing in relation to different categories of residential placements across older persons, disability and mental health services. It also covers examples such as primary care networks and mental health community teams as well as taking the opportunity to revisit existing financial reporting and costing arrangements in areas such as the fair deal cost of care and shared site costs. These are areas for priority development effort immediately however it is likely that this effort will be ongoing before, during and after the implementation of IFMS.

2. Benefits[2] to be realised from investment in the new IFMS

2.1 Summary Benefit 1: Better Financial Information for stakeholders across the health service

The health service requires better financial information to support decision making at all levels. "Better" looks like a single source of more accurate, understandable and comprehensive information that enables like for like comparison and explanation of current and future service costs. Financial information is required in real time with monthly reports to be available within 5 working days of month-end to decision makers at local, regional and national level across health and social care services. Better decision making is key to better financial management and will assist in improving how services are funded and in enhancing service delivery. It will also assist in delivering better value for patients and demonstrating this value to taxpayers and their representatives in order to support appropriate additional investment. Value in this context means quality services that are as economic, efficient and effective as possible. Ultimately value means better outcomes for patients and service users at the lowest cost per capita. The new Finance Operating Model (FOM) seeks to bring all of this together i.e. People (our staff), Process (national standard processes) and Technology (IFMS).

Good quality financial information should enable past or future movements in the total costs of inputs or outputs to be analysed. Movements caused by changes in the price per unit of the **inputs**[3] that go into delivering any given service need to be readily differentiated from movements caused by changes in the mix or volume of those inputs. This is a basic requirement. Over time, our ability to link financial and activity data via a costing process will continue to develop. In due course the same "price versus volume" differentiation needs to become readily available in respect of movements in the costs of all service **outputs**[4].

Financial information in this context refers to the financial and procurement information to be produced within the new Integrated Financial Management System (IFMS). It also includes relevant information to be produced within the National Integrated Staff Records and Pay System (NiSRP) which will be accessible via IFMS. These systems are mandated by the Finance Reform Board (FRB)[5] for use within all directly operated HSE services as well as all services funded by the HSE under s.38 agreements. In the case of IFMS, larger services funded under s.39 agreements are also in scope.

2.2 Summary Benefit 2: Strengthened System of Internal Financial Controls

Improved and better supported governance, data governance, compliance, performance and accountability at local, regional and national level are central to the design and delivery model for IFMS. The health service requires a strong control environment. This must be consistent with its overriding requirement to deliver safe services to patients and service users and to do so as efficiently and effectively as possible. Control breaches, such as those identified in the reports produced by internal audit and the C&AG, undermine confidence in the health service and weaken its ability to attract additional investment. A strong control environment is one which is as simple to understand and comply with as practical. The burden of compliance needs to be as low as possible. Managers and staff need to be supported in terms of knowing **what** they need to comply with i.e. what are their roles and their responsibilities. They also need to be supported by practical assistance as to **how** they can comply i.e. assisted in terms of capacity and capability. The cost of compliance and the level of compliance should both be visible and capable of being readily tracked over time by managers at all levels.

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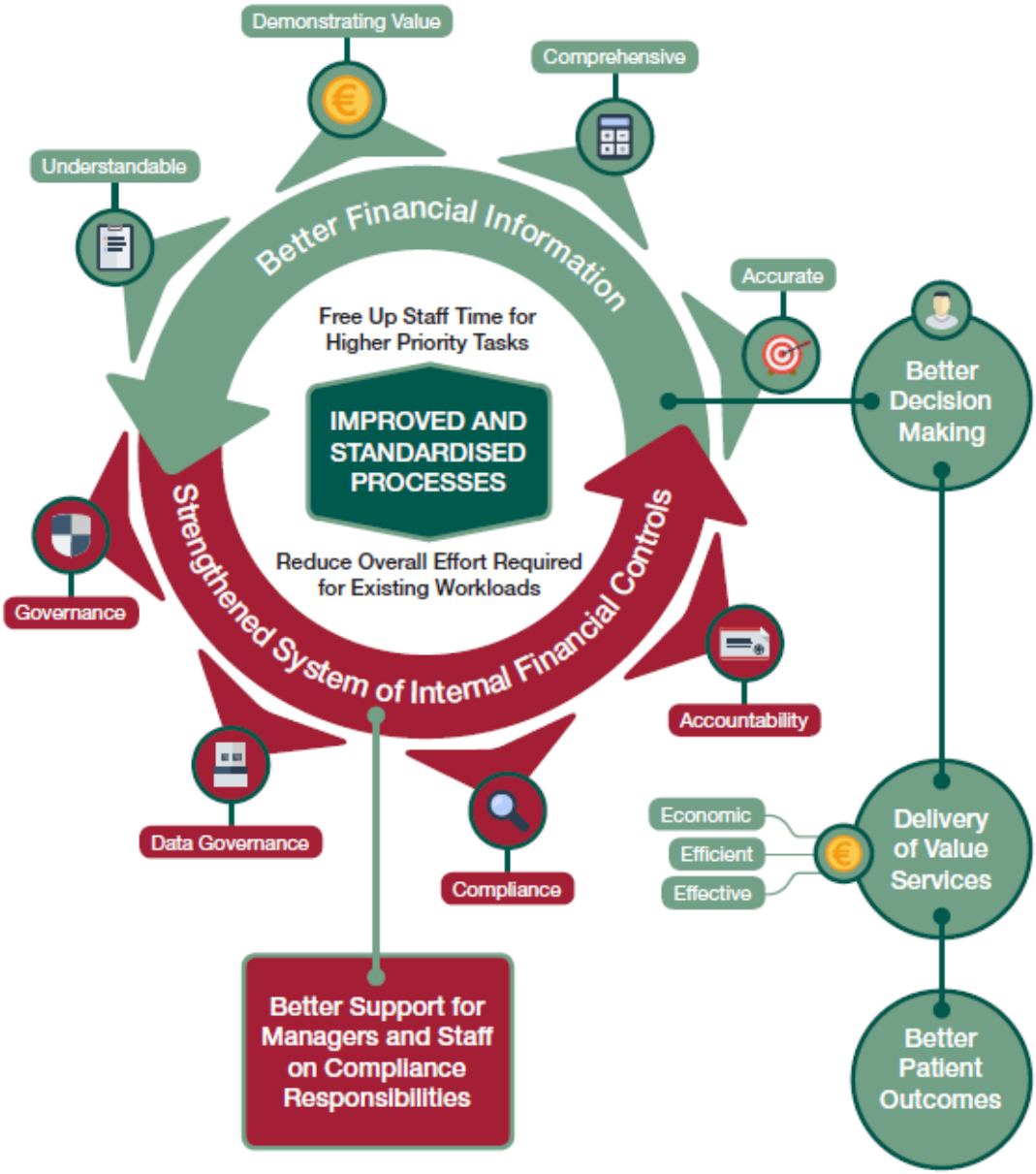
[2] See appendix 3 for details of the IFMS benefits outlined in the Finance Reform HSE ICT Business Case.
[3] Staff hours, consumables or other non-pay items.
[4] Procedures, home visits, residential places, etc.
[5] FRB is chaired by HSE DG, members include Sec Gen DOH and Assistant Sec Gen DPER. The board overseeing the NiSRP system has similar but expanded membership, including DG and Sec Gen DOH.

Streamlined standard national processes will reduce the overall staff effort required to deliver current process outputs at current quality levels. The default objective in implementing IFMS, is to avoid, to the greatest extent practical, any significant ongoing net additional time of frontline clinical staff being tied up in its operation post go-live. Where current processes are of reasonable quality, such as in many financial areas, it should be practical to free up staff time for higher priority tasks including decision support. However, there are instances where current processes require significant improvement, such as in many aspects of the purchase to pay process. In such cases there will be a requirement for well designed, very streamlined and user friendly national processes coupled with focused local change and reconfiguration over the short to medium term. This will maximise the delivery of the benefits of improved compliance and information while minimising any potential for ongoing additional costs.

Figure 1: Summary - Key Benefits from IFMS



2.3 Delivering benefits to the users of health service financial information[6]

For many stakeholders, including managers and clinicians, their main expectation as regards likely benefits from a new financial system revolve around the receipt and use of financial information. They are seeking insights from that financial information that will assist them with the tasks of planning and delivering services.

There are many aspects to the sustainable realisation of such benefits and these aspects go beyond the key foundational elements e.g. the provision of a new system, the operation of standard processes and other technical considerations.

These aspects have been brought together into a draft reporting strategy which is included at Chapter 5 Financial Reporting Strategy below. In summary this reporting strategy seeks to set out a roadmap as to how the investment in IFMS can be leveraged to deliver specific benefits such as:

1. Phased embedding of high level safety and quality indicators within relevant financial reporting.
2. Improved input based reporting i.e. tracking movements in pay and non-pay costs with the ability to readily report on the extent to which these are caused by changes in the volume of inputs used or the unit cost of those inputs.
3. Improved standard operating procedures for analysis, forecasting, planning and budgeting supported by an automated consolidation tool.
4. Moving to a norm where all financial reports include or are accompanied by the identification, evaluation and recommendation for consideration of necessary decisions and actions.
5. The phased introduction of a structured assessment of economy, efficiency and effectiveness as a routine feature of financial reports.
6. Performance dialogue supported by better financial reporting that addresses a set of agreed topics at each level of the performance management process with the goal of achieving a shared view of performance and realistic actions to improve it.
7. High level output based reporting which involves lining up pools of costs against pools of activity e.g. this list of individual community mental health teams each cost €Xm to operate and delivered X, Y and Z in terms of activity. To be achieved by maximising the potential of financial reporting (careful use of cost centres etc.).
8. Better informed and more equitable commissioning and resource allocation.
9. Phased expansion of detailed output based costing to provide visibility of detailed costs for different categories of service users or for individual service users. To be achieved by linking financial data, activity data and quality data via appropriate costing methodologies and longer term costing projects.

From a clinical perspective the benefits listed above, when taken together, provide significant potential to further support efforts to:

I. Better understand the cost drivers within services in a way that enables collaborative working between clinicians and managers.

[6] See Chapter 5 Financial Reporting Strategy

II. Identify opportunities to reduce costs or improve productivity without impacting the quality of services.

III. Demonstrate the value being delivered by current clinical services.

IV. Make the case for additional investment in clinical services to implement new models of care.

V. Improve service quality for patients and their families.

VI. Improve service integration for patients and their families.

3. Consideration of the approach to "designing" processes to achieve these benefits

Without standard processes, operated in a consistent way across all health and social care services, it will not be practical to achieve the benefits of better financial information and a stronger control environment. It remains the case that investment in people, technology **and** process is required. However, any investment in technology and people will be wasted unless the necessary process changes are designed and implemented. "Process design" is something of a misnomer in the context of implementing the IFMS. A full set of best practice, internationally standardised process maps for finance and procurement, including logistics and inventory management, has already been acquired. They came as part of the contract for the SAP platform on which the IFMS will be based.

The health service needs more than just a defined set of standard processes. These processes must also be **operated** in a way that is consistent, efficient and sustainable over the longer term. This includes data consistency and ensuring common approaches to coding and classification of activities and costs via the adoption of a single chart of accounts within a single overall enterprise structure (see Chapter 5 – Financial Reporting Strategy). More complex or specialist processes that depend on each individual local provider consistently recruiting, retaining and prioritising the time of a number of expert staff members will not meet these criteria. They would, in effect, be subject to "multiple points of failure". This has significant implications for where we locate the various elements of each major process.

It is reasonable to assume that the availability of funds to invest in additional "finance and procurement people" will be limited given the overall pressure the health service is under and the appropriate prioritisation of frontline staff. In this context it makes sense to focus any available investment in people towards the earliest possible implementation of standardised processes. The alternative is that overall progress is delayed, as investment is diluted to also supplement local teams who, in the interim, are trying to overcome the challenges caused by the current non-standard processes.

All of this clearly points to the need to optimise the effective use of local self-service and the utilisation of Health Business Services (HBS). HBS is the established national shared services provider for the public health service. This is in line with government policy for the development of the Public Service. Self-service will allow for simplified local direct entry of data such as purchase requisitions, requests for new cost centres etc. with amalgamation, validation, manipulation and more specialist and complex processing activities either automated or carried out nationally by HBS, NFD, etc.

Making the change from the current disparate local processes to a set of nationally standardised best practice processes operated in a consistent way is a major part of the challenge that the health service must overcome if it wants to achieve the benefits of improved financial information and a stronger control environment. Some services or service providers may believe that they or their needs are in some way unique and they may of course be right. Reasonable efforts can and should be made to ensure that current "innovations" perfected or planned by individual providers are incorporated into the new standard processes, where their value is proven and they are transferable. However, ultimately, the benefits to all decision makers, service users and taxpayers of operating standard processes outweigh any perceived losses to individual providers of non-inclusion of local "niche" processes.

3.1 Key governance arrangements in relation to the "design" and implementation of standard national processes

Following on from the consultation process that began in January 2018, the Finance Reform Steering Committee (membership listed below) will be convened during March-May 2018. A key objective will be to review and endorse the design principles contained within the Financial Management Framework document and their application to the end to end processes for IFMS. These principles will be detailed to a sufficient level to ensure that all subsequent design and implementation decisions cannot adversely impact the intended standardised nature of the processes. This is necessary to protect the achievement of the desired benefits of better financial information for all and a stronger control environment. Local processes that do not conform to the national standard will need to be changed. It is not expected that there will be any exception to this and only the HSE CFO, having consulted with the Finance Reform Steering Committee, can ratify such exceptions.

Assuming endorsement of the Financial Management Framework is received from the Steering Committee, the agreed principles will then be applied to validating the standard national processes maps for the Irish Health Service. Further details on how standard national processes will be developed are contained in Chapter 7 – Process Governance Model. Any feedback on this paper will be considered as part of the overall decision making process outlined above. It is intended that the decision making process on the initial financial management framework text will be completed during Q2 2018. Thereafter there will be further engagement including local decision making around the changes necessary to implement the approved set of nationally standardised processes. Where practical, process changes, or elements of same, should be made in advance of implementation of IFMS.

The current members of the Finance Reform Steering Committee are as follows:

Chief Financial Officer (Chair)	Stephen Mulvany
Programme Director for IFMS & ACFO Operations Excellence, HSE	Valerie Plant
Chief Information Officer (Acting), OoCIO, HSE	Fran Thompson
Head of Finance, Health Business Services, HSE	Damian Casey
Community Healthcare Organisations Heads of Finance Representative, HSE	Michael Morrow
Head of Procurement, Health Business Services, HSE	John Swords
National Director, Human Resources, HSE	Anne-Marie Hoey
Hospital Group Chief Executive Officer Representative and Childrens Health Ireland CEO	Eilish Hardiman
s38 Community Representative and CEO of Carriglea Cairde Services	Vincent O'Flynn
CFO Dublin Midlands Hospital and CFO HG Representative	Joe Campbell
ACFO Planning & Performance, HSE	Colum Maddox
National Director of Acute Operations , HSE	Liam Woods
National Director of Community Operations, HSE	David Walsh
CHO, Chief Officers Representative, HSE	Mellany McLoone
Head of HR/Payroll Systems & Analytics, HBS, HSE	Mike Connellan
National Director, Health Business Services, HSE	Jane Carolan
Finance Director, Tusla	Pat Smyth
National Director of Strategic Planning and Transformation & Representative of Chief Strategy and Planning Officer, HSE	Stephanie O'Keeffe
s.38 Acute Representative and Director of Finance of The Mater University Hospital	Brid Cosgrove
s.39 Representative and Director of Finance of Ability West	John McHugo
Government Chief Procurement Officer & CEO Office of Government Procurement	Paul Quinn
Department of Health - Finance Representative	Fiona Prendergast
General Manager Healthcare & Life Sciences, DXC	Cathy McCartan

In attendance:

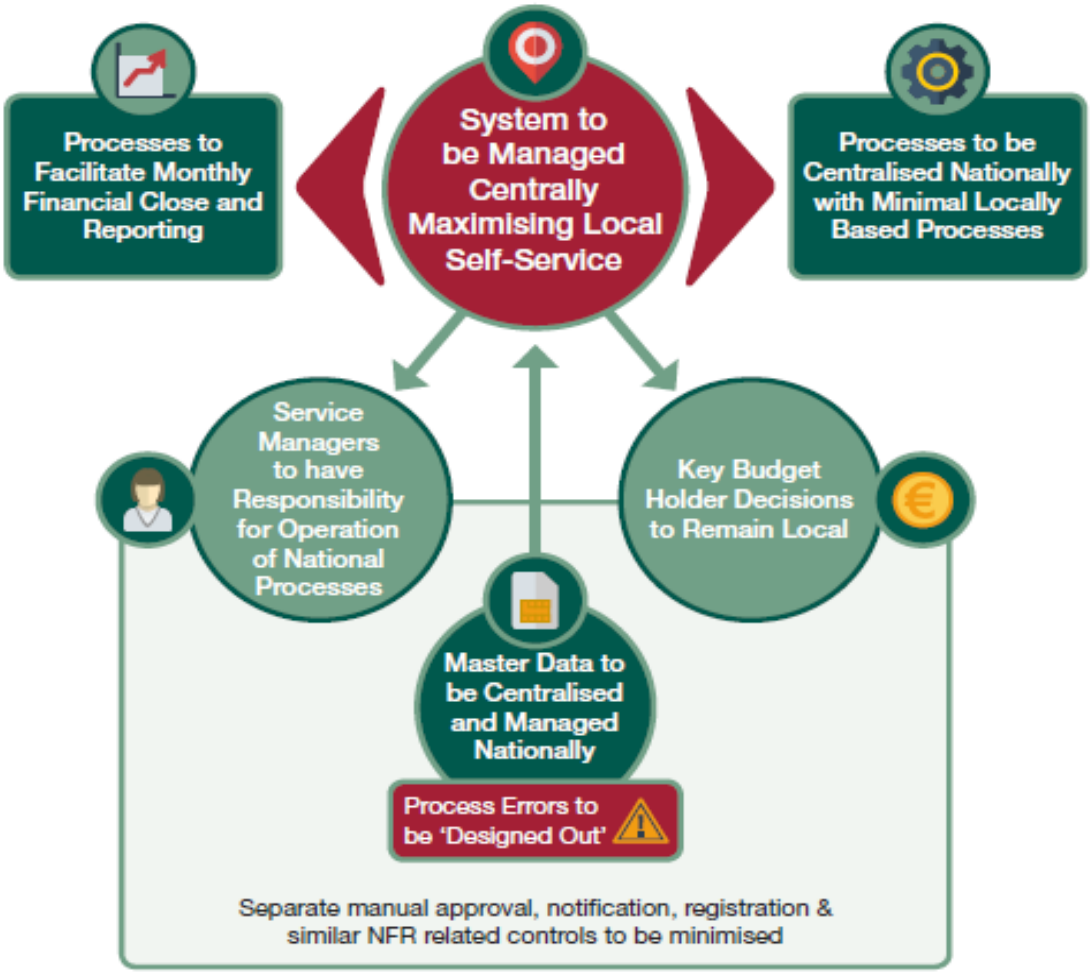
Finance Reform Programme Manager (Acting)	Áine McGuire
IFMS Project Manager	Ken Egan
DXC Programme Director	Anthony Moynihan
Quality Assurance	TBC

3.2 Key overarching process "design" principles:

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

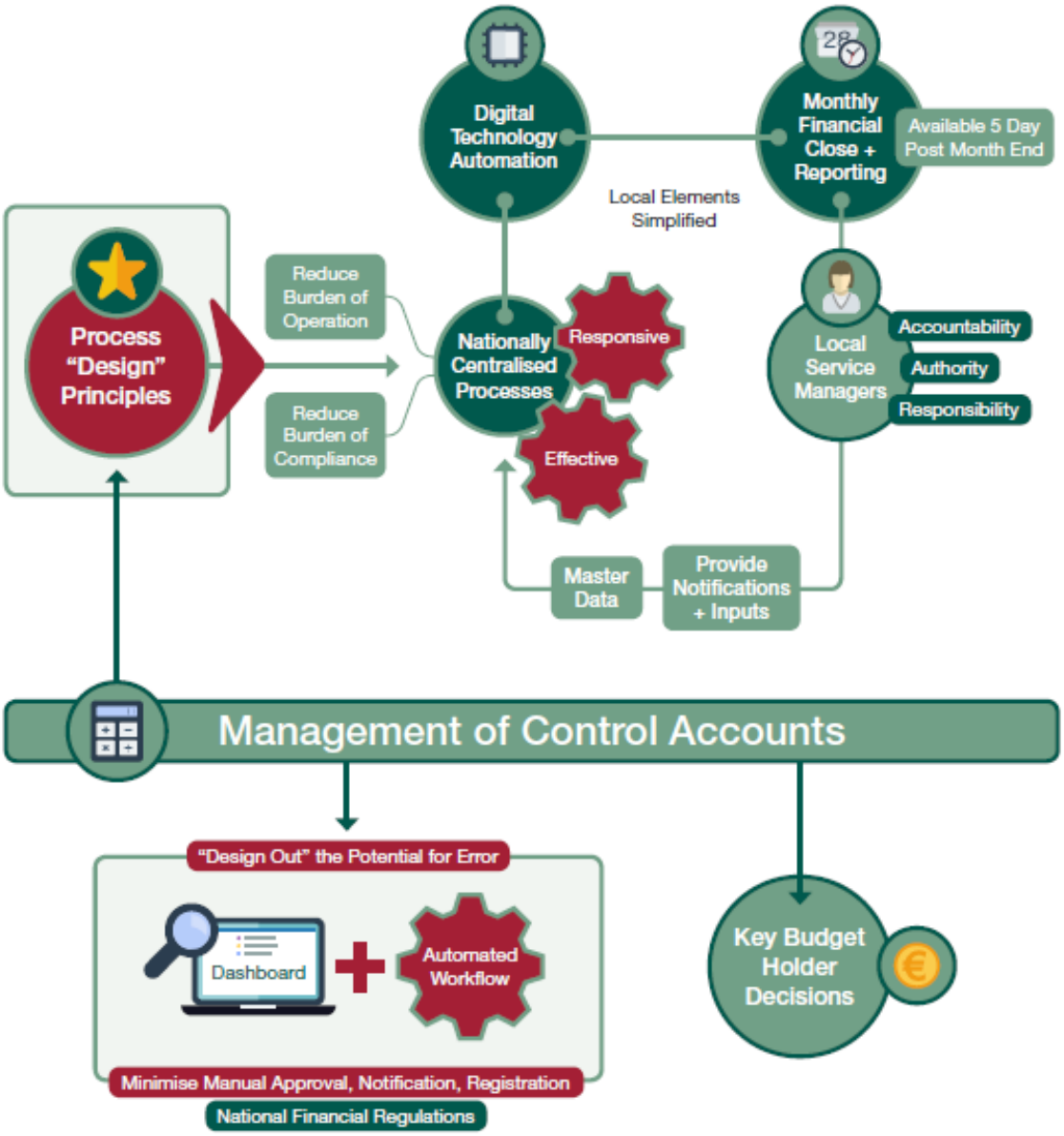
2. **Governance, compliance and accountability are central to the design and delivery model.** For the benefit of all stakeholders the system will be managed and delivered from the centre. The local element of any process will be simplified as much as possible and will seek to maximise local self-service via the IFMS. This will facilitate optimal use of one time local capture of data for processing /onward processing. This will see the substantial elimination of the use of excel and other templates outside of IFMS to gather data locally and submit it centrally for processing. Opportunities for automation and the optimisation of digital technology will be considered.

Figure 2: Overarching Design Principles



3. **A best practice shared service model including standardised processes and controls is integral to the successful delivery of IFMS.** National processes will be designed to facilitate the requirement for monthly financial close and reporting, including to the HSE Board, to be available by the end of working day 5 post month end. Relevant key budget holder decisions which are part of any process will remain local.

Figure 3: Process Design Principles



4. **System is managed and delivered from the centre with the responsibility for the correct recording of transactions remaining with the service organisations.** Only those parts of a process that should be based locally, consistent with point 1 above will be based locally[7] regardless of what process it is. As much of each process as possible, consistent with points 1 and 2 above, will be centralised nationally[8] in order to reduce the burden of operation and compliance on local services. Centralised services will need to be responsive and effective in order to ensure local confidence.

   Local service managers will have full accountability, authority and responsibility for the proactive operation of all local aspects of each national process. This will include providing timely necessary notifications and inputs etc. to enable the centralised elements of the process to operate effectively. The same principle applies to managers responsible for the central process elements e.g. HBS, NFD etc

[7] Local refers to outside the centre of the HSE i.e. within community services, CHOs, hospitals, Primary Care Reimbursement Service (PCRS), National Ambulance Service (NAS), providers funded under sections 38 (s.38) and relevant providers funded under sections 39 (s.39).

[8] Central refers to within the centre of the HSE i.e. HBS, NFD or other national entity as appropriate.

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

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

7. **Workflow will be deployed as a matter of principle to facilitate and automate business processes where the right work is brought in the right sequence at the right time to the right people.** A high priority will be placed on efforts to "design out" the potential for error within each process in so far as is practical. A high priority will be placed on efforts to "design in" the capacity for local services to monitor the detailed operation of each major process and the level of compliance with its related controls. This will be prioritised at the start of detailed planning and implementation rather than at the end. The requirement for separate manual approval, notification, registration and similar controls which are a necessary feature of the current National Financial Regulations will be minimised in so far as is practical (see note 1 on next page).

8. **Optimise the use of the software functionality available.**

9. **A standard data model is in place for all data that supports a standard approach to the availability and use of all data.** The management of all master data[9] relevant to any process will be centralised and dealt with nationally through an integrated set of procedures that will be designed and resourced to provide timely responses to local requests. The same approach will apply to the management of all control accounts and similar. Automated workflow will be deployed as a standard part of all relevant processes coupled with appropriate dashboards or similar for managers to give necessary visibility of process operation. Must meet the needs including financial reporting needs of managers and staff at all levels and not be weighted towards meeting the needs of the centre of external stakeholders at the expense of local.

[9] Master Data refers to the set-up and maintenance of supplier accounts, material /service codes, cost centres, general ledger codes, grade codes, organisation units and similar essential data items which are part of all processes.

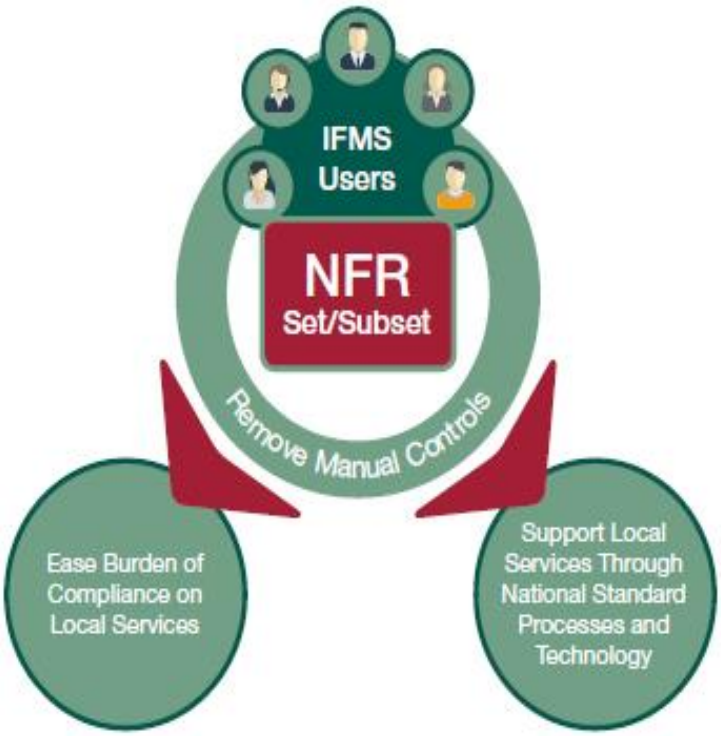
Note 1 – Requirement to update the National Financial Regulations (NFRs)

The current NFRs provide a robust underpinning to the existing system of internal financial controls and set out minimum best practice controls applicable across the health service. A process is already underway to carry out a general update to the NFRs in order to make them more accessible and to address organisational changes since they were last updated. In addition it is noted that the current NFRs were written to try and cater for the reality that existed at the time of the establishment of the HSE in 2005. This reality included multiple disparate financial and other systems coupled with non-standard processes and the absence of shared services other than in the former East. Despite some progress in the intervening years, including the extension of shared services, the current NFRs still have to cater for a similar situation and this significantly impacts how they are written and the level of manual approval, notification and registration controls they specify. It is unfortunately the case that it is often very difficult to evidence at national, regional or local level whether these controls are being complied with.

It will be necessary to create a set / subset of the NFRs to cater for those services that have access to the IFMS and have therefore adopted the standard national processes. This will include substantially removing the type of manual controls referred to above. This removal will be part of easing the burden of compliance on local services and taking advantage of the benefits of the investment in national standard processes and the technology to support them.

As assessment will also be made of the accounting policies and standards applied by the 16 s.38 funded voluntary hospitals in line with previous Department of Health (DoH) instructions. This will determine the extent of the variation between these and DoH accounting policies that the HSE is required to follow. The intention is to work with DoH colleagues to eliminate these variations to the greatest extent practical in order to simplify the implementation of IFMS.

Figure 4: Impacts on NFRs



3.3 Key implementation principles include:

1. Where processes or parts of same are being transferred from local to central operation e.g. to HBS, the necessary central resources will be in place prior to transfer. Individuals may or may not transfer with their workload depending on their personal preferences and the needs of the health service. This will be governed by the IR / ER arrangements in operation at the time including the provisions in respect of redeployment[10]. Particular care will be taken in relation to the family and personal circumstances of individuals, as part of the overall change management strategy.

2. Where all or part of a process is centralised a single central team in a single physical location will look after the centralised element of the process for the entire health service. Where, with the agreement of the HBS Governance Committee[11], having consulted with the Finance Reform Steering Committee, it is necessary to sub-divide a centralised process over more than one physical location, then:

    a. Each location will look after a sub-set of the overall process for the entire health service i.e. if the AP process has to be split over 2 HBS locations then each location should look after a clearly defined and logical subset of the overall AP process for the overall country rather than dividing the process by geography.

    b. The entire process should be managed by a single virtual team under the direction of a single manager.

3. Where a significant part of an individual's workload is transferring to central operation then the budget and WTE for that part of their workload which is transferring will fall to be reallocated by the CFO having consulted with the relevant local senior manager and the Finance Reform Steering Committee.

4. Where necessary the once-off local implementation and change management cost of the new standard processes will be supported by a contribution from nationally available resources. Thereafter local services management will need to proactively prioritise the local change process to minimise any excess cost that local existing resources (budgets) will have to bear.

5. The **ongoing** central and local operating cost of the new national standard processes will be a first call on all local and central resources (budgets) currently supporting the existing elements of those processes. The new standard processes are expected to be more efficient and higher quality than the existing disparate processes. It is unclear at this point whether the efficiency gain will outweigh the cost of quality improvement albeit the intention is that it would wherever practical. Accordingly, it is unclear whether the ongoing cost of operating the new processes will exceed the cost of operating the current processes. This will be clarified as part of detailed implementation planning and any shortfall will fall to be addressed collectively, in the first instance, between HSE centre and local services.

[10] The Croke Park Agreement and successor national agreements are relevant in this regard.

[11] The HBS Governance Committee is a sub-committee of the HSE Directorate, chaired by the DG with a membership that includes a CHO Chief Officer rep, a HG CEO rep and National Directors. It is charged with oversight of the implementation of the HBS Strategic Plan.

4. Approach to organisations funded under s.38 and s.39 Health Act, 2004.

The adoption of a single integrated finance and procurement system across the health service offers the potential for significant benefits to all stakeholders. This includes relevant "voluntary provider organisations" i.e. a defined subset of those funded under the above legislative provisions. The general benefits, including more timely financial information for decision support and the capacity to properly compare one's own organisation to others across the health system, are summarised in Chapter 2 above (see also Financial Reporting Strategy below and Appendix 13).These benefits will be added to by the adoption of the single national staff records and payroll system which is also being developed.

It is noted that the cost of implementation and long term ownership of a modern Tier 1 finance, procurement, staff records and payroll system will be substantially less "per provider" when addressed via a single nationally shared system. The alternative would be for each individual provider, including each s.38 or s.39, to buy, implement and maintain their own system. In effect the state, via the HSE funding already provided to s.38s or additional targeted investment, will substantially cover the associated costs. Individual s.38s and HSE directly provided services will have to engage proactively with local implementation. This includes engaging with necessary process change and associated resource reconfiguration. This will mitigate the risk that there is any residual additional cost to local providers beyond any reasonable additional support the HSE can provide. Similar provisions will apply in respect of the relevant larger s.39s albeit it is not expected that they will adopt the national staff records and payroll system.

The HSE is conscious that some organisations may have concerns in relation to adopting a single integrated financial and procurement system with an associated set of nationally standardised processes. The HSE is conscious, in particular, of the need to provide relevant reassurance to the board members and senior leadership teams of s.38 and relevant s.39 agencies. It is also recognised that their separate legal entity status is an important factor and in this overall context the following principles are considered appropriate:

1. The HSE must work with organisations to ensure that adoption of the IFMS assists with, and does not adversely impact on, the obligations and responsibilities of board members, for example, as they relate to:

    a. Their obligations under the Companies Act, 2014 (including filings with the CRO) or whatever trust, charter or statute they were established under.

    b. Any obligations under legislation or government policy generally including Data Protection requirements, public procurement requirements, charities regulation etc.

    c. Their fiduciary duties as board members.

    d. Their effective oversight of the organisation including provision of support and challenge to the CEO or equivalent and his/her senior team where relevant.

    e. Meeting their Annual Financial Statement preparation, auditing and filing requirements comprehensively and on time. The HSE is happy to engage with the auditing profession to assist in this regard.

2. The adoption of the IFMS must not interfere with the reasonable exercise of their proper autonomy as befits separate legal entities operating within relevant policy, legal, regulatory and contractual frameworks.

3. Specifically, the HSE will not by virtue of the implementation of IFMS, seek to second guess the judgement of s.38 / s.39 management by inserting a requirement for additional "approvals from the centre" to be obtained via IFMS for example before a purchase can be made or an accrual or other journal entry posted.

   Where such transactions are initiated by a s.38 / s.39 in the absence of available budget or similar, this will, where appropriate, be taken up post "close and reporting" as part of the normal performance management process.

4. It is noted that there will be earlier and more comprehensive visibility of financial and related information available to CHOs, Hospital Groups and the central HSE. This is in keeping with the current and emerging transparency and accountability expectations. It is acknowledged that the HSE also has a requirement to take cognisance of provider organisation concerns, including those of s.38s and s.39s, as to the appropriate use of that information. The HSE's overriding aim in implementing IFMS is to enable better decision support and better controls at all levels in order to drive and demonstrate better value in the broadest sense. This includes being better able to demonstrate the value already being delivered thereby improving the case for additional investment in the public health and social care services.

5. The requirement for the IFMS to be adopted by all organisations funded under s.38 and also by larger s.39 organisations is mandated by the Finance Reform Board as referenced on Appendix 2[12]. Any obligations arising from IFMS will be dealt with through the current formal SLA process the HSE has with s38s and s39s. Similarly, there will be a requirement mandated for all s.38 funded organisations to adopt the single national HR and payroll system being developed by the National Integrated Staff Records and Pay Programme (NiSRP). Both systems are being developed on the SAP platform and the intention is that they will be interfaced and integrated over time becoming a single ERP system covering finance, procurement, HR and payroll for the Irish Health Services.

6. The governance arrangements in relation to the implementation of IFMS, including the "design" of standard national processes, are summarised in Section 3.2. That governance includes a Steering Committee that will to be chaired by the CFO. The HSE is happy to invite the following groups to nominate a representative from each of the respective groups to that Steering Committee; group of acute hospital s.38s, group of community service s.38s / larger s.39s, Hospital Groups and CHOs. Through this high level governance mechanism, it is hoped that both the HSE and voluntary organisations can oversee the necessary enhanced collaboration to ensure successful delivery of IFMS. This includes the "design" and adoption of a standard set of processes. These processes will be operated in partnership between the centre of the HSE e.g. HBS, the HSE's national shared services organisation, and local services, including relevant voluntary organisations.

7. The expectation is that IFMS will become the financial and procurement system for the specific legal entities that the HSE funds under s.38 of the Health Act and certain larger entities funded under s.39. In some cases these entities may have separate "parent legal entities" or related "private legal entities" that the HSE is not contracting with, the latter might include separate legal fund raising entities. It is not intended that IFMS would be adopted or utilised by such related or private entities. This can be worked through in further detail in due course in collaboration with the relevant entities.

8. The HSE will develop a robust engagement and consultation process between it and all s.38s and larger s.39s to ensure an efficient roll out and implementation of IFMS. The first step within this process is the development and agreement of the Framework itself and its approval by the Finance Reform Steering Committee.

[12] See Appendix 12 for membership of the Finance Reform Board.

5. Financial Reporting Strategy - Delivering the benefits to the users of health service financial information

5.1 Financial Reporting - A working definition

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

Data is unprocessed facts and figures without any added interpretation or analysis. *"The hospital spent €100k on agency nursing in January".*

Information is data that has been analysed and interpreted so that it has initial meaning for the user. *"The €100k spent in January represents a 10% increase on the previous month and a 20% increase on the same period in the previous year".*

Insight is a combination of information, experience and knowledge that may benefit the individual or the organisation. *"At current levels the hospital is spending more on agency nursing as a percentage of its total costs than any other comparable hospital. It is not experiencing vacancy, attendance or other activity trends that indicate why it would be such an outlier in this regard. Also its average cost per unit of agency hour is higher than most comparable hospitals."* This insight would prompt a number of decisions and actions e.g. the need to look at the agency contract and its procurement plus also the need to review the clinical and operational control procedures around approval and utilisation of agency hours.

The context for this strategy is financial reporting and therefore it encompasses financial and related non-financial information (inputs e.g. staff hours, activities that convert inputs to outputs, the outputs themselves etc.)

The takeaway message is that financial reporting is not an end in itself and is only of value if it prompts and informs decisions that lead to appropriate actions being taken.

5.2 Diagnosis - what things look like today, and why?

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

However, in order to make progress, it is necessary to stand back from these islands of excellence and make as objective a diagnosis as possible of the general state of financial reporting across the wider health system: **5.2.1 Data**

Our financial data i.e. our raw numbers are an output from our transaction and accounting processes. These processes operate on disparate systems, are not designed, or defined, in a standard way and are not operated in a standard way. The key reference points for these processes i.e. the master data[13] is also non–standard. The implications are that our financial data lacks comparability, becomes available at different points in time and can be prone to errors and time consuming reconciliations or other forms of checking.

[13] Cost centres, G/L codes, material codes, grade codes, supplier numbers etc.

5.2.2 Information

The process by which we bring data together and convert it into information via analysis (trending, variance analysis, forecasting etc.) is also not standard or operating to particular guidelines. It is not supported by standard tools utilised in a consistent way. Coupled with the data issues outlined above, this means that an inordinate amount of scarce accounting staff time and energy is spent trying to bring together disparate financial data into a coherent set of very basic financial information. This leaves limited capacity and time to focus on the generation of insight.

5.2.3 Insight

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

5.2.4 Decision making

Our current financial reporting does not optimally enable, nor is it sufficiently focused on, prompting decisions and actions. At best there is significant variability in the extent and standard of any decisions and actions that are routinely flagged in the financial reports that are exchanged between the different levels of the health system. While some of this could be perceived as possibly being for "tactical" or "motivational" reasons it also a logical implication of the lack of assessment and reporting on economy, efficiency and, ultimately, effectiveness.

Such assessments, if routinely carried out, would naturally assist in the identification of further improvements that can be made in terms of costs without impacting on quality. This would provide essential insights into what decisions and actions need to be considered.

For example, let us assume that, in the future, we know from our improved financial reporting, that we are delivering a good standard of economy from a given service i.e. its input costs per unit are as low as could be reasonably expected for the necessary level of quality.

Armed with this insight we know that any decisions and actions need to focus on overall efficiency (the ratio of inputs to outputs e.g. cost (input) per patient treated (output)) or effectiveness (is it the right service to be providing in the first place and is it a higher or lower priority than other services).

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

5.2.5 Staffing

In light of the above foundational issues, any detailed discussion on what is the appropriate future level, mix and location, of experienced financial staff necessary to support best practice financial reporting and decision support across the health service is premature. However, it is the case that today, based on the existing systems and processes which are not fit for purpose, the current staffing level and skill mix of financial staff is insufficient.

5.2.6 Detail

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

I. Not timely or sustainable – need to move to 5 working day close and report

II. Overly focused on "simple breakeven" – breakeven is an essential hygiene factor but not sufficient in itself

III. Overly focused on inputs, with limited output based reporting

IV. Suffers from a general absence of price / volume analysis for both inputs and outputs

V. Overly retrospective in focus – need more and better forecasting supported by standard tools and models

VI. Generally not sufficiently focused on the wider control environment, cash / working capital etc.

VII. Generally not sufficiently focused on Value i.e. Economy, Efficiency and Effectiveness including the quality aspects of same

The issues at 5.2.1 to 5.2.6 (I to VII) above, when taken together, significantly hamper the capacity of our dedicated financial staff to support high quality planning for, and performance management of, our health and social services. The overall "system" (our financial people, financial processes and financial technology) is stretched to meet a very basic monthly reporting cycle. When that cycle coincides with the October to February time period when additional year end and year start workload is at its height, the "system" becomes overloaded to the detriment of our staff and the services they are seeking to support.

See Appendix 1 for further information in relation to I to VII.

5.3 Moving forward - the future for health service financial reporting - Design Principles and Objectives

The main design principles and objectives for financial reporting in the Irish public health service, are aligned with the **Sláintecare** programme, and can be summarised under the following four headings

1. Purpose of financial reporting
2. Standardising, through the use of SAP consolidation tool(s), our approach to analysis, forecasting, planning and budgeting in order to deliver timely financial reporting within a more sustainable workload cycle
3. Safety, quality and overall value for money including effectiveness, efficiency and economy
4. Additional design objectives

5.3.1 Purpose of Financial Reporting

As was stated on the first page of this strategy, financial reporting is defined as follows: The production and capture of data, it's conversion into information, the conversion of that information into insight and the use of that insight to inform decisions leading to necessary actions. These actions may relate to any financial aspect of the overall commissioning cycle including planning, resource allocation, budgeting or performance management. Improved financial reporting is therefore a necessary support for implementing the priorities of the health service. For example the HSE Directorate has decided that the hierarchy of priorities for the implementation of the 2019 National Service Plan, are as follows:

1. The over-riding requirement is to prioritise the delivery of safe services within the available resources (budget, WTE, facilities etc.). It is acknowledged that for certain services this this will involve a balanced judgement including the application of the HSE's integrated risk management policy where appropriate.
2. Thereafter, maximise the delivery of the volume, access, quality improvement and other targets as set out in the NSP, without jeopardising the 1st priority. This requires maximisation of the effectiveness, efficiency and economy of services.

The balance of the text of the HSE Directorates decision in relation to the hierarchy of priorities is set out in Appendix 2.

Health and social care services are delivered at local level and therefore the immediate priority for financial reporting is to support high performing service delivery and ongoing improvement at local level. **Thereafter,** appropriate weight will be given to providing for the financial reporting needs of decision makers at regional and national level. It is noted that local staff resources should not be tied up continually answering basic and routine questions from the level(s) above. These should be answered in an automated way by IFMS and related systems. Following on from the above, financial reports relating to ongoing performance should come from "the bottom up" and include, or be accompanied by, suggested decisions and actions for consideration.

It is the role of senior finance staff at each level to oversee the preparation of the financial reports and then be part of the subsequent collective senior decision making process at which actions are decided upon. This should be part of an ongoing performance dialogue, the aim of which is, in so far as practical, for each level of the system to reach a shared consensus with the levels above and below it, around performance status and realistic actions to improve it. This dialogue will be based on minimum standard report formats, that seek to address an agreed set of questions, albeit typically at varying levels of detail, as the dialogue moves up through the levels of the health system (e.g. from local community team / ward to up through the various levels to the national performance discussions between the HSE and the DOH / DPER).

5.3.2 Standardising, via SAP consolidation toolset, our approach to analysis, forecasting, planning, savings measure reporting and budgeting in order to deliver timely financial reporting

In order to be useful in the ongoing performance dialogue, and to produce a sustainable workload cycle, financial reporting must be available within a set of core timeline requirements including:

- ✓ 5 Working day close and report for monthly financial reporting including initial commentaries
- ✓ 10 Working day turnaround for detailed quarterly forecasts (Basic forecasts will be included in the monthly 5 working day reporting cycle)
- ✓ End of 2nd full week in December for completion of the financial planning cycle including all budgets uploaded onto IFMS by that date, following the determination of how any financial challenges will be addressed via savings measures and value improvement initiatives etc.

Consequently the design and implementation of all IFMS processes, and NiSRP (National HR & Payroll System) processes, must facilitate the sustainable ongoing adherence to a set of core financial reporting timelines on a monthly, quarterly and annual basis. This includes all transaction processes as well as all financial reporting related processes, including processes related to planning, forecasting, budgeting, variance analysis and other aspects of performance management, including savings measure proposal and forecasting, as well as those related to the production of the Annual Financial Statements.

In particular, efficient and robust monthly and quarterly forecasting processes, which integrate financial and core non-financial data (HR and Activity), and that produce trusted results, will be key to meeting the mid-December deadline for completion of the financial planning cycle set out above. Meeting these objectives will require the use of the relevant SAP S4 HANA toolset in order to capture and automatically consolidate, in real time, the output from monthly variance analysis and forecasting efforts from across the health system. This will include proposed savings measures and reporting against same.

5.3.3 Safety, Quality and overall Value for Money including effectiveness, efficiency and economy

Financial reporting that focuses purely on costs and budgets without any regard to how it rates in terms of key value and quality characteristics, including effectiveness and efficiency, will be of limited utility in the medium to longer term. Similarly, in financial management terms, if a service cannot report on whether, and why, it is relatively effective, efficient or economical compared to other services, it is more difficult for it to determine and demonstrate what decisions and actions are appropriate and feasible to deliver any necessary adjustment or improvements. This will require the phased introduction of a structured assessment of value (economy, efficiency and effectiveness) within financial reporting, aligned to expected improvements in overall non-financial reporting around the quality of services i.e. safe care, effective care, efficient care, timely care, person centred care and equitable care. See Appendix 10 for further detail.

5.3.4 Additional design principles and objectives for health service financial reporting:

I. Emphasis on phased reporting improvements pending implementation of new systems including IFMS

II. Mitigating the typical operational realities of public health and social care provision i.e. an element of unavoidable costs and funding constraints

III. Balance sheet and working capital reporting

IV. Control and compliance reporting

V. Cash and commitment based reporting

VI. Internal commissioning and reimbursement transactions

VII. Reporting for s38 & s39 bodies who are operating IFMS – ("HSE Centre view" V "Consolidated View")

NB - See Appendix 3 for supporting detail in relation to I. to VII above

5.3.4 Main areas of work to deliver on the financial reporting design principles and objectives

These areas may change based on detailed programme and project planning however at this stage they can be summarised under the following six work area headings:

Work Area 1 – Governance, capacity and capability

Work Area 2 – Service Engagement to inform financial reporting improvement

Work Area 3 - IFMS consolidated Analysis, Forecasting and Planning Tool

Work Area 4 - Enhanced Input based reporting

Work Area 5 – Phase 1 re output based reporting (part of IFMS core work)

Work Area 6 - Enhanced detail output based reporting (not core IFMS work– parallel and core Finance Reform)

Work Area 1 – Governance, capacity and capability => enables and includes:

I. Establish representational financial reporting decision making process, informed by wide consultation and engagement, within process governance model, reporting into the Finance Reform Steering Committee.

II. Externally supported assessment of level and mix of financial staff across the health service.

III. Ongoing development of staff capability in relation to financial reporting informed by III above.

See Further supporting text in Appendix 4.

Work Area 2 - Service Engagement to inform financial reporting improvement => enables and includes**:**

I. Externally supported research, and internal knowledge and capacity building, on relevant technical aspects of SAP S4 HANA related to financial reporting.

II. Structured engagement with relevant service and clinical senior stakeholders to determine key benefits required from financial reporting including Identification of:

   a. Required conceptual representation of health service and various reporting views / service descriptors within same required now and in the foreseeable future ("how do you want to view your services").

   b. Key inputs, activities and outputs per main service area that reporting is expected to provide insight on ("what are the key financial and related questions you want better and quicker answers to both now and in the foreseeable future"?).

   c. Preliminary quality indicators available now and development path for same per main service area.

III. Finalisation of Chart of Accounts including appropriate external research and validation.

IV. Determination of IFMS technical approach for linking financial and non-financial data (currently available or as when becomes available) within financial reporting.

V. Determination of high level Enterprise Structure / Enterprise Architecture – sufficient for SI prerequisite

VI. Finalisation of detailed enterprise structure.

See further supporting text in Appendix 5.

Work Area 3 - IFMS consolidated Analysis, Forecasting and Planning Tool => enables and includes:

I. Externally supported research and internal knowledge and capacity building on relevant technical aspects of SAP S4 HANA related specifically to meeting financial reporting requirements set out at 3.2 above (consolidation toolset)

II. Scoping the implications of the 5 working day close and report timelines, and the other timelines (quarterly 10 working day forecast, budget loading by end 2nd full week December, AFS by early February), on all IFMS processes and related business processes, including ensuring those implications fully factored into work of each process design council and team.

III. Externally supported research and stakeholder consultation as to best practices to be adopted in relation to standardising analysis (including trend, variance and performance analysis), forecasting (including proper use of models, recording of detailed assumptions and reporting actuals against same), planning and budgeting (including proposing / bidding for developments / additional funding) and savings measures (proposal and reporting against) etc.

In summary, through significant improvement, via standardisation and use of the SAP consolidation toolset, to our variance analysis, forecasting, planning, budgeting and savings measures processes, the goal is that by mid-December each year the system (national, CHOs & HGs / ICOs, s.38s etc.), will have gone through at least 2 full quarterly forecasts that project to the end of the following year i.e. Qtr. YTD June and Qtr. YTD Sept. Shortly after government budget day in early October, draft budgets will be made available on IFMS and modelled against the Qtr. YTD Sept forecasts at local, regional and national level. In the approximately 3 month period from early September to late November, via various iterations of scenario planning on the system, including online submission and profiling of savings measures, the forecasts, including savings measures, will be brought in line with the available budget. This scenario planning will initially be based on estimated budgets prior to government budget day. This will involve a combination of top down and bottom up collaborative working. Once this is completed the final forecasts will be converted to budgets and the National Service Plan will be finalised and submitted to the Board and DOH for approval. In this way the NSP will be based on the output of real bottom up plans rather than representing the starting point for same, which leads to obvious difficulties.

IV. High Level design of architecture and process by which analysis, forecasting, planning, budgeting and savings measures will be dealt with within relevant SAP consolidation toolset, **sufficient for SI prerequisite**.

V. Detailed design, Build and Test following on from IV above.

See further supporting text in Appendix 6.

Work Area 4 - Enhanced Input based reporting => enables assessment of economy

VI. Non Pay - Price and volume movement analysis for non-pay expenditure – requires 100% coverage of unique material or service codes or equivalent, including drugs and grants, and reporting to be designed to take advantage of same, building on the work under Area 2 above.

I. Pay - as for non-pay – 100% of hourly units of labour, including agency, and reporting design to take advantage of same.

II. Income – as for non-pay.

Full input based reporting is expected to be available as and when each site goes live and where, by exception (earlier sites), this is not immediately available, the formal go / no go decision must incorporate a credible plan to achieve 100% coverage within no more than 3-6 months post go-live.

See further supporting text in Appendix 7.

Work Area 5 – Phase 1 re output based reporting (part of IFMS core work) => enables initial assessment of efficiency and effectiveness

I. Initial support for community costing => High Level / Summary output based reporting i.e. lining up buckets of costs against buckets of outputs => enables assessment of efficiency (without significant costing development – driven primarily off enterprise structure / chart of accounts). Involves significant clean-up of staff coding once sufficient clarity available re enterprise structure.

II. Hospital ABF including current Patient Level Costing. IFMF to engage with HPO to ensure IFMS, at minimum, supports current and already planned ABF related processes, currently being supported by existing finance systems. Determine practical IFMS capacity to better facilitate current or already planned / being planned overall ABF related processes including costing processes. Specific focus on potential for IFMS enhanced input reporting to facilitate ABF cost benchmarking and assessment of relative cost efficiency and drivers of same across hospitals.

III. Initial phases of integration of available quality indicators and measures into reporting building on technical approach work completed under work area 2 III above.

See further supporting text in Appendix 8.

Work Area 6 - Enhanced detail output based reporting (not core IFMS work– parallel and core Finance Reform) => enables assessment of efficiency and effectiveness

I. Phased Integration of safety and quality indicators and measures into reporting – effectiveness

II. Phased Integration of outcome indicators and measures into reporting – effectiveness

III. Phased enhancement (Acute) and development (Community) of detailed / low level output based reporting (requires significant costing development projects outside of IFMS) – enables more detailed assessment of efficiency.

As progress is made via the enhanced input based report and enhanced output based work areas (4. 5 and 6. above), this will feed into ongoing "releases" of updated reporting processes via the IFMS Planning and Consolidation tool.

See further supporting text in Appendix 9.

6. Additional Supporting Strategies

6.1 Change Management and Communications Strategy[14]

The implementation of IFMS is a key enabler of Finance Reform which will transform the way Finance is delivered across the HSE by creating a single accurate financial picture that will allow people across our Organisation to make better financial decisions. Under IFMS, there will be significant changes to peoples' ways of working, to the systems they use, and to their roles and responsibilities. *'People's Needs Defining Change- Health Services Change Guide (June 2018)'* is the policy framework and the agreed approach to change in the HSE. The IFMS Change team will refer to this document as a tool to support the detailed work at local level on the implementation of IFMS.

6.1.1 Change Management Principles:

1. Be clear on **what** the changes are.
2. Be clear on **when** the changes are happening.
3. Be clear on who is impacted by the changes and how they are impacted.
4. Communicate the changes in a timely and consistent manner.
5. Have the appropriate supports (Central and Local Change Resources, Communications, Consultation, Training) in place to help people through the changes.
6. Engage with all stakeholders and offer a platform for their feedback on activity.
7. Have 'step by step' National and Local plans for delivering Change and Communications activity; Monitor,

[14] This chapter is an executive summary of the Change and Communications Strategy. The complete Strategy is available on request.

measure and report on progress and adapt our approach accordingly at each stage of the Project.

8. Base activity on Lessons Learned from the implementation of Stabilisation Phase 1 (Mid-West Area, 2016) and Phase 2 (North-West Area, 2017 and Our Lady's Children's Hospital Crumlin, 2018).

9. Share ownership and delivery of change management activity across the Finance Reform Programme.

10. HBS Procurement, HBS Finance and Local IFMS Implementation Sites (across Community, Hospital and legacy ledgers).

6.1.2 Managing and Supporting the Change Journey for all IFMS Stakeholders

Development and implementation of a robust Change Management and Communications approach for IFMS is necessary, building on the lessons learned from Stabilisation. This is also required to meet the expectations of and challenges presented by local implementation sites. All Change resources need to be given comprehensive and detailed training on their Change Management related roles and responsibilities and be equipped with the appropriate time, supports, information, tools and guidelines to lead the implementation and embedding of change in local areas. These resources can commence Change Impact Analysis activities and Stakeholder Engagement activities to achieve stakeholder buy in and support in advance of aggressive implementation timelines which will reduce the risk of delayed implementation.

6.1.3 Change Management Resourcing

Change will be centrally managed by the IFMS Change Team but delivered in a collaborative way right across the core IFMS Project Team. A network of local change resources will be required on a full time basis to deliver and coordinate communications and change management activity locally and embed IFMS implementation in their relevant areas. They should have the necessary local knowledge/ experience and local relationships to be able to contribute valuable insight and information to support the timely and effective delivery of the IFMS solution. A network of dedicated local Change Team Leads are required across all impacted Organisations and Areas, managed by the IFMS Change Team and being key members of Local Implementation Teams.

6.1.4 Communication Management Principles:

1. Do the simple things better – provide clear, regular and repeatable messages from the Finance Division

to all relevant Stakeholders.

2. Use Communications activity to resolve change management challenges.

3. Communicate key messages fully, accurately and on a timely basis to all levels of Staff who will be most impacted by IFMS.

4. Deliver a comprehensive understanding of the project mandate, objectives and benefits.

5. Use communications to help change behaviour and perceptions, where necessary.

6. Share ownership and delivery of communications activity across the Finance Reform Programme, HBS Procurement, HBS Finance and Local IFMS Implementation Sites Communication of change as a positive force will enable project success.

7. Build stakeholder engagement involving two way Communication and active listening thereby ensuring that all stakeholder groups can provide feedback and providing assurance that there is understanding of the messages being delivered.

Communications will be delivered across Face-to-Face, Digital and Print mediums via an integrated and planned approach. A National 6 month Communications plan will be developed and delivered by the IFMS Project Team and they will work with Implementation Sites locally to develop local Communications plans and supporting activity.

6.1.5 Measuring progress throughout the IFMS Implementation

The IFMS Change Team together with the External Implementation Partner, will monitor measure and evaluate all Change activity at each phase of the Change Management process. Progress will be tracked via digital analytics, feedback and insights, HR metrics and Event attendance to ensure that the support activities meet the needs of the people impacted at all times. Responsibility for each measurement area will be agreed at each phase of the project. Measurement will be collated by the Project Management team.

6.1.6 Conclusion

The Change Management and Communications activities for IFMS are significant. To deliver change under IFMS with the full support of our stakeholders, we will need to combine effective Project Management and sensitive Change Management. The Change and Communications strategy as outlined aims to set out our proposed approach for all Change & Communications activity in line with the Implementation Approach for IFMS and best practice.

6.2 Data Migration Strategy

One of the key overarching process "design" principles for IFMS relates to the use of a standard data model which will be in place for all data that supports a standard approach to the availability and use of all data.

The purpose of this paper is outline the data migration strategy in the context of the new national integrated finance and procurement system (IFMS) which is being delivered as part of the overall Finance Reform programme.

Data migration is typically a 'one-off' activity prior to go-live where data that has been identified as in scope for migration to the new system is transferred across. The data migration activity will require the data sources to be identified, cleansed where required and mapped to the new IFMS standard in advance of go-live.

Any on-going data loads required on a frequent or ad-hoc basis are considered to be interfaces, and are not part of the data migration scope. This document outlines how the programme intends to manage the data migration from the various legacy finance and procurement systems into the new IFMS.

6.2.1 Different Types of Data

In the context of this document legacy systems are defined as those finance and procurement related systems which are storing data, some of which may need to be migrated to IFMS. There are 3 primary types of data which should be considered for migration into IFMS.

i) Master Data

Master Data refers to the set-up and maintenance of supplier accounts, customer accounts, material /service codes, cost centres, general ledger codes, grade codes, organisation units and similar essential data items which are part of all processes.

ii) Configuration Data

This is data that is set up on SAP during the build and configuration process as it is configured. This type of data is not part of the migration process, as it will be transported to the production system through the transport procedure along with all other configuration.

iii) Transaction Data

Transaction data is generated during normal finance and procurement activities and it can be grouped with associated master data and more detailed reference data such date, time, type of activity.

Transactional Data falls into two categories;

- **Open Transactional Data** - is transactional data that has not completed its business cycle, for example an outstanding invoice or open receivables entry.
- **Completed Transactional Data –** is transactional data that has completed its business cycle and is subsequently used for information purposes only.

6.2.2 Data Migration Approach

The following section outlines the high level approach that should be taken for the different types of data.

i) Master Data

Master data will be migrated into SAP providing these conditions hold:

- The master records are required to support SAP functionality post-go-live.
- There is a key operational, reporting or legal/statutory requirement.

- The master data is current (e.g. records marked for deletion need not be migrated).
- The legacy data is of a sufficient quality such so as not to adversely affect the daily running of the SAP system OR will be cleansed by the business/enhanced sufficiently within the data migration process to meet this requirement.
- Any new master data adheres to the agreed set of master data standards as will be defined and governed by the programme governance structure.

ii) Open Transactional data

Open transactional data will be migrated to SAP providing these conditions hold:

- There is a key operational, reporting or legal/statutory requirement to migrate the data
- The parallel 'run down' of open items within the legacy system is impractical due to operational, timing or resource constraints
- The SAP build and structures will provide an accurate and consistent interpretation of legacy system data items alongside SAP generated data items
- The Health Service's internal project teams are able to commit resources to own data reconciliation and sign-off at a detailed level in a timely manner across the project phases

It is envisaged where possible that practical business solutions would be used to limit opening balance transfers i.e. Payment of Creditors, double week ordering etc.

iii) Summary Balances

Summary current and previous year financial balances such Profit and Loss balances may be migrated to IFMS.

iv) Historical Master and Completed Transactional data

The approach is that historical master and completed transactional data will not be migrated into IFMS.

6.2.3 Data Migration Activities

The migration strategy is essential to provide the context for data migration and the principles within which any data migration plan is completed. It should provide a high level overview as to what is 'in' and what is 'out' of scope for migration while allowing for changes in the data migration process once lessons learnt from subsequent migrations have been assessed.

The complexity of data migration demands a process that ensures the accurate transfer of data into the new system from legacy systems. The activities involved in the data migration process are detailed below.

Data Migration activities will be led by the Health Service's internal project teams who will have overall responsibility for delivery and specified responsibilities for data identification, cleansing and validation as well as user acceptance testing and productive data loads.

i) Define the SAP Data Requirements

These define in detail the SAP Data structures, tables and fields. Including the field name, field attributes (e.g. data type and length) and field properties (mandatory, optional, conditional or suppressed). This process requires a detailed knowledge of the associated SAP business processes and careful analysis of the configured SAP system.

ii) Identify the Legacy Data

This activity identifies where the legacy data currently resides, in which applications/databases, and how it is currently entered and maintained, the data tables and fields, the field attributes and properties including the data type and length. This process requires a detailed knowledge of the associated legacy applications.

iii) Define Data Standards

The data standards define the required appearance, consistency and content of the data. For example, the name and address formats, uppercase & lowercase requirements, providing a consistent look for the data that will be visible both internally and externally to the business.

iv) Legacy Data Cleansing

Legacy data required for migration into SAP must be completely cleansed prior to the final data load in SAP with the aim to ensure the consistency and accuracy of the data.

All transactional data will be cleansed on the legacy system before extraction. As a general approach the non-transactional data will also be cleansed on the legacy database before extraction, however there may be circumstances where this is not the best method and the non-transactional data will be cleansed after it has been extracted.

v) Determine the Data Transfer Method

The following choices are available for data transfer:

- Standard SAP data transfer programs.
- Manually enter data with online transactions.
- Develop bespoke batch input programs.

Data volumes, data complexity and availability of standard SAP data load programs are all to be considered before deciding between automated or manual load.

vi) Data Mapping, Transformation and Consolidation

This is a manual process where the data fields that have been identified for migration from the legacy data source are assigned corresponding fields in the SAP system. Field text in the legacy system rarely agrees with the corresponding terminology in the SAP system, therefore a variety of mapping methods are required. At the end of this step every SAP field that requires data must have been:

- Assigned a corresponding field from the legacy system.
- Assigned a transformation – i.e. converted from the original state to the required state using variety of methods including lookup tables, combining fields or logical rules for data transformation.
- Assigned a constant value.

Data consolidation should also be taken into consideration where a deployment includes a number of agencies and data relating to such items as vendor records need to be consolidated.

vii) Identify Missing Data

Missing data is identified during the data mapping process, where a table or field in the SAP systems does not have an identifiable source from the legacy applications. Any issues where a SAP module that requires data that does not exist in the legacy systems may be resolved by populating the missing data within the data load programs, either by calculation or mapping tables.

viii) Extract Legacy Data

Legacy data is extracted from the legacy systems and the extracted data is loaded into a data migration staging area. Extracted legacy data will be held on the data migration staging area for further analysis, manipulation and cleansing using appropriate software tools noting that all transactional data will be cleansed on the legacy system before extraction. Integrity checks are required to ensure the correct data has been extracted, for example, all records are included in the extract, duplicates have not been created etc.

ix) Design and develop Automatic Loads

Where an automatic load process has been chosen as the best method to load the data into SAP, the data load programs are designed and a technical specification written. The technical specification will define an appropriate SAP load technique, all data mapping (legacy field to SAP field) and data transformation logic. Every effort should be made to maximise the use of data migration tools across the programme.

x) Manual Data Entry

Where manual data entry has been chosen as the best method to load the data into SAP, data will be manually entered into SAP using the appropriate transaction. Instructions for the data load to be written and agreed for all data objects in scope.

xi) Test Data Loads

The process of running test data loads into the SAP system will help ensure data accuracy, the correct load sequence, determine load duration and correct any loading errors. The test data loads will continue until the load process completes successfully. There should be a minimum of 2 acceptable test loads before the final go-live load is executed.

xii) Dual Data Maintenance

Where master data is migrated before actual go-live any data changes on the legacy system must also be reflected on the new SAP system. Dual maintenance is best avoided if there is a large volume of master data changes as the additional workload may be excessive.

xiii) Data Cutover

This is the final Data Migration into the SAP production system. The cutover period is the time between the shutting down of the legacy system (ceasing of all related business activities on that system) and commencement of use of the SAP. During cutover the all processing on the legacy system is frozen and the data extracted.

xiv) Reconcile the Migrated Data

This process checks that the data migrated into SAP meets the specified data requirements. This includes, but is not limited to manual data checks, record counts, checking balances, running reconciliation reports, approval of acceptable differences (rounding errors) etc.

xv) Data Sign-off

After the migrated data has been reconciled and checked the data loads will be signed-off, this data sign-off will form a critical part of the overall go-live sign-off. The sign-off process will be linked into the overall project governance process where the IFMS Programme Board and Steering Committee will expect each deployment to have its own local 'Project' governance structure in place with a separate Steering Committee, separate deployment PMO and local deployment team. The local 'Project' governance structure will be responsible for the sign-off of migrated data.

6.2.4 Roles and Responsibilities

The successful migration of data into SAP requires a significant and diverse input from many different sources. A complete understanding of legacy systems and SAP data structures is necessary as well as a functional and business understanding of the processes the data is supporting.

Data Migration activities will be led by the Health Service's internal project teams (comprised of central and local resources) who will have overall responsibility for delivery and specified responsibilities for data identification, cleansing and validation as well as user acceptance testing and production data loads. These activities will be co-ordinated at an area ledger level such e.g. East, South or South East as opposed to CHO or Hospital level.

The System Integrator will have general responsibilities for guiding/assisting the internal project team and will have specific responsibilities for development and testing of the data migration conversion programs in a format and structure that facilitates re-use for all future IFMS deployments

The legacy system owner which in some cases could be a financial, systems accountant or application support specialist who has an in depth knowledge of the system will be required to support the build of extract routines from the legacy system and support the test and live data loads.

All parties involved in the data migration process must comply with the General Data Protection Regulation (GDPR).

6.2.5 Legacy data not migrated to IFMS

There is a significant level of resource required to migrate all data from legacy finance and procurement systems to a new SAP ERP environment with no certainty of a successful outcome. If it is seen as an absolute requirement to migrate all legacy data, then it will lengthen each project deployment delivery schedule by a significant time.

As the approach outlines historical master and completed transactional data will not be migrated into IFMS. The three recent HSE stabilisation projects adopted this approach and it aligns with what is standard practice where disparate legacy finance systems are being replaced by a new modern system.

A separate programme of work should further examine the options available to deal with any regulatory data retention requirement such as outstanding legacy bank transactions within legacy systems; however, it is ultimately the responsibility of each individual legal entity to manage their own legacy data that has not been migrated over to IFMS.

Some options to consider for each site would be to:-

- Restrict access to the legacy system to a small number of key users providing them with read only access. Maintain the software support and maintenance (if such a service is available) for a period of 12 months after go-live of IFMS. Thereafter restrict support and maintenance to the infrastructure operating the legacy system.

- Extract all the required legacy data into another storage system with a facility to retrieve information as required.

6.2.6 Reporting

Outside of the regulatory data retention requirements the HSE may at times require access to legacy financial information for management and other decision support purposes. The system integrator is required to ensure that the design and build of IFMS BW/4HANA reporting solution includes the necessary infrastructure and integration to support the medium to long term integrated Finance and HR/Payroll reporting requirements. They will be required to base the design of an Integrated Reporting Strategy and Solution on the principles of the Reporting Strategy from 'Health Services' Financial Management Framework Document'.

The primary reporting infrastructure and applications that currently deliver the Health Service's financial reporting requirements are:

- Legacy Financial and Procurement Systems: - The existing legacy ERP and Financial systems including SAP ERP, ARAN, Masterpiece etc. are the primary applications that delivery financial and management accounting reporting for the Health Service. These systems facilitate all local financial accounting and operational management accounting reports
- Consolidated Financial Integration (CFI) system:- CFI is a consolidated single 'SAP BW 7.5 on HANA' reporting platform where monthly extracts are taken from numerous legacy financial systems (including SAP ERP, Masterpiece, etc.) and uploaded to CFI with a comprehensive enterprise structure mapping ensuring consistency for reporting. Numerous performance reports are generated for national, regional and local reporting. CFI supports Full Previous Year Data and Year-to-Date data. Data is available for both Statutory and Voluntary Business areas, Actual and Budget, to legacy Cost Centre and GL Account.
- SAP HR/Payroll and BI systems: - HR & Payroll reporting is delivered by a combination of reporting from the SAP HR & Payroll ECC 6.0 system and the SAP HR & Payroll BW system (BW version 7.5 BI 4.2). This reporting infrastructure delivers a high number of key strategic and operational HR & Payroll reports for the HSE.
- Patient Level Costing (PLC):- A comprehensive patient level costing system has been designed and developed and is currently in operation for acute hospitals.

The Legacy Financial and Procurement Systems will be replaced by the core SAP S4/HANA solution which will include financial accounting and operational management reports. The HSE's vision is to have a single SAP Business warehouse reporting environment will require input from the Systems Integrator to develop an overall integrated Business Warehouse reporting strategy/roadmap for the Health Service. This reporting strategy/roadmap will determine how and when the integration or replacement of existing reporting applications is achieved.

6.3 Integrated Master Data Strategy (across Finance, procurement, HR, Payroll and other Systems)

6.3.1 What is master data, why is it important and what is the problem?

Master data is the data held by an organisation that describes the entities that are both independent and fundamental for that organisation, and that it needs to reference in order to perform its transactions[15]. Entities in this context would include suppliers, materials, customers, staff, assets, cost centres, organisational units etc. Individual master data records generally tend to be long lasting and to be changed relatively infrequently. The growth in the volume of master data tends to be relatively stable over time and it generally needs to be referenced to and by other data types and processes. In the ideal situation master data is unique for a whole organisation or "enterprise" i.e. it is generated once and maintained for use by all staff and systems across the enterprise. The overall master data architecture and its proper governance is important for the successful running of any organisation. Transaction processes depend on it as do the reporting, analytics and decision supports which the operation and management of the organisation depends upon.

The health service has many reports that emphasis we are in a far from ideal position in relation to the overall quality of our data / information and its overall governance. Master data falls within this.

6.3.2 Master data architecture

There is a need for a coherent approach to the overall architecture of master data across the whole organisation. For the purposes of this paper the organisation is the publicly funded health service. The more interdependent the different parts of the organisation are and the more they rely on the same processes and systems that need to reference the same master data, then the greater the need for an integrated approach to master data architecture.

As indicated above the ideal is for master data to be unique i.e. generated once and maintained for use by all, without out of date duplicates and similar problems. How individual building blocks of master data **within a single system** are fitted together to make a coherent master data architecture is very important. It is also very important that **between systems** those blocks of master data that are most linked are also fitted together in a coherent way.

For example, SAP HR has a master data item called "organisational unit" that could be set up to represent a ward in a hospital. SAP Finance might typically use a master data item called a "cost centre" to represent the same ward and the Patient Administration System (PAS) will also have a way of representing that ward. A coherent approach to how, for what and when these and other master data items are used will make a significant impact on the success or otherwise of the systems and processes which have to reference this master data.

There is a need to prioritise our efforts around the coherent architecting of master data. Certain systems are more integrated or interfaced than others and some elements of master data are linked to greater numbers of other master data items. In the example above the single national finance and procurement system being developed (IFMS) has an immediate priority need to be interfaced at a quite extensive level with the single national HR and Payroll system that is being developed (NiSRP). In time the two systems are expected to become fully integrated.

There is also a need for IFMS to be linked with other systems such as PAS in respect of income, activity reporting, patient level costing etc. Coherent master data architecture plays a significant role in the success or otherwise of such efforts.

6.3.3 Master data governance

A governance process is needed to oversee the design and implementation of the master data architecture referenced above. This governance needs to be properly representative of the various stakeholders and to take

[15] As per ISO 8000-2 www.iso.org

input from relevant internal and external experts as well as from an ongoing engagement process. Once implemented it will need to be maintained and continuously improved which will also require this sort of governance process.

Given the integrated nature of master data as outlined above there will be a need for a fully integrated approach to its governance over the full life-cycle of the systems within which the master data sits. This life-cycle covers the 3 stages of design, implementation support and post implementation maintenance and continuous improvement. This mirrors the full lifecycle approach being proposed in respect of process governance which is appropriate given that processes depend on master data.

In the immediate term there is a need for the IFMS and NiSRP programmes to agree a joined up approach to master data governance across the 3 stages of the systems lifecycle. It is likely that this will require a single structure to operate it and a single integrated process. In light of existence of the overall HSE Information Governance Programme it is also recommended that this approach be scoped in conjunction with senior representatives of that programme.

6.3.4 Master data conceptual framework and how it fits in with the Reporting Strategy, Chart of Accounts and Enterprise Structure

The architecture analogy i.e. "the art or practice of designing and constructing buildings" might assist us here. In this analogy we are building a new university. The finished campus of buildings is our overall systems landscape across the health services including IFMS, NiSRP, CHIS[16], PAS[17], NIMIS[18], MEDLIS[19] and in due course the community and acute hospital EHR[20].

Master data is part of the overall materials that will go into the construction of the different buildings on the campus and is this analogy is specifically the different components that make up the structural elements of the building i.e. steels, concrete, windows, roofing etc.

In order to design the buildings, the architect needs to have at least 2 things:

1. **A good conceptual framework** across all of the components i.e. a solid understanding of the different components, what their general purpose is, what they can be used for and how, what are their strengths and weaknesses and how well or otherwise they fit with other the components etc.

2. **A brief** from the client i.e. what is it that the client wants to achieve from the construction of the buildings in terms of functionality, aesthetics etc.

The brief from the client is akin to the reporting strategy.

The Financial Reporting Strategy, see Chapter 5, looks at what it is the health services wants to achieve from the system(s) in terms of the information and insight they produce to support decision making. The reporting strategy, like the brief given to the architect, will focus more on the "what" i.e. the desired output and outcome the client

[16] CHIS – Child Health Information System
[17] PAS – Patient Administration System
[18] NIMIS – National Integrated Medical Imaging System
[19] MEDLIS – National Medical Laboratory Information System
[20] EHR- Electronic Health Record

or in this case the health service wants to achieve. It will focus much less on the specifics of the "how" or the details around the underlying components that go into making the "what" and the "how" achievable.

It is stressed that the Chart of Accounts and Enterprise Structure are a subset of the overall master data items within the finance part of IFMS. They are one of the more critical master data sets on which financial **reporting** is dependant and need to be closely and coherently linked with other master data items, including with procurement master data and HR/ Payroll master data.

6.3.5 Recommended next steps

A logical next step is to ensure we have a good conceptual framework for our master data, recognising the priority around IFMS and NiSRP. "Good" in this context means a single integrated master data framework at a minimum covering IFMS and NiSRP and preferably also looking at some of the more significant master data items within the most relevant other systems.

This will require colleagues from IFMS, NiSRP and the information governance programme working together with relevant SAP and other expertise. The task is to agree and document a common understanding of each of the main master data items across the various systems i.e. IFMS, NiSRP and any others selected. The priority for this joint work is those master data items that have the most bearing on other master data items within the same system or in related systems. A common understanding means that for each master data item we can agree and document:

I. What is the definition of each master data item – should be readily available from SAP etc.?

II. What is its main purpose and function – per SAP and our initial assessment for health service context?

III. What options are there for its use and purpose – ditto as per II above?

IV. What are the pros and cons of its use – ditto as per II above?

V. What other master data items is it most linked with – should be readily available from SAP etc?

VI. Initial view of whether we will use it and how, at a high level – working assumption for further testing via consultation etc.

VII. Points I to VI should be summarised within an overall **"draft master data conceptual framework" and accompanied by:**

VIII. Suggestions for further work.

IX. Observations to inform design of ongoing master data governance approach, at least in respect of IFMS and NiSRP.

Coupled with the "brief" reflected in the reporting strategy (currently being prepared), the master data conceptual framework should inform the finalisation of the design of individual elements of master data including, for example, the IFMS Enterprise Structure and the related HR Organisational Structure.

The output of the steps above should also enable decisions in relation to the establishment of a governance process in relation to master data, at least in respect of IFMS and NiSRP.

6.4 HSE Centre of Excellence (Integrated HR, Payroll, Finance and Procurement)

Health Business Services division is expanding HR/Payroll Systems and Analytics (HPSA) to support the full SAP application suite (including finance and procurement) across HSE/HBS. This expansion will result in an enterprise

SAP Center of Excellence (CoE) based on industry-best practices and the SAP support needs of the HSE. The HSE has initiated two enterprise-wide transformation initiatives expanding the scope and breadth of SAP and the HSE CoE will participate fully on these initiatives:

- National Integrated Staff Records and Pay (NiSRP) to standardize HR and payroll processing across HSE/HBS.
- Integrated Financial Management System (IFMS) to standardize finance and accounting processes across HSE.

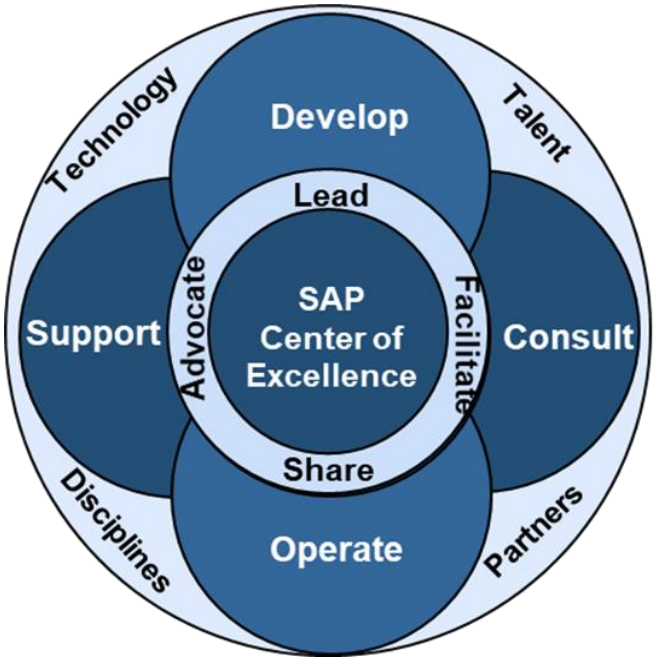
6.4.1 What is a SAP Centre of Excellence?

IBM's Institute for Business Value conducted a global survey of SAP users in 2013 to identify characteristics of leading organizations who use SAP. Their findings are set out below:-

- They have centralised CoEs that are aligned to major business processes and technology
- Strong ties between the business and SAP delivery ensure business alignment and appropriate prioritization supporting business goals.
- These leading SAP organizations establish business-driven Global Process Owners (GPO) to drive continuous process improvement across the organization by breaking down departmental silos. They restructure their SAP CoEs to support this GPO model across the enterprise. The HSE has implemented a similar process governance structure as outlined in Chapter 7 of this framework with the HSE CFO designated as the Global Process owner for all Finance and Procurement process
- They ensure consistent, common business process and controls across their regions and departments through a common design defining a global SAP application template, a single SAP application instance to which all local variations apply
- Application maintenance and operations are outsourced to a third-party
- They transition their program resources into their CoE(s) as a major initiatives complete so that business knowledge is retained within the CoE

They establish a robust network of super users to provide personal local support and adoption much like the stated intention of HPSA where that objective has already begun to pay dividends.

A Centre of Excellence (CoE) is an organization, *physical or virtual*, with resources, skills and sponsorship. It will be used to leverage information, support current and future implementations, and maintain and upgrade technical and business process environments. Typically, the **CoE resources**, particularly in the strategy and direction and end-user support functions, **are experienced business users themselves**.



SAP Centre of Excellence Explained

A SAP Centre of Excellence is a body of expertise in the enterprise that supports the efficient implementation, enhancement, and maintenance of common business processes and systems built around SAP. Typical functions include leading or participating in SAP projects, consulting and guiding the business units, establishing templates and standards, and support of production SAP svstems

What does it look like?

As illustrated to the left, an SAP CoE would provide SAP-centric business and technology resources operating under ITIL and the Software Enterprise Institute's CMMi disciplines. Delivery expectations are set through service level agreements that are measured and reported on regularly.

6.4.2 HSE Centre of Excellence Design

Guiding Principles

The new HSE CoE will be designed in accordance with the provisions of this framework and according to the following guiding principles that are directly informed by the best practice observations from the Institute for Business Value as described in section 6.4.1.:

1. **Scope:** The SAP CoE will be the single leadership function in HSE/HBS for SAP direction (e.g., SAP product plans, architecture and standards definition, release planning, etc.) as well as the support and maintenance of current SAP solutions (e.g., new process and application configuration, technical change management, and production support, etc.).
2. **Governance:** The governance process will establish an environment of clear accountability where all service requests are balanced against a common resource pool covering current and future plans.
3. **Business Alignment:** Align the business and the CoE through collaborative development of requirements, business cases, and strategic planning to support strategic business goals. The CoE structure will be aligned to the business either by functional area (e.g. finance, HR, etc.) or by process ownership (e.g. Procure to Pay, Core Finance etc.) through a business delivery management (BPM) role serving as the liaison between the business and the CoE.
4. **Business Process Expertise:** Whilst the Integrated Financial Management Systems/National Integrated Staff Records and Pay programmes will provide the initial SAP business process expertise, HSE/CoE will build business process domain knowledge in the form of business process management analysts who work alongside the business community whilst aligning to existing HSE governance structures and incompliance with the process governance framework per Chapter 7.
5. **Corporate Standards:** Any demand placed on the SAP CoE for infrastructure and technology will align to corporate HSE OCIO/ICT standards.
6. **Industry Practices:** The SAP CoE will be implemented using CMMi and ITIL disciplines.
7. **Exceptions:** The "lean" for exceptions will be to implement the out-of-the-box SAP practises and the requesting business group will need to defend why they need exceptions
8. **Delivery Model:** The delivery model for the SAP CoE will comprise the current HPSA CoE structure extended to incorporate industry best practises for organizing and staffing critical services.
9. **Staffing:** CoE design will require experienced team members to move into high-value added roles that manage support and project resources while developing and maintaining a close alignment with their business counterparts. Staffing will include augmentation and out-sourcing to third parties where appropriate.
10. **Project Ownership:** The majority of SAP projects will be owned and managed by the HSE/CoE business units. The CoE will act as the integrator for potentially disparate projects, bringing them together into release packages and SAP rollout/support plans
11. **SLAs:** The SAP CoE will support client organisations by service level agreement, not by named individuals.
12. **Success Measures:** The CoE will create a "Balanced ScoreCard" to report business engagement, CoE development effectiveness and SAP operational performance.

There is a general consensus that a fully functional single SAP COE will be established for all SAP modules. Significant investment has already been made and further investment via NiSRP/IFMS, it is felt that in order to protect this significant asset, the option highlighted below will be adopted.

6.4.3 SAP Super - Users

In implementing the recommended organization, it is necessary to map activities and their measurements in the functional model to an accountable organizational entity. HPSA has as part of its structure, **the concept of "super-users" embedded in the business** that can act as a part-time local 1st level support. This model will minimize the need for potentially significant growth in centralised resources and will also ensure a degree of autonomy and responsiveness to routine issues that would otherwise tie up (inappropriately) technical expertise in the COE.

This extends the principle of "Super Users" to incorporate the requirements of IFMS but to embed it as part of each implementation. HPSA intends a similar approach as part of its participation in the NiSRP programme. Experience to date suggests that it is extremely challenging to introduce the Super User concept post Go live phase. To ensure this, Super Users should participate in any business requirements analysis and blueprinting sessions during the Programme. They should also be leveraged as testers during end-user testing activities.

7. Process Governance Model

7.0 Process Governance – essential for efficient integrated approach to end to end processes

7.1 General – Shared nature of process "ownership" within the public healthcare context

There is a requirement for clarity around what the project literature and most of the external systems implementation support companies refer to as process "ownership". This "ownership" is seen as critical to enabling an **integrated** approach to be taken to processes that typically cut across many functional or service divisions, often referred to as "silos", within any organisation.

In the context of the structure and culture of the public health service and given that finance and procurement are support processes rather than the core "reason for being" of our services, there is a significant "shared ownership" of these processes.

There are at least 2 parts to the "shared ownership" of finance and procurement processes within health:

I. **Central Finance and Procurement (NFD, HBS Finance & HBS Procurement, HBS Estates, OoCIO)** – are typically responsible for coordinating the design, build, support, ongoing maintenance and improvement of processes etc. They are not directly responsible for "compliance" i.e. correct use of the processes by staff reporting to managers within services. They do have a major responsibility to ensure the operation and compliance burden on services and their staff is as low as possible. This needs to be achieved through good design and also through ensuring the process as designed and maintained, and the centrally operated parts of the process, are efficient and responsive to the needs of the services.

   It is intended to refer to **Process Custodians** when referring to specific formally designated senior managers within the centre with key responsibilities in relation to finance and procurement processes. A custodian typically has responsibility for taking care of and protecting something.

II. **Services – at local, regional and national level including s.38s and larger s.39s** – Services are typically focused on using the processes to support their needs in terms of ensuring delivery of services to service users including patients. Service managers are responsible for ensuring their staff operate their part of the processes in a way that complies with the NFRs and control requirements generally.

   It is intended to refer to **Process Operators** when referring to specific formally designated senior managers within services with key responsibilities in relation to finance and procurement processes.

7.2 Process Governance Model

Overall Ownership: Notwithstanding the shared nature of ownership of these processes it is felt necessary that there is a single overall owner of finance and procurement services on behalf of the health service. As provided for in the FOM this will be the HSE CFO who will be the **Global Process Owner (GPO).**

Thereafter it is intended that within the **functional areas** (HBS Finance, HBS Procurement, and NFD) process custodians will be specifically designated at up to 3 levels i.e. Main Process Custodians (MPCs), Process Custodians (PCs) and Assistant Process Custodians (APCs).

It is intended that within **service areas** (CHOs, Hospitals, Hospital Groups, PCRS, NAS, and National Operations etc.) process operators will be specifically designated at up to 3 levels i.e. Regional Process Operators (RPOs), Local Process Operators (LPOs) and a National Process Operator (NPO).

7.3 Designation of Process Custodians – within functional areas (HBS, NFD)

It is suggested that the detail of assignment of process custodians will require engagement with SAP and then internal decision making. Senior colleagues likely to be considered as process custodians should be involved in that engagement and decision making. What follows is subject to engagement, is indicative and is based on the SAP process taxonomy for S/4HANA 1709. It is noted that best practice indicates that a process custodian should be involved in all stages i.e. can be summarised as:

1. Design
2. Implementation
3. Post implementation continuous improvement and ongoing support

This has a bearing on who should be assigned as custodians i.e. ideally the custodian holds a post that is and will continue to be very heavily involved with the process.

Potential custodian levels:

A: Main Process Custodians (MPC) – Designated for each Level 1 end to end process: Likely to be AND or GM level – for illustration purposes only it may be the case there will be 4 end to end processes requiring the designation of an MPC, e.g.:

I. Streamlined Procure to Pay

II. Core Finance

III. Order to Cash (Income)

IV. Financial Planning and Analysis & Treasury and Financial Risk Management

B: Process Custodians (PC) – For most if not all Level 2 SAP processes. Likely to be GM or AND level depending on the process etc. In total there are 14 level 2 processes which for illustration, within Streamlined Procure to Pay, may require the designation of a PC, e.g.:

I. Operational Purchasing

II. Collaborative Sourcing and Contract Management

III. Inventory and Basic Warehouse Management

IV. Invoice and Payables Management

V. Supplier Management & Procurement Analytics

C: Assistant Process Custodians (APC) – For some process groupings at Level 3-5. Likely to be VIII or GM level depending on the process etc.

It is suggested that a process custodian is likely to be a head of a team or unit whose main purpose and function revolves around the process in question. **It will be necessary to consider to what extent existing units and teams need to be restructured to ensure that they are aligned appropriately with key processes.**

Unless specifically agreed it is not intended that designation of custodians would require an alteration to formal line management reporting arrangements. Custodians will be accountable to, seek and take direction from the relevant custodian at the level(s) above them, **in relation to their role as a process custodian only**. The responsibilities associated with the role of process custodian will become part of the overall responsibilities of specific posts within the organisation rather than being assigned to individuals. Where individuals assume a post in which custodianship responsibilities has been assigned, they will take on the role process custodian, with all the corresponding responsibilities for the relevant process.

They will continue to be accountable to, seek and take direction from their line manager in respect of the totality of their duties. Where this gives rise to any potential prioritisation or other conflicts the custodian will refer the matter to their line manager for direct resolution following reasonable initial efforts to resolve it themselves.

7.4 Designation of Process Operators – within service areas (CHO, Hospital, HG, NAS, PCRS etc.)

It is suggested that the detail of assignment of process operators may require engagement with SAP and then internal decision making. The responsibilities associated with the role of process operator will become part of the overall responsibilities of specific posts within the organisation rather than being assigned to individuals. Where individuals assume a post in which operator responsibilities has been assigned, they will take on the role of process operator, with all the corresponding responsibilities for the relevant process. Senior colleagues likely to be considered as specifically designated process operators will need to be involved in that decision making.

Potential operator levels:

A: Regional Process Operators (RPO) – These will be assigned within each CHO, HG, NAS and PCRS in respect of each Level 1 process and are expected to be at management team level within those entities. A single regional process owner can be assigned for one or more Level 1 processes. The assignment is a matter for each CHO Chief Officer, HG CEO or equivalent.

B: Local Process Operators (LPO) – These will be assigned within each Hospital, s38 or relevant S39 in respect of each level 1 process and are expected to be at management team level within those entities. A single local process owner can be assigned for one or more Level 1 processes.

Process operators should have good subject matter knowledge (of the processes) and significant service knowledge (of the service and how the process impacts the service and vice versa – in SAP / ICT terms, what we call “the service” they refer to as “the business”).

C: National Process Operator (NPO) – Deputy Director General for Operations or his nominee(s). The NPO role relates specifically to the oversight role of HSE Operations for the delivery system and includes overall compliance and resourcing of services within the remit of RPOs and LPOs and their line managers (Chief Officers, CEOs etc.).

Individual national divisions, including NFD and HBS and all other national divisions, are in effect “local process operators in their own right i.e. in respect of the use of the IFMS and its processes to meet their own needs (e.g. ordering stationary for their own divisions use). Each National Director will identify one or more LPOs for this purpose.

7.5 Process Governance Model – Ways of Working

Summary:

It is proposed that there will be a **process council** for each level 1 end to end process. This will be a standing decision making entity made up of the relevant designated process custodians, process operators and other senior stakeholder representatives. Each process council will appoint a **process team** made up of relevant staff of its members who are tasked with carrying out the day to day work overseen by the council. The process councils will also be supported by the Process Standardisation Unit (PSU).

Process Councils:

The Main Process Custodian (MC) or their nominee will chair a Process Council, with the MC in regular attendance.

Process councils will:

I. Be an ongoing standing entity i.e. continues through all 3 phases, design, implementation and post implementation.

II. Be a representative decision making body of key stakeholders appointed to enable both custodians and operators to meet their responsibilities.

III. Operate collaboratively and in so far as practical by consensus in making decisions.

IV. Develop and decide on initial process designs that are fully aligned with the Financial Management Framework and other relevant documents and submit these for endorsement by the Steering Committee

V. Support the implementation and post implementation continuous improvement and support of the process.

VI. Proactively identify and seek to mitigate the change impacts inherent in moving from the current processes to the new national standard processes.

VII. Rely largely on the knowledge, expertise and decision making capacity of the council and its members or attendees. The actual work being overseen by the council and the administration work associated with the council itself will be largely carried out by the process team and PSU referenced below.

VIII. Will be supported by the PSU who will be standing attendees, will bring Business Process Management expertise to the council table and whose role will include providing continuous assessment and feedback in relation to alignment of process designs as they are developed – see below for more on role of PSU and process team.

IX. Will be supported by a process team who will report to the council through the MC or his or her nominee - see below for more on role of the process team.

X. Require all PC's within remit of MC to be members and attend.

XI. Require representatives of regional, local and national process operators to be members and attend

XII. Requires other representative to be members or attendees to ensure proper stakeholder representation.

Support for Process Councils and their members:

I. **Process councils will be provided with initial training and ongoing development in relation to Business Process Management (BPM)** and any other key development needs identified in an initial development needs assessment. BPM is seen as the art / science of the design, implementation and continuous improvement of processes, regardless what processes they are or what business / service they are in. Therefore, it is seen as the third key competency with Subject Matter Expertise (of the process) and Service Knowledge being the other two.

II. **Process council members will be given clarity around expected time commitments** and should be afforded reasonably protected time for same, particularly where their main roles do not significantly revolve around the process.

III. **Process councils will be supported by the Process Standardisation Unit (PSU) -** The PSU reports to the Steering Committee through the ACFO Operations Excellence (Op Ex). It is not a decision making body, a process custodian or a process operator. It is intended to access external BPM expertise, develop in-house BPM expertise over time and support the process governance model by:

a) **Acting akin to a PMO for all of the process councils** – This includes providing each council with:

i. Supporting the MPC and the council to develop a prioritised work programme, with the same approach and methodology to be followed by each process council.

ii. Secretarial support and assistance in convening, preparing for, running and following up on meetings including action tracking etc. This will be achieved by way of PSU providing a "Secretary" to each process council and that person being seen as a key support to the chair and MPC.

iii. Training, development, tool kits, templates etc. to each process council in terms of the organisation and running of their meetings.

iv. Similar to II above for their process teams.

b) **Acting as the main Quality Assurance (Q/A) support to the Process Councils and the Steering Committee** – a key part of this will be providing continuous feedback and guidance to the councils in relation to the alignment of their process designs and work generally to the financial management framework and other key documents including the FRP plan. This will also include providing a review and assessment to the Steering Committee on any process designs submitted by a process council for the Steering Committee's endorsement. This role is critical to ensuring a consistent approach to standardised national end to end processes.

c) **Acting as main access point for SAP best practice advice** – The PSU will also provide technical advice on SAP functionality, SAP best practice etc. either directly or via third parties to ensure that business requirements, process designs and SAP best practice and functionality are fully aligned.

d) **Acting as the access point for business process management expertise** – Initially this will need to be externally sourced with the aim being to develop a significant in house capacity in this regard within the PSU. This expertise, including the provision of BPM training and development, will need to be provided to the process councils and their teams to assist them in their work. This includes the development and roll out to all councils and process teams of a standard BPM methodology. The aim of this is to assist the councils and their process teams with their work and ensure a standard approach and pacing.

e) **Design, implement and manage an online integrated management solution** to manage the business standardisation process. This solution will facilitate process analysis, change tracking, mapping, modelling and design, simulation and online collaboration between the various process stakeholders.

IV. **Process councils will be supported by one or more process teams** whose sole or primary role is to engage in the day to day work associated with the design, implementation and continuous improvement of the processes within the councils remit.

The process teams:

a) Will be appointed by the process council members. It is expected that process team members appointed by the main process custodian or the process custodians will include full time dedicated staff whose roles currently revolve around the processes in question. Process team members appointed by or on behalf of operators or other stakeholders are not expected to generally be full time on the process team albeit they may be at specific times. In the first instance it is expected that process teams will be populated by prioritising / reprioritising the workloads of existing staff and thereafter identifying the optimum minimum additional investment required to complete the process teams.

b) Will be **led by** senior nominees of the MC or PCs and will **be supported by** the PSU (BPM and other training, development, toolkits, templates etc.) and will engage proactively with the PSU.

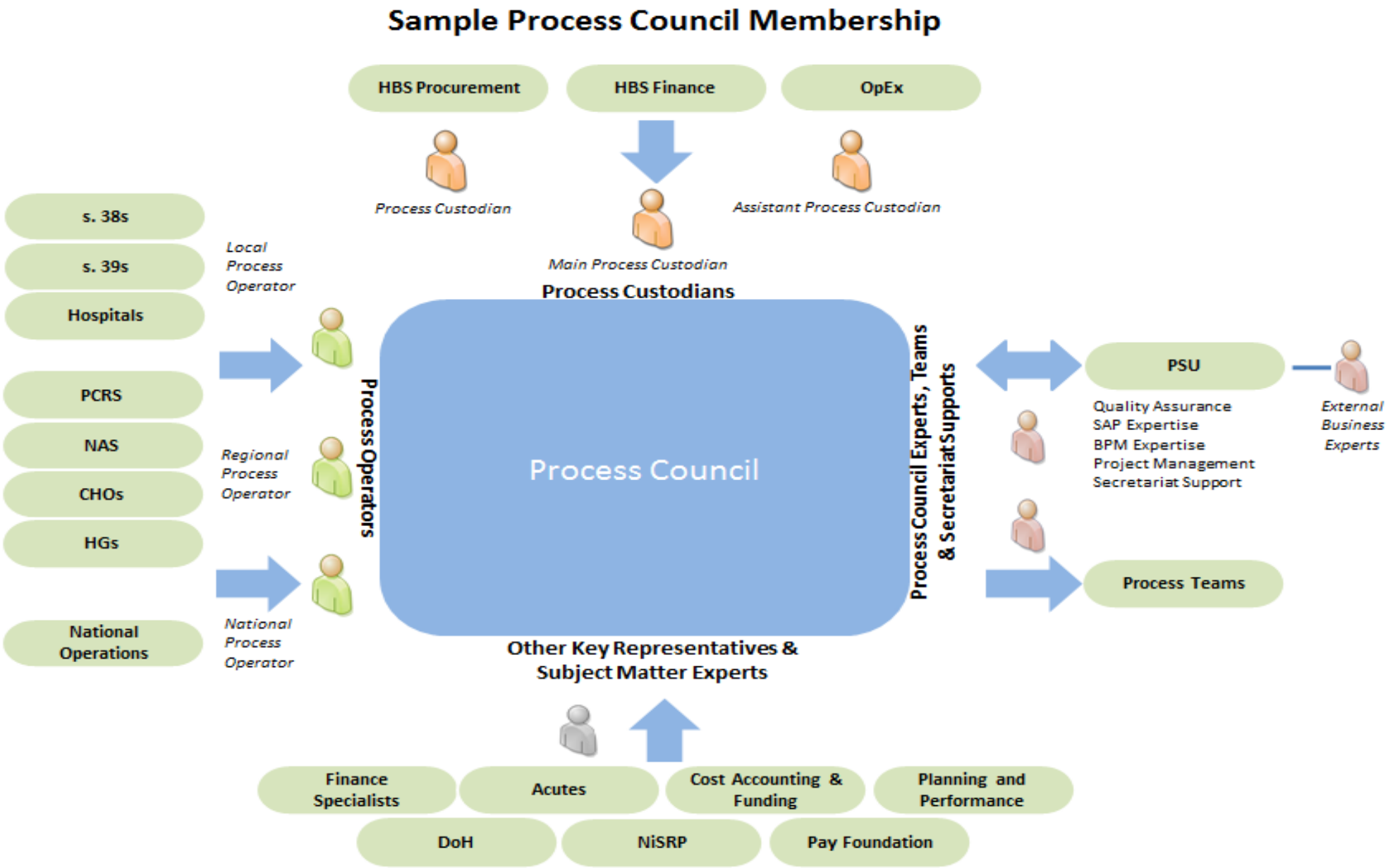
c) Will carry on the day to day work associated with the design, implementation support and post implementation continuous improvement of the process(s) – a council may decide to create one or more process teams to cover its area of process responsibility. Given the end to end and preferably integrated nature of the desired national processes, it is the preference that each council give strong consideration to operating with a single integrated process team that can have sub-teams within it as required.

V. **Process councils will establish** a number of **<u>process interest and advisory fora</u>** to assist them in their work. These would most likely be organised at the SAP process level 2 but this open to further teasing through by PSU etc. as there are some complexities in this. Fora will operate through a number of engagement channels including but not limited to:

1. Formal workshops
2. Webinars
3. Yammer or similar
4. Surveys / Questionnaires
5. Other communication channels

It is suggested that membership of the fora would be a mixture of formally sought and appointed nominees and "self-selection" of relevant interested parties. In effect the process team, with input from individual process council members and support from PSU and Corporate Development would manage the fora on behalf of the process council.

Figure 5: Sample Process Council Membership



PROCESS CUSTODIAN & OPERATOR DESIGNATIONS LIST[21]

Process Council	Main Process Custodian
Procure to Pay	Head of Procurement, HBS
Financial Planning & Analysis	ACFO Planning and Performance
Order to Cash	Head of Finance, HBS
Core Finance	Head of Finance, HBS

[21] When complete, this will be a list of custodians and operators – 1st priority is to designate the Main Process Custodians who can then play a key role in the implementation of the governance model with the support of the PSU and the Steering Group

Figure 6: Processes to be standardised

8. Process 1 – Streamlined Procure to Pay

8. Process 1 – Streamlined Procure to Pay

At a high level this process map includes:

I. **Sourcing** – planning for and putting in place central contracts or equivalent with suppliers to meet the needs of local providers. Sourcing is generally intended to be a centralised process, with an appropriate level of focus on both securing value and public procurement compliance. Sourcing includes the provision of a centralised assisted sourcing service to support local purchasing where no contract is in place yet.

It is acknowledged that, via the streamlined procure to pay process council, provision can be made for certain specialised sourcing to be carried out or led by relevant local providers on behalf of the whole or part of the system. Sourcing carried out in this way must comply with the national process including being visible nationally through use of IFMS sourcing tools, and its output i.e. eventual framework or contract must be "put up" on IFMS like any centrally sourced effort.

II. **Purchasing** – Utilising contracts locally to buy products and services from suppliers. Includes following the advice of the centralised assisted sourcing service where no contract is yet in place.

III. **Receipting** – Local confirmation via IFMS of satisfactory receipt of goods or services.

IV. **Inventory and Logistics Management** – Including optimising use of the National Distribution Centre (NDC) and its hubs.

V. **Payment** – all financial processes and accounting entries associated with paying suppliers for goods and services received including reconciliation of supplier accounts and statements.

8.1 Key process design principles for procure to pay:

I. Key local decisions / responsibilities:

These are focused on:

a) **Sourcing** - Proactively engaging with HBS procurement to outline local requirements as part of rolling 3 year procurement planning (sourcing planning) by HBS on behalf of all providers. Delivery of value including savings is the key long term priority of our sourcing efforts.

a) **Purchasing** – complying with the national standard process. The 3 main local responsibilities are:
   i. Identifying clearly the good or service that is required by the provider.
   ii. Confirming the availability of budget to support the purchase typically via approval of requisition / order (see point III below).
   iii. Confirming the satisfactory receipt of the good or service – this confirmation means that a relevant invoice can be paid once received without further reference to the purchaser of the good or service.

b) **Local Logistics and Inventory Management –** This may be run on behalf of local management by HBS Procurement. In any event it will operate standard national processes. Where appropriate this will include Materials Requirement Planning (MRP) with full integration with the National Distribution Centre and its hubs.

c) **Compliance** – Complying with competitive public procurement requirements by adhering strictly to the national standard sourcing and purchasing processes.

d) **General query resolution** – Responding proactively to queries and other reasonable requests from HBS or similar in relation to the smooth operation of each element of the national standard procure to pay process.

NB – Unique Material / Service Codes for all non-pay expenditure both revenue and capital – A core overriding priority is for staff involved in local purchasing to accurately select the correct unique material / service code in relation to all non-pay purchases. The process "design" should simplify this and ensure maximum support to the local user to substantially reduce the potential for incorrect codes being selected and maximise the likelihood of early detection. The proper use of a unique material / service code is the key to enabling analysis and reporting of input cost movements as between unit price and volume of units. It is also the key to gathering sufficient data to inform future sourcing and asset accounting where relevant.

II. Key central decisions / responsibilities:

All other aspects of the procure to pay process are to be carried out centrally e.g. via HBS unless expressly approved as an exception by the HSE CFO having consulted with the Finance Reform Steering Committee.

Specifically, the following are considered to be centralised process elements to be dealt with nationally e.g. HBS, NFD etc.:

a) Sourcing process i.e. engaging with suppliers to put in place and manage contracts including subsequent supplier relationship management.

b) Inventory and logistics management i.e. Management of NDC and its hubs, coordination with local inventory and logistics operations (stores) including managing local operations on behalf of providers where agreed.

c) Payment of suppliers for goods and services received.

d) The receipt (if necessary) and checking of supplier invoices prior to payment.

e) All related tax processing and compliance.

f) The financial accounting and other tasks related to procure to pay – including centrally initiated journal entries, creditor reconciliations and similar. NB – The centre has an ongoing obligation, in so far as is practical, to reduce the burden of processing and compliance on local providers. This includes responding proactively to queries and other reasonable requests from local services.

g) **Master Data** – All master data governance will be managed/coordinated centrally with local self-service for requests for new/change to existing data routed via workflow a central unit for validation against an agreed set of standards or similar before release into production. The agreed set of master data standards should, like the processes themselves, be subject of a decision making group that is representative of the key stakeholders including CHOs and HGs, etc. Master data management (supplier accounts, material /service codes, cost centres, G/L codes etc.).

III. Other

a) The streamlined procure to pay process will be designed to facilitate the requirement for monthly financial close and reporting, including board reporting (S.38, s.39, Hospital Group and HSE boards) to be available by the end of working day 5 post month end.

b) The national standard process will make it as simple as possible for local purchasers to identify the goods or services they wish to purchase. Issues such as contract compliance, material /service coding, cost centre and G/L code assignment, delivery address etc. will either be fully automated via the centralised sourcing process, user profiles etc. or based on pre-set "favourites" or similar. However, after any allowed for "bedding in period" requests for supplier payments that do not conform to the national standard processes will be rejected.

c) A key aim of the procure to pay process design will be to substantially eliminate the requirement for local manual accruals and prepayments. This will particularly target high volume / low value routine accruals and prepayments which delay the availability of monthly financial reports despite their generally low overall level of materiality.

d) The process design will aim to support improved compliance and visibility in relation to prompt payment requirements, creditor statement reconciliation (centralised) and the appropriate maximisation of supplier discounts.

e) The intention is to reduce and ideally, over time, substantially eliminate the use of invoices and move to "payment following confirmation of goods or services being received". The invoice receipt and payment process is a significant overhead and offers little additional control **in cases where the <u>local</u> goods or services receipt process is robust**. Where invoice receipt and processing cannot be immediately dispensed with as part of the introduction of the new processes it will be substantially centralised with maximum use of electronic invoicing in line with OGP strategy and EU directive.

f) It is intended that all non-pay expenditure including drugs[22] and medicines, services, utilities and, in due course, grants, will require the use of unique material / service codes. This is essential if Price versus Volume analysis on input cost movements is to become a reality. To facilitate this, the use of barcodes (e.g. GS1 codes or similar) by suppliers to the health service will become mandatory on a prioritised and phased basis. In addition, there will be a single integrated national list of suppliers (vendors) maintained by HBS Finance.

   The default position assumed in all process design will be that there must be formal local approval of all non-pay expenditure including services, grants and utilities. A set of nationally standard alternatives to the default use of purchase requisition / purchase order approval will be designed and approved. These will be for use in respect of certain defined goods, services, grants and utilities etc.

g) These alternatives will include a capacity, where appropriate, for "local pre-approval up to a value and/or time limit subject to periodic review and re-approval" as an alternative to individual approvals via a multitude of requisitions or purchase orders.

[22] Drug costs must be recorded as net of rebate received under non-pay expenditure and utilise separate and unique material codes.

h) Cash management is ultimately the responsibility of local providers whose available cash and capacity to fund payments to suppliers will become restricted if they are consistently overspent against notified budgets. This restriction is a fundamental part of the overall financial control environment and its preservation takes priority over the desire for streamlined transaction processes. Accordingly there will be a nationally standard process put in place to deal with exceptional situations where a local provider does not have sufficient cash available to meet its full supplier payment run. At a minimum CHOs, Hospital Groups and organisations funded under s.38 (including individual hospitals) will be expected to operate within the limits of their available cash and therefore will potentially be impacted by this requirement.

i) Accrual based expenditure is the principal basis of reporting in respect of the output of the purchase to pay process. However the capacity to readily report on a payment basis (excluding accruals) is also a key requirement.

j) It is also expected that commitment based reporting may be a requirement and it is proposed that a feasibility / desirability assessment in relation to both commitment reporting and reporting on a "matured liability basis" (vote reporting) will be carried out before any final decision is made in this regard.

k) A set of key process performance indicators will be designed, approved and implemented to provide ready ongoing visibility relevant to the issues outlined above. This will be prioritised to be in place from the initial deployment of the new standard process.

l) The default position is that the provisions above in relation to non-pay expenditure within the purchase to pay process apply equally to revenue and capital non-pay expenditure unless otherwise approved by exception. National standard capital expenditure exceptions will be designed and approved as required.

9. Process 2 – Asset Management & Asset Accounting

9. Process 2 – Asset Management & Asset Accounting

At a high level this process map includes:

I. **Identification of need** – includes addressing funding requirements and other relevant approvals, such as via business cases or similar where relevant.

II. **Acquisition (of assets)** - via sourcing (& purchase), construction or via donation or similar.

III. **Registering –** including identification, tagging and ongoing asset register maintenance.

IV. **Stewardship -** including safeguarding, ensuring appropriate use, proper maintenance, logistics and insurance.

V. **Verification –** including periodic inspection and annual valuation.

VI. **Disposal –** including all assets including those sold, scrapped and traded in.

VII. **Asset Accounting** – from acquisition through to disposal.

Valuation / revaluation of different asset classes and the calculation and recording of depreciation etc. on same means that there is significant technical accounting complexity in the asset accounting part of this overall process. The existence of separate revenue and capital income and expenditure accounts and the fact that, as required by DoH accounting policies, depreciation is not charged against income and expenditure, brings further differences from the standard accounting approach (GAAP[23]). The current thresholds for individual asset capitalisation are €2,000 for ICT assets and €7,000 for all other asset classes. These thresholds apply regardless of whether the asset is purchased from revenue or capital funds. Below these thresholds there are different treatments depending on whether the asset is funded from revenue or capital.

Asset management and accounting has typically been an under developed area within many parts of the health service as evidenced by recent negative Internal Audit and C&AG findings. It is, like all others, covered by all of the overarching process "design" principles outlined at Section 3.2 above. In creating a standard national set of processes the first two overarching process "design" principles are stressed, particularly given the technical complexity involved in asset accounting i.e.

1. Only those parts of a process that must be based locally will be based locally[24] regardless of what process it is. The local element of any process will be simplified as much as possible.

2. As much of each process as possible will be centralised nationally[25] in order to reduce the burden of operation and compliance on local services.

[23] Generally Accepted Accounting Principles

[24] Local refers to outside the centre of the HSE i.e. within community services, CHOs, hospitals, HGs, PCRS, NAS, providers funded under s.38 and relevant providers funded under s.39

[25] Central refers to within the centre of the HSE i.e. HBS, NFD or other national entity as appropriate.

9.1 Key process design principles for Asset Management and Asset Accounting:

I. Key local decisions / responsibilities:

These are focused on:

a) **Acquisition & Disposal –** In volume terms the vast bulk of assets are purchased. For such assets the local part of the process will be similar to that proposed in relation to the procure to pay process i.e. mostly limited to identifying what is required, confirming budget availability and subsequently confirming satisfactory receipt of the goods (assets). Disposal of purchased assets will have a similarly limited local element within a largely centralised national standard set of processes for different types of assets. In line with our overarching principles for all processes this will involve optimisation of local self-service directly onto IFMS.

b) **Stewardship** – This will remain substantially a local responsibility particularly in respect of general safeguarding, ensuring proper use and security.

c) **Verification** – This periodic inspection to confirm existence, assess condition and inform annual valuation will largely be a local responsibility albeit coordinated and supported centrally. This support will include provision of detailed reports allowing each relevant manager to readily access a list of the assets for which they or their staff are responsible. It will also allow entry of inspection results into the national register / repository.

d) **General Query Resolution** – Responding proactively to queries and other reasonable requests from HBS or similar in relation to the smooth operation of each element of the national standard asset management and asset accounting process.

II. Key central decisions / responsibilities:

All other aspects of the asset accounting and asset management process will be carried out centrally e.g. via HBS unless expressly approved as an exception by the HSE Chief Financial Officer having consulted with the Finance Reform Steering Committee. Specifically, the following are considered to be centralised process elements to be dealt with nationally e.g. by HBS, NFD etc.:

a) **Registering –** The identification of purchased assets will be a substantially centralised process, relying primarily on the effective design and implementation of the relevant elements of the procure to pay process. An integrated national asset register is the preferred choice. A defined subset of assets on the register will be required to be tagged. Asset tagging will be a largely centralised process albeit where necessary local services will have to take responsibility for attaching centrally produced asset tags to individual assets.

b) **Asset Accounting** – from acquisition through to disposal will be substantially a centralised process.

c) **Stewardship –** the maintenance of purchased assets will be coordinated and supported centrally including where relevant as part of the original sourcing contract or similar nationally sourced commercial arrangements. Insurance for purchased assets will be treated in the same way.

d) **Verification** – The centrally supported verification process will include ensuring local and central visibility of status and key outputs from the periodic inspection of assets i.e. these will be inputted locally on the system and will be available locally and nationally.

e) **Disposal –** the national process design will include a disposal process for the various asset classes and will be a predominantly centralised accounting process with information provided by local services. The centre will act on disposal information provided to it in conjunction with responding proactively to queries and other reasonable requests from local services.

f) **Master Data** – All master data governance will be managed/coordinated centrally with local self-service for requests for new/change to existing routed via workflow a central unit for validation against an agreed set of standards or similar before release into production. The agreed set of master data standards should, like the processes themselves, be subject of a decision making group that is representative of the key stakeholders including CHOs and HGs, etc. Master data management (asset numbers, asset assignment hierarchy etc.) will be centralised.

NB – The centre has an ongoing obligation, in so far as is practical, to reduce the burden of processing and compliance on local service providers.

III. Other

a) The asset management and accounting process will be designed to facilitate the requirement for monthly financial close and reporting, including board reporting (S.38, s.39, Hospital Group and HSE boards), to be available by the end of working day 5 post month end.

b) The design of the national standard processes will take account of the central expertise and national coordinating roles / potential of HBS Estates, HBS Clinical Equipment Unit, OoCIO and NAS in regard to Land and Buildings (including WIP), Medical Equipment, ICT assets and Vehicles respectively.

c) The asset tag process for purchased assets will be designed to facilitate, to the greatest extent practical, delivery of assets with asset tags already attached or for the tags to arrive at the same time as the asset is delivered.

d) Geocoding of all relevant assets, including stationary assets and options to enable physical tracking of portable assets (GPS?) will be assessed for feasibility as part of the registration and tagging process.

e) For constructed or donated assets the standard national processes will most likely require a greater local element. This will be limited to what is unavoidable.

f) The national process will ensure that each relevant manager can readily be provided with a list of all assets that are under her / his control including the control of her / his staff. This implies a clear link between individual items on the asset register and the enterprise structure (cost centres, organisational units etc.). The national asset register is intended to both support asset management and also asset accounting. In the context of the latter it must be designed so as to contain the necessary financial information, including valuation and depreciation information in respect of each individual asset on the register.

g) In deciding how individual assets will be defined on the register the intention is that any “grouped” assets will be reserved for items that individually would be of low value e.g. perhaps below the €2,000 and €7,000 current capitalisation thresholds. Thereafter it is expected that each asset would be listed separately. This area will be subject to further scoping before key principles in relation to grouping of assets is finalised. In carrying out this scoping we will bear in mind that the threshold for capitalisation is not necessarily the appropriate threshold for individual identification on the register.

h) The depreciation component of the national accounting process will need to be able to support a dual option in relation to charging of depreciation i.e. GAAP compliant and DoH accounting policy compliant. It is noted that the current accounting policies specified for the HSE by the Minister are not compliant with GAAP in a number of respects, one of which relates to depreciation (charged to balance sheet reserves rather than Income and Expenditure Account). For IFMS the requirement will be for all assets, whether funded via revenue or capital, to be capable of being linked with one or more revenue cost centres (or similar). This will facilitate potential future reporting in the event that DoH policy becomes aligned with GAAP. It will also give greater potential for more comparable costing where otherwise similar services are using rented versus owned assets and will support entities not subject to DoH accounting policy (s.38/ s.39?).

i) A set of key process performance indicators will be designed, approved and implemented to provide ready ongoing visibility relevant to the issues outlined above. This will be prioritised to be in place from the initial deployment of the new standard process.

10. Process 3 – Income Management & Accounting (SAP Order to Cash)

10. Process 3 – Income Management and Accounting

At a high level this process map includes:

I. **Income Generation –** The activities related to the provision of whatever services or goods that generate the income e.g. provision of acute or long stay beds, provision of assessment in Emergency Department or provision of canteen, carpark, registry and other services for which the health service can charge etc.

II. **Charging –** The calculation and initial recording of the amount to be charged including operation of patient and other systems used for data gathering relevant to charge calculation (PAS or similar etc.) where these exist. This includes the maintenance of any automated "rules engine" that calculates the charge and similar workload.

III. **Collection** – The formal issue / notification of the charge to the patient or other "customer", including the raising of invoices where relevant, pursuit of payment, recording of payment, including daily visibility of cash, and other debtor management activities.

IV. **Write-off** – the decision to no longer pursue and formally remove the amount of any validly raised debt from debtor accounts based on compliance with debt-collection protocols.

V. **Accounting** – Throughout the process from "issue of charge" onwards. Dealing with the necessary control account reconciliations and other debtor management related technical accounting entries including those related to bad debt charge, accruals, provisioning, write-offs etc. Also includes accounting for payments received whether invoices utilised or not ("not" e.g. canteen, car park and similar income).

10.1 Key process design principles for Income Management and Accounting:

I. Key local decisions / responsibilities:

These are focused on:

a) **Income Generation –** This is to be a predominantly local service responsibility. These activities and the related decisions and responsibilities are for local services to manage within whatever policy, guidance and legislative frameworks that are applicable. They involve a high degree of direct service related interactions with service users and their families. Performance management issues related to sufficient generation of income, or otherwise, will be a matter for local management.

b) **Charging –** This is to be a predominantly local service responsibility including recording patient details on the locally operated systems based on face to face interaction. Charging calculations may be carried out manually or on an automated or system supported basis within operational systems utilised locally, such as Patient Administration Systems (PAS) or similar, where these already exist and are functioning. In either case the responsibility for accurate data gathering and entry to facilitate correct calculation of charges rests with local services. See 6.1.2 below in relation to shared local and central responsibility in relation to maintenance of "rules engines" within PAS and similar operational systems.

c) **Collection –** This is to be predominantly a central service responsibility. Where charges are advised "at point of service" to service users without the requirement for an invoice or where invoices are issued "at point of service" then this specific part of the process is a local service responsibility. All other aspects of collection or debtor management should be a central service with local services required to respond proactively to reasonable queries necessary to facilitate efficient operation of the centralised process.

d) **Write-off** – This is to be predominantly a local decision albeit supported by the centralised collections, debtor management and accounting process. It is for local managers to decide to write-off debts and they must have sufficient visibility of, and confidence in, the centralised debtors management services to make such decisions. It is intended to amend the NFRs accordingly i.e. to reflect the establishment of CHO's and Hospital Groups. Operating the existing "external to HSE" approval threshold in relation to debt write off will be facilitated by the overall debtors management process and workflow within IFMS.

e) **Accounting –** This is to be predominantly a central service responsibility. Local services are responsible for accurate and timely data gathering, data input and responding proactively to reasonable queries necessary to facilitate the centralised process.

II. Key central decisions / responsibilities:

a) **Income Generation –** This is to be a predominantly local service responsibility.

b) **Charging –** This is to be a predominantly local service responsibility. The preference is that over time PAS and similar major operational support systems will be national systems managed centrally on behalf of the health service. In the interim, the centralised national debtor management function will be required to liaise closely with local and national ICT to provide assurance that "rules engines" within existing PAS or similar systems are accurate and kept up to date.

c) **Collection –** This is to be predominantly a central service responsibility. It is expected that the issue of invoices will be centralised, other than where best practice is to issue the invoice at the "point of service", and automated. Where it is consistent with effective collection it will also be moved to electronic format. The overall collection process will be operated by a national debtor management function and have responsibility for the issue of relevant invoices, pursuit of all debt collection and all related accounting matters. This function will operate the national debtor management system component within IFMS. Where charges are not calculated within IFMS it is expected that sufficient information will be interfaced to IFMS to enable both the raising of the invoice and the efficient pursuit of the debt centrally. To enable this, it is essential that the staff within the national debtor management function have ongoing immediate electronic access to all relevant information supporting the calculation of the individual charges.

d) **Write-off** – This will be a predominantly local service management responsibility facilitated by the workflow within IFMS i.e. it will be a process that is operated within IFMS rather than a "manual / external" process. The process workflow of the centralised national debtor management system will ensure sufficient involvement of local managers in ongoing review of the operation of relevant aspects of the debtor management process. This will facilitate local ownership and confidence when it comes to local decision making in relation to formal write-off of debts.

e) **Accounting –** This is to be predominantly a central service responsibility.

f) **Master Data** – All master data governance will be managed/coordinated centrally with local self-service for requests for new/change to existing data routed via workflow a central unit for validation against an agreed set of standards or similar before release into production. The agreed set of master data standards should, like the processes themselves, be subject of a decision making group that is representative of the key stakeholders including CHOs and HGs, etc.

III. Other:

a) The income management and accounting process will be designed to facilitate the requirement for monthly financial close and reporting, including board reporting (S.38, s.39, Hospital Group and HSE boards), to be available by the end of working day 5 post month end.

b) Where the collection process requires a direct face to face engagement with service users or their families this is likely to be a local service responsibility prompted by the centralised function.

c) The intent is to encourage payment at "point of service" wherever feasible and accommodate various types of payment, for example, online payments, payment by instalment, payment by card, etc.

d) It is also the intent to reduce the incidence of cash in so far as practical but consistent with maximising collection and encouraging payment at "point of service" as referenced above. In order to maximise collection it is accepted that cash will most likely have to remain a payment option. However alternative payment options will be optimised for all income types particularly recurring patient charges such as contributions under the NHSS[26] scheme.

e) The intent is to maximise the receipt of electronic information to support assignment and recording of payments received. It is noted that this will require significant engagement with private insurers to change current practices.

f) It is noted that in the case of private maintenance income the bulk of this is collected from a small number of private insurers. The system will be able to cater for this practical reality but also cater for the legal reality. The legal reality is that the individual patient is the contractual debtor, on whose behalf the insurer issues payment.

g) It is also noted that the "charging" process in respect of insurer paid debt is particularly onerous. Completion and signing of the claim form and gathering the additional clinical documentation are tasks that can only be performed at a local level, due to availability of information. Currently, fully collated claims for private and public charges are submitted to the insurers using the Claimsure system. The current Claimsure system and process will be reviewed to ascertain whether any changes to it are required to ensure it fits with the overall principles being adopted for IFMS and the extent of any appropriate interface between Claimsure and IFMS. This review will also consider the implications of planning work underway, chaired by DoH, in relation to the potential rollout of full electronic claiming.

h) It is assumed that a significant element of non-patient related income is paid immediately and does not give rise to a debtor e.g. canteen, shop, car park, registry (births marriages and deaths) and similar. Other non-patient related income charging that **does** requires an invoice and debtor process, such as secondment income, should be facilitated via a module of IFMS. This would utilise the local self- service data input principle with process design thereafter consistent with Section 7 points I & II above.

i) Controls should be in place to ensure patients/debtors are recorded once and all future debt is recorded against the same debtor across all hospitals. There should be a live link between the hospital PAS systems or other relevant operational systems and the national debt management system within IFMS. The appropriate use of the IHI will be progressed in this context.

[26] NHSS – Nursing Home Support Scheme

j) “Internal income” e.g. reimbursement of drug costs from PCRS to Acute Hospitals, NHSS payments from the fair deal office to CHO in respect of long stay care is an area that will require the IFMS design to readily facilitate appropriate consolidation and financial reporting in line with best practice norms. The current external review being supported by KOSI will inform the approach this aspect of income and reporting.

11. Process 4 – Accounting and Closing Operations

11. Process 4 – Accounting and Closing Operations

At a high level, and focusing on monthly rather than annual reporting, this process map includes:

I. **Feeder Systems / Modules and similar inputs** – coordinating the monthly cycle that ensures information from these is available within the ledger by the dates specified in the monthly close and report schedule (includes Payroll, Accounts Payable, Accounts Receivable, Inventory Accounting, Asset Accounting, Cost allocation).

II. **Journal entries** – including accruals, prepayments, expenditure transfers and budget adjustments.

III. **Ongoing control account and other reconciliations or similar** – including bank and control account reconciliations, working capital reconciliations and balance sheet reconciliations generally. Recurring journal entries and those that flow from the reconciliation type work also included.

IV. **Pre-close review and close –** All month end tasks are to be completed in time for a 5 day close and report. The precise timetable for these tasks will be determined by the previously mentioned Process Councils.

Post close review and reporting – Post close review and reporting will be in line with a 5 day close period. This includes board reporting (s.38, s39, Hospital Group and HSE Boards). Any errors detected are explained and where necessary, in line with materiality thresholds and rule set, agreed with input relevant stakeholders, highlighted and adjusted in later period. Reporting by day +5 includes completion of system generated variance, trend and forecast analysis and capture of local, regional and national initial insights into same (captured online via integrated SAP Business Planning and Consolidation tool and similar). **Post close review and reporting is dealt with in more detail under Process 5 – Financial Planning and analysis** (Incorporates core Management Accounting process).

As outlined in the benefits section on page 3, *"Financial information should be available within 5 working days[27] of month-end to decision makers at local, regional and national level across health and social care services".* The current overall timeline for completion of "post close review and reporting" is circa working day +15/16 with the equivalent of "pre-close review and close" currently at working day +10/11. The HSE early close pilot completed in late 2016 indicated that a 9th working day target for "post close review and reporting" was feasible within the current multiple legacy system environment. This was subject to a degree of process standardisation and other related changes and work is underway in that regard.

However the introduction of IFMS provides the opportunity to move to national fully standardised processes and also to a single integrated system. Both of these, if approached correctly, can be utilised to deliver much earlier close and reporting. In order to secure the benefits of reporting by +5 a core commitment that will be needed from all stakeholders relates to the issue of "time for review" and what that actually means. In effect the only review period that can lead to a change to budget or actual figures each month will be within the "pre-close review and close" window which will end on working day 0 or +1. Relevant managers and staff at all levels will need to appropriately "block out time in their diaries" each month to deal with their role in this review.

After this deadline has passed the "post-close review and reporting" window will only allow for explanation and interpretation of any "errors" that it brings to light. It will not allow for any changes to that month's figures.

[27] 5 working days for month end close and external stakeholder reporting is the CIPFA best practice benchmark for similar organisations (source: HSE early close pilot report 2016).

11.1 Key process design principles for Accounting and Closing Operations:

I. Key local decisions / responsibilities:

These are focused on:

a) **Feeder Systems / Modules and similar inputs:**

1. **Payroll** – ensure collaborate proactively with maximisation of standard automated accruals / prepayments for payroll and with rule set in relation to accurate and up to date coding of staff. Developments in relation to the NiSRP are relevant in this context.

2. **Accounts Payable –** ensure the simplified local elements of the streamlined national standard purchase to pay process outlined above are adhered to fully. In summary this means using the system to requisition and record receipt of goods and services in real time rather than "ringing suppliers and just waiting for the invoice to arrive". This will significantly reduce the month end volume of work for local staff associated with accrual, prepayment and expenditure adjustment journals.

3. **Accounts Receivable, Inventory (Stock) Accounting, Asset Accounting and Cost Allocation –** ensure the simplified local elements of these process areas are adhered to fully.

b) **Journal entries –** locally originated entries including accruals, prepayments, expenditure transfers and budget adjustments. The intent is to maximise the use of self-service so that non-complex data is gathered once and in the most efficient way. This involves substantially eliminating the use of manual/excel templates or similar. These carry a similar burden for local staff as direct entry on a modern system with an intuitive user interface. Manual / excel templates also involve a level of transmission risk and additional overhead at the centre. The use of system validation features and workflow will be optimised in order to ensure errors are minimised and appropriate local approvals are secured where necessary (based on value thresholds etc.).

c) **Ongoing control account and other reconciliations or similar -** These will be centralised given their complexity and the fact that IFMS is a single integrated system. Local staff will need to respond proactively to requests for information, clarifications and review but otherwise they will be freed up from this work and the associated risks.

d) **Pre-close review and close** – By working day 0 or +1. The pre-close review and check will include a role for relevant local managers and staff. This will need to be appropriately prioritised, scheduled in diaries and contingency arrangements put in place to deal with planned and unplanned absences.

II. Key central decisions / responsibilities:

All other aspects of the accounting and closing operations process will be carried out centrally e.g. via HBS or NFD unless expressly approved as an exception by the HSE Chief Financial Officer having consulted with the Finance Reform Steering Committee. Specifically, the following are considered to be process elements to be dealt with centrally:

a) **Feeder Systems / Modules and similar inputs –** The centre will be responsible for coordinating the monthly cycle that ensures information from these is available within the ledger by the dates specified in the monthly close and report schedule. This will include Payroll, Accounts Payable, Accounts Receivable, Inventory Accounting, Asset Accounting and Cost Allocation. Each of these areas will have deadlines beyond which no further local or other inputs will be accepted with contingencies planned in advance to address any risks to achieving "pre-close review and close" by working day 0 or +1.

b) **Journal entries –** The centre will originate and post journals that emanate from the control account and other reconciliations managed by the centre (see next point). The centre will also ensure that the system is closed to all journal entries, including local entries, by the specified deadline.

c) **Ongoing control account and other reconciliations or similar -** This work will be carried out centrally. It includes bank and control account reconciliations, working capital reconciliation and balance sheet reconciliations generally. Recurring journal entries and those that flow from the reconciliation type work also included.

d) **Pre-close review and close** –The centre will coordinate the pre-close review on behalf of the overall health system. Contingencies will be agreed with relevant stakeholders to ensure unplanned events or individual missed deadlines do not jeopardise the working day 0 or +1 close. The centre will not require any "confirmation that local area X is finished" – close occurs when it is scheduled and the centre is pre-authorised not to wait for any individual or group of individual stakeholder inputs.

e) **Master Data** – All master data governance will be managed/coordinated centrally with local self-service for requests for new/change to existing routed via workflow a central unit for validation against an agreed set of standards or similar before release into production. The agreed set of master data standards should, like the processes themselves, be subject of a decision making group that is representative of the key stakeholders including CHOs and HGs, etc.

It is acknowledged that the regime proposed above is different to that currently in place and will require a readjustment for many stakeholders. It is necessarily rigid in order to prevent the overall benefit for all stakeholders of early reporting being lost based on unaddressed issues in a minority of stakeholders. Reasonable assistance will be offered to enable such issues to be addressed.

III. Other

a) **Balancing workload and resources** – A key design principle will be minimising the percentage of total "monthly close related work" that is left until the "month end / last week". Processes should be designed to allow as much as possible to be done on a daily and weekly basis.

b) **Income Management and Accounting** – See Process 3 – this is an area that has traditionally been under developed in accounting and process terms. It is a significant cause of current poor monthly close and report timelines and will require significant enhancement in moving to IFMS.

c) **Board "approval" of reports** - This is sometimes raised as a barrier to early close and reporting and seems somewhat anomalous in corporate governance terms. The chief executive and senior management team are typically responsible for ongoing day to day management of the entity. Production and issue of basic monthly financial reports usually falls within ongoing management and is typically delegated to the lead finance executive or their nominee. Where senior management feel it is necessary to review and / or approve reports prior to issue they can do so by scheduling their review within the "post close review and reporting" window. In theory boards can do likewise if they felt that was appropriate.

d) **Materiality rule set and thresholds** – This will be set out via the same governance as the design of the standard national processes. All users of financial reports, including HSE and its external funders, will have to accept the "explain rather than correct" principle in respect of any errors discovered post close.

12. Process 5 – Financial Planning and Analysis (Incorporates core Management Accounting process i.e. includes trend analysis, variance analysis, forecasting, budgeting and budgetary control)

12. Process 5 – Financial Planning and Analysis

There are processes detailed below which are described in more granular detail in the Financial Reporting Strategy, Treasury Management and Cost Management & Profitability Analysis chapters and these should be referenced accordingly. This chapter must be read in conjunction with these areas as principles contained in this section cannot be considered in isolation and must be read and considered as part of the overall financial management framework.

At a high level this process map includes:

a) **Financial Reporting –** The production and capture of data at the lowest level, it's conversion into information, the conversion of that information into insight and the use of that insight to inform decisions leading to necessary actions. This is an enabler to allow comprehensive evaluation of current and future performance, both financial and non-financial.

b) **Financial Forecasting –** The ability to accurately forecast financially to year end and for multiple years. The requirement is for a common platform, process and toolset to support and automate the forecasting function, while using activity and related non-financial (output) data to drive and inform the forecast. This should also encapsulate and integrate cash and working capital reporting and cost analysis in addition to allowing bottom up and top down organisational views.

c) **Financial Planning -** This forecasting toolset will also be used as part of the annual planning process to provide both a top down and bottom up plan for the following year. The annual planning cycle will be completed in an automated fashion via the consolidation tool in IFMS. This consolidation tool will also have the ability to track and allocate resource down to cost centre and general ledger level. This will enable planning to be scenario tested and then refined once resources are known for the financial year.

d) **Resource Tracking –** to isolate, allocate, track and report on available resource / funds in a given financial year. All funding received and collected is required to be managed, tracked and matched to the services or entity that have been given use of those funds. In addition in should also account for separately commissioned services (See Chapter 15).

e) **Enhanced Reporting (Input & Output) –** the ability to analyse cost (volume & price) movements over time and enable users to differentiate in changes in volume of units used and or price per unit movements. It should also allow the integration of non-financial service based quality and safety indicators into reporting in addition to service outcome indicators (See Chapters 14 & 15)

12.1 Key process design principles for Financial Planning and Analysis

I. Key local decisions / responsibilities:

These are focused on:

a) **Financial reporting –** Financial analysis and text / reason based analysis will be entered at a local level by appropriate users which will facilitate the production of local reporting requirements. At each stage of the process, analysis will then be consolidated to meet the minimum requirements of the next governance level within the health system. This will thereby meet the agreed minimum reporting and analysis without requiring analysis and commentary to be completed outside of the financial system.

b) **Financial Forecasting –** The system will flag exceptions thrown up by forecasts and enable local users at all levels to provide analysis, structured commentary and suggested adjustments to these forecasts based on local knowledge and insight. The input of these local insights into the forecasting model is predominately a local function.

c) **Financial Planning –** It will be a local responsibility to prepare bottom up plans to the end of the following year as part of the annual planning process. The forecasting toolset will also be used as part of this process to provide scenario planning locally for that year. Planning can be reset when resources are actually known and service levels, savings measures and other adjustments can then be adjusted for in the final annual financial plan.

d) **Resource Tracking –** This is both a local and central process. All funding received locally must be allocated to service, GL, cost centre etc. At a local level funding received and generated must be tracked against relevant expenditure and reported on both monthly and annually. In addition locally commissioned services must be reported on separately.

e) **Enhanced Reporting –** This is predominately a locally driven process. This process is an assessment of the economy and efficiency of costs at service level and also enables an assessment of these costs to be readily available in financial reports. This process is an enabler to allow an assessment of services and overall value comparisons. It will include the linking of financial and non-financial values.

II. Key central decisions / responsibilities:

These are focused on:

a) **Financial Reporting –** The input of explanations for variances is predominately a local responsibility, the system will utilise the principal "enter data once and use many times" in relation to this process. All local financial analysis and text based explanations will be consolidated to meet the minimum requirements of the centre to enable better decision making. This allows a macro view of the organisation and its respective services and also an exception driven lower level service analysis if required.

b) **Financial Forecasting –** This is a local and central responsibility. Through the consolidation process, forecasts, along with commentary and adjustments, for each level of the system will be aggregated thereby converting a base service forecast into a bottom up consolidated forecast. A centrally driven top down forecast will be also be produced with the link between the two maintained for review by all levels.

c) **Financial Planning –** The responsibility for driving this annual planning process will be at national level, however there will be significant collaboration with local levels in relation to the following year's forecasts and the finalisation of plans. Through various iterations of scenario planning on the system, the following year's forecasts, including savings measures and other adjustments, will be brought in line with the available funding once it is known. This scenario planning will initially be based on estimated funding levels prior to government budget day. This will involve a combination of top down and bottom up collaborative working. Once this is completed the final forecasts will be converted to budgets.

d) **Resource Tracking –** The ability to detail and manage funds received from Government, to allocate that funding to services and to track and report on funds distributed in a given financial year is a centrally driven process. Funds are allocated to services from a central function once funding levels are known. The functionality will permit the distribution of funding to the lowest organisational levels and to allow further cascade to GL, cost centre etc. locally by local users. At a central level both the use of funds and source of funds must be controlled and tracked. In addition in should also account for separately commissioned services and developments (Chapter 15).

e) **Enhanced Reporting –** At the centre reporting will allow comprehensive evaluation of current and future performance, both financial and non-financial. This process will provide past, present and prediction information that helps in decision making, people management and project management. It will provide the functionality to allow the evaluation of economy, efficiency and effectiveness of organisational units as well as assisting in resource allocation in a given financial year. This will also involve a combination of top down and bottom up collaborative working.

III. Other:

a) In order to be useful in ongoing financial reporting it is expected that financial reports would be available within a set of core timeline requirements including: (i) 5 Working day close and report for monthly financial reporting including initial commentaries (ii) 10 Working day turnaround for detailed quarterly forecasts (iii) End of 2nd full week in December for completion of the financial planning cycle including all budgets uploaded onto IFMS by that date.

b) The management of all master data relevant to processes will be centralised and dealt with nationally through an integrated set of procedures that will be designed and resourced to provide timely responses to local requests. This includes data consistency and ensuring a common approach to coding and classification of activities and costs via the adoption of a single chart of accounts within a single enterprise structure.

c) This includes all relevant information to be produced within the national integrated staff records and pay system (NiSRP) which will be accessible via IFMS. The intention is that these systems will be interfaced and integrated over time becoming a single ERP system covering finance, procurement, HR and payroll.

d) A key enabler of community and ABF/Patient level costing will be the implementation and maintenance of cost allocation rules within IFMS.

e) Improved standard operating procedure for forecasting will require the implementation of best practice forecasting modelling across the whole Health sector.

f) System Health Accounts – The requirement to report by SHA classifications (Funding type/Health Care provider/Healthcare classification) will need to be catered for in IFMS.

g) Pensions Management – The requirement to report centrally on the costs and resources allocated to overall health pensions. This will require an organisational view of pension payment, lump sums payment, income collected, income transferred to the exchequer, and flexible modelling of future pension costs and income generation.

h) Enterprise structure / Chart of Accounts – The enterprise structure and chart of accounts must be capable of supporting multiple stakeholder views including service view, management hierarchy and a number of other views to be agreed during the system design.

13. Process 6 – Master Data Governance

13. Process 6 – Master Data Governance

This process in relation to master data governance should be read in conjunction with the Integrated Master Data Strategy set out in Section 6.3 above. That strategy sets out a series of next steps to rapidly develop a **draft master data conceptual framework**. This is seen as a task that should involve relevant IFMS, NiSRP and Information Governance Programme colleagues with input from SAP and other relevant expert colleagues. It is expected that the output from this task will also include observations to inform the design of the ongoing master data governance approach.

References below to "finance" master data governance should be considered in this context and this process will be revisited when the outputs from the task referenced above are available. It is expected that the master data governance process may become broader than "finance" master data but the main process steps, sequencing of same and "central" versus "local" responsibilities etc. are more likely to broadly remain as set out below.

The process governance model set in Section 4 above is also relevant to this master data governance process. The regional process operators and local process operators as defined at 4.4 are the same as those referenced below.

At a high level this process map includes:

1. **Periodic Update of Master Data Conceptual Framework and related guidelines** – This is the baseline against which requests for master data changes will be assessed by both local authorisers (regional and local process operators designated under the process governance model at Section 4) and the central validation unit. The approval of updated guidelines will be coordinated **centrally** with decision making that involves key stakeholder representatives similar to the Process Council and Steering Committee arrangements proposed for the process governance model.

2. **Initiation of Finance Master Data Change Request –** The activities related to identifying and communicating the need to add or change Master Data e.g. opening of a new care home or other organisational changes requiring the setup of a new cost centre. It is expected that master data change requests may be initiated locally, regionally or centrally depending on the specific circumstances. This means that such requests can be initiated from within CHOs, s.38s, s.39s, Hospitals, Hospital Groups, NAS, PCRS or National Divisions depending on the specific circumstances.

3. **Authorisations for Finance Master Data Change Requests –** The process by which requests for Master Data Changes are routed through the organisation for authorisation ahead of seeking central validation for the change e.g. routing of requests for non-pay GL or for new cost centres. Authorisation of change requests will be made by the relevant process operator, process custodian, other relevant senior manager or their nominees designated on IFMS for that purpose.

4. **Central Validation for the Master Data Change –** The process by which the central Master Data Unit validates the change request. Validation can lead to the request being released, rejected or deferred pending receipt of further clarification.

5. **Release of Master Data into the Financial Systems** – the central process by which the validated Master Data is updated in IFMS.

In summary master data governance is a largely centrally governed process with the sole exception of the initiation of change requests which can originate from local services or the centre. The intent is to enable the local service to have the ability to request master data changes in a controlled manner with reference to well defined rules and

principles but that all master data changes must be validated centrally to ensure consistency before being updated to the financial systems.

I. Other

a) It is the intention that this will be a highly automated workflow driven process aided by the use of the SAP MDG (Master Data Governance Tool). SAP MDG enables a high level of governance and control by automated routing of change requests and their approval based on defined rules whilst reducing the reliance on manual methods such as email and spread sheets. This will facilitate local, regional and central staff to track change requests and have ongoing visibility of their status (local self-service).

b) Changes requests related to significant organisational changes which occur less frequently but have significant master data impact are expected to be initiated centrally with guidance to local areas or where possible one mass change request driven from the centre.

c) A single set of finance master data will be adopted for IFMS and will be applicable to all users of the system including s38s and the larger s39s.

d) It is the intent that large organisational changes will be driven from the centre and where possible will be carried out by a mass system update facilitated by SAP MDG reducing the workload on the local services to initiate large numbers of change requests in these instances.

e) It is noted that this is a significant change in the manner of governing master data centrally and will have a significant reliance on well-defined guidelines together with an ongoing training programme for local areas.

f) It is also noted that there is significant master data management associated with the Procure to Pay and Order to Cash. It is assumed that their management is considered under those processes.

14. Process 7 – Treasury Management

14. Process 7 – Treasury Management

There are processes detailed below which are described in more granular detail in the Financial Reporting Strategy, Cost Management & Financial Planning & Analysis chapters and these should be referenced accordingly. This chapter must be read in conjunction with these areas as principles contained in this section cannot be considered in isolation and must be read and considered as part of the overall financial management framework.

The HSE's current treasury management process is a principally cash driven service, with little integration with core finance systems and a heavy reliance on manual reconciliations. This process map will have greater integration of cash management, expenditure management, working capital management, balance sheet analysis and forecasting (cash and expenditure). Treasury management is an integral part of financial management and cannot be considered separate.

At a high level this process map includes:

I. **Bank Account Maintenance –** The activities relate to the creation and closure of bank accounts and activities directly related to this. These activities include maintaining and tracking multiple signatories / mandates, review of accounts, viewing and reporting on accounts and account fact sheets.

II. **Cash Management, Operations–** The preparation of annual cash profiles linked to available resource, the calculation of cash limits for statutory and voluntary services based on these profiles and the drawdown and distribution of exchequer funds to services. The matching of funding to cash requirements.

III. **Cash Management, Reporting –** periodic calculation of cash balance position by entity / service, cash forecasting vs. available resource with the generation of both short and medium / long term cash liquidity forecasts. In addition this includes the preparation of monthly cash reports for internal and external distribution and bank account reconciliations which are consistent with enterprise structures.

IV. **Integrated Cash and I&E Reporting** & **Working Capital Management**- To fully align service based reporting to actively manage cash balances by service. This would align working capital reporting, cash reporting and expenditure reporting by distinct service / function through the operation of both physical and virtual bank accounts, in order to respond to any future organisational reorganisation. This would include 'reason codes' and a free text field in order to explain cash / working capital variances.

V. **Cheque Tracking & Transfers / Direct Debits –** The creation and maintenance of cheque registers, linking to UB voucher imaging systems, internal account transfers (IAT) payments and the maintenance of SEPA compliant direct debit mandates.

VI. **Integration with External Networks-** Forward payment instruction to banks, the receipt of status notifications for payment instructions. To receive and upload bank statements in multiple standard formats, the creation and maintenance of currency master data and the posting of currency adjustments.

VII. **Patient Private Property (PPP)-** the separate management of patient private property accounts including tracking and reconciliation of patient cash balances, tracking of investment funds on patient's behalf, disbursement of funds to patients electronically and through drawdown of cash,

depending of individual patient needs. It will also include the production of detailed annual financial accounts for PPP.

14.1 Key process design principles for Treasury Management

I. Key local decisions / responsibilities:

These are focused on:

a) **Bank Account Maintenance –** This is predominantly a central service. In order to maintain the control and correct use of funds, local areas should not have access to make changes to banking transaction details. An automated system process is required where local areas make requests to a central service to be processed.

b) **Cash Management, Operations –**This is not a local service as the overall cash management is controlled centrally. Local areas are given a budget and cash profiles and they must use these funds appropriately in order to ensure they adhere to limits. Local areas will require the facility to review and be notified of profile changes and make requests for additional funding electronically (cash accelerations).

c) **Cash Management, Reporting –** This information will need to be carried out by local areas. Local inputs should feed up through the system to inform central reporting and analysis. This information will then be collated and used centrally to prepare cash management reports. All local areas will require the ability to prepare local cash management reports.

d) **Integrated Cash, I&E Reporting** & **Working Capital Management**- This information will need to be collated by local areas. Local inputs should feed up through the system to inform central reporting and analysis. This information will then be collated and used centrally for expenditure reporting and working capital management. Local areas need to prepare, review and analyse giving explanations of cash, expenditure and Working Capital Management.

e) **Cheque Tracking & Transfers / Direct Debits –**Local areas need access to cheque registers and voucher imaging system in order to effectively perform local reconciliations and reports. This ensures the integrity of the bank transactions are maintained and can be monitored.

f) **Integration with External Networks-** While this is predominantly a central function local areas need to have access to view all local information. This access by the local areas will need to be approved centrally to ensure the integrity of the data.

g) **Patient Private Property (PPP) -** This is predominately a central responsibility. The management, accounting and disbursement of patient funds is a local task once in receipt of patient funds from central.

II. Key central decisions / responsibilities:

a) **Bank Account Maintenance –** This is predominantly central service responsibility. Central service needs to be notified of local requests and all requests need to be tracked and processed through the finance system. Banking requests need to be approved at appropriate levels in-line with bank mandate authority levels.

b) **Cash Management, Operations –** This is predominantly central service responsibility. Central services need to be able to make changes to monitor and control funding in order not to breach funding limits. Central services need the facility to notify local areas of updates and changes to limits. All requests for additional funding need to be approved at multiple levels of authorisation through the system and approved changes to profiles and budgets need to be carried out centrally.

c) **Cash Management, Reporting –** Central services will require the ability to prepare consolidated cash management reports at a high level and the ability to review and analyse all local inputs and explanations.

d) **Integrated Cash, I&E Reporting & Working Capital Management -** Central services require the ability to monitor, review and analyse all local input**s** and report and prepare consolidated organisation wide reports. Standard and ad-hoc reporting should be facilitated.

e) **Cheque Tracking & Transfers / Direct Debits –** All tracking and registers should be controlled at a central **l**evel. Central service needs to be notified of local requests and all requests need to be tracked and processed through the finance system. Request need to approved at appropriate levels in-line with bank mandate authority levels.

f) **Integration with External Networks-** This should be a central function as there needs to be control of external network access and to what extent. To ensure that the access does not comprise sensitive data integration this will need central approval.

g) **Patient Private Property (PPP)-** The central process involves the management of investment funds on behalf of patients, monitoring of all local arrangements through standard reporting and reconciliations such as client statements, revenue reports and it will also include the production of detailed annual financial accounts for PPP.

III. Other:

a) Financial information is required in real time with monthly reports to be available within 5 working days of month end to decision makers. There will be a requirement for well designed, very streamlined and user friendly national processes coupled with focused local change and reconfiguration over the short to medium term.

b) The system should allow for cash, expenditure and working capital to be reconciled and reported at both national level and also at a local level to facilitate more detailed and meaningful reporting for the organisation. At each level it will be required to input both reason codes and free text explanations for variances and movements which can then be consolidation at a national level.

c) The system will need to facilitate the current facilities of petty cash, cheques and procurement cards. All requests for procurement cards should be automated and tracked. This is in line with need to move to a self-service approach. It is also envisaged that cash and cheque payments would be eliminated on a phased basis in the medium term.

d) A decision is required in relation to the overall approach to bank accounts within the overall framework of IFMS. This will inform the approach to treasury management and the use of a virtual banking framework.

e) While there is not a current national requirement for traditional treasury facilities of investments and other treasury products these facilities will be required by some section 38 and section 39 organisations.

f) Balance sheet and working capital reporting will be required for all entities.

g) Cash and commitment based reporting - These will be a standard requirement along with accrual based reporting.

15. Process 8 – Cost Management and Profitability Analysis

15. Process 8 – Cost Management and Profitability Analysis

Introduction

There are processes detailed below which are described in more granular detail in the Financial Reporting Strategy, Treasury and Cost Management & Financial Planning & Analysis chapters and these should be referenced accordingly. This chapter must be read in conjunction with these areas as principles contained in this section cannot be considered in isolation and must be read and considered as part of the overall financial management framework.

This process will allow the organisation to zero in on cost and performance issues across services and structures and allow thorough cost and profitability (contribution) analysis through a streamlined defined cost and financial management process. This process should be driven by a hierarchy of principles of 1) Data, 2) Information, 3) Insight and then 4) Decision making, with each of these principles flowing through all cost management and profitability analysis processes. The solution should give deep insight into our costs to facilitate decision making and resource allocation. It should also harness advanced contribution analysis, financial modelling and forecasting, activity-based costing, and cost allocation methods – to help maximise cost savings and boost overall organisational contribution.

At a high level this process map includes:

I. **Enhanced Input Based Reporting –** the assessment of the economy of costs at service / entity level and also enable an assessment of costs to be readily available in financial reports. This will facilitate economy related decisions and actions. This is in addition to being able to analyse cost (volume & price) movements over time and enable users to differentiate in changes in volume of units used and or price per unit movements. This includes all categories of costs including the ability to track and readily report on individual units of labour hours used by any organisational service.

II. **Enhanced Output Based Reporting –** builds on input based reporting and these two processes have a high inter-dependency. This process is an enabler to allow an assessment of efficiency and effectiveness of services and other organisational functions. It should allow the integration of non-financial service based quality and safety indicators into reporting in addition to service outcome indicators. This will allow tracking and reporting of costs and contribution at a service / entity level and also allow what if scenarios across multiple dimensions to assist resource allocation.

III. **Service Based Costing / Funding Model –** Summary output based reporting which will enable the assessment of efficiency. Involves lining up buckets of costs against buckets of outputs, financial data such as WTE's, products, agency hours, patient groupings and activity indicators etc. will be required to be integrated into IFMS in order to accurately report on outputs. The enterprise structure will be required to be flexible enough to report by service area i.e. Primary Care Network, or by acute specialty and also key is the visibility of patient groupings.

IV. **Contribution Analysis** – This process relates to the contribution margin of a service. The contribution margin is the excess between the allocated funding for the service and total variable costs of providing that service. It represents the payment made by individual services towards recovering the fixed costs of the business. Contribution analysis assists in analysing the effects of changes in costs in services which can drive more effective resource allocation and more informed decision with this insight into service costs.

V. **Project Based Costing / Service commissioning / Developments –** to isolate, track, report and assess individual project costs and commissioning of services. The health sector has a functioning

internal (i.e., Cancer Services) and external (i.e., NTPF) commissioning processes where services are commissioned using existing in year resources. In addition to the above this process should allow a comparison of original cost estimates, actual costs, projected costs, and see the variances between costs at any time and at any level of detail. It should also match with allocated resource for a specific initiative and allow variance reporting against plan. This will also include scenario and financial modelling for overall assessment and tracking of project / service cost management.

VI. **Capital Management –** to provide a robust online accessible means of tracking and reporting on all capital activity relating to any given project. This process will include master data maintenance, budget allocation, payment and depletion, reporting and also providing other cost reporting functionality.

15.1 Key process design principles for cost management and profitability analysis

I. Key local decisions / responsibilities

These are focused on:

a) **Enhanced Input Based Reporting –** This is predominately a locally driven process. This process is an assessment of the economy and efficiency of costs at service level and also enables an assessment of these costs to be readily available in financial reports. This process is an enabler to allow an assessment of services and overall value comparisons. It will include the linking of financial and non-financial values and this will facilitate local economy related decisions and actions.

b) **Enhanced Output Based Reporting –** builds on input based reporting. It should allow local integration of non-financial service based quality and safety indicators into reporting in addition to service outcome indicators.

c) **Service Based Costing / Funding Model –** This is a local driven process. This will provide summary output based reporting which will enable the assessment of efficiency across local services, to gain insight into service costs and collect, analyse and line up these buckets of costs to inform better local financial management decisions.

d) **Contribution Analysis** – This process relates to the contribution margin of a local service. It will allow local managers to gain insight into overhead costs, eliminate non value added activities and understand the effect of costs & processes variations on performance. Contribution analysis assists in analysing the effects of changes in costs in services which can drive more effective resource allocation at a local level.

e) **Project Based Costing / Service commissioning / Developments –** to isolate, track, report and assess individual local project costs and commissioning of services. This process should allow a comparison of original cost estimates, actual costs, projected costs, and see the variances between costs at any time and at any level of detail. This analysis can then be consolidated and viewed at the centre.

f) **Capital Management –** Reporting on capital expenditure is the joint responsibility of Finance Capital and the Estate Managers. The implemented system should provide for complex parameterised local reporting allowing for the production of fixed and variable format hierarchical reporting. The system needs to have a flexible search facility across all project fields.

II. Key central decisions / responsibilities:

These are focused on:

a) **Enhanced Input Based Reporting –** At the centre reporting will allow comprehensive evaluation of current costs, past costs and prediction information that assists in decision making. This includes all categories of costs including the ability to track and readily report on individual units of labour hours used by any organisational service. This is in addition to being able to analyse cost (volume & price) movements over time and enable users to differentiate in changes in volume of units used and or price per unit movements. This will also involve a combination of top down and bottom up collaborative working.

b) **Enhanced Output Based Reporting –** At the centre reporting will allow assessment of the efficiency and effectiveness of services and other organisational functions. In addition, an insight into service costs and a deeper understanding of organisational cost drivers and the causes of financial underperformance. It will allow the running of scenario modelling of costs with an eye on value.

c) **Contribution Analysis / Service Based Costing / Funding Model –** At the centre reporting will allow assessment of service costs to enable better informed resource allocation decisions. This will drive efficiency and effectiveness and drive lower costs. This will assist and improve financial planning effectiveness by identifying the cost and performance relationship of different service levels.

d) **Project Based Costing / Service Commissioning / Developments –** to isolate, track, report and assess individual project costs and commissioning of services. At the centre reporting of these services will include tracking of detailed service costs, matching of funding to these costs and comparison of original cost plan versus actual. This will allow overall assessment of project costs which can be factored into any performance management process.

e) **Capital Management –** This is principally a central process. To provide a robust online accessible means of tracking and reporting on all capital activity relating to any given project. This process will include master data maintenance, budget allocation, payment and depletion, reporting and also providing other cost reporting functionality. Budget availability checking will be improved with various options for automated notifications being generated, in addition to recording monthly, annual and multi annual budget information at project level and by service. Payment checking and an approval process will be built into the payment proposal and payment run process. The production of budgets based on external factors, running 'what if' scenarios against budget plans, maintaining several budgets based on different factors, splitting budgets periodically and making budget available piecemeal. The system will upload and attach electronic documentation to individual projects.

III. Other:

a) The management of all master data relevant to processes will be centralised and dealt with nationally through an integrated set of procedures that will be designed and resourced to provide timely responses to local requests. This includes data consistency and ensuring a common

approach to coding and classification of activities and costs via the adoption of a single chart of accounts within a single enterprise structure.

b) This includes all relevant information to be produced within the national integrated staff records and pay system (NiSRP) which will be accessible via IFMS. The intention is that these systems will be interfaced and integrated over time becoming a single ERP system covering finance, procurement, HR and payroll.

c) Output based reporting should initially be high level based reporting which involves the lining up of pools of costs against pools of activity. There would be a phased expansion of detailed output based costing to provide visibility of detailed costs for different categories. This would be achieved by linking financial data, activity data and quality data via appropriate costing methodologies and longer term costing projects. This should also include a phased embedding of high level safety and quality indicators with relevant financial reporting as well as a structured assessment of economy & effectiveness.

d) Financial information is required in real time with monthly reports to be available within 5 working days of month end to decision makers. There will be a requirement for well designed, very streamlined and user friendly national processes coupled with focused local change and reconfiguration over the short to medium term.

e) A key enabler of community and ABF/Patient level costing will be the implementation and maintenance of cost allocation rules within IFMS.

Appendix 1 – Supporting text in in relation to section 2.6 Detail (what things look like today, and why)

I. **Current financial reporting is not timely or sustainable – need to move to 5 working day close and report**

The timeliness of financial reporting across the health system is variable and this is before we consider, as indicated above, that what constitutes financial reporting is in itself variable across the system. Individual local sites, particularly where they have their own financial systems (s38/s39), will typically have access to their financial information earlier than is the case for regional levels (CHO or Hospital Group) or national levels (HSE National Divisions, DOH). Even at local level, the evidence indicates that the best practice of close and report within 5 working days[28] of the month end is likely to be the exception rather than the rule.

The annual estimates and service planning process effectively concludes with the creation of operational plans at local and regional level and the upload of budgets on the disparate local systems across the health service. This process could not be considered to be timely. Government budget day is typically mid-October however by the time the national service planning, operational planning and budgeting is completed and budgets are loaded it is close to the end of February. This is not a solely financial process and in many ways, given the scale of the system and the various constraints, this timeline reflects very significant efforts by all concerned.

However, as we look forward to the significant investment of time and money over the next 5 or so years to implement a single integrated finance and procurement system, these timelines will not be acceptable to us.

Best practice would require the planning and budgeting process to be complete, with the full upload of all budgets, before the commencement of the year in question in order to give services the maximum opportunity to deliver on the actions necessary to successfully implement their plans. Best practice also requires that the budgets as uploaded are merely the financial expression of specific decisions already made to ensure the delivery of the various plans within budget. In many instances the budgets uploaded across the health services would fall short of this best practice requirement and this could not reasonably be solely attributed to perceptions around the sufficiency or otherwise of the total funding available.

The Annual Financial Statements for the HSE are provided in draft to the C&AG by the end of February, which is a significant achievement, given that they represent the consolidation of more than 10 sub-AFS returns from the legacy systems of the former health boards. However, in general, it is a process that is not well integrated with the ongoing monthly management accounting processes and typically requires a substantial amount of concentrated effort in the period November to February.

The net result of the current annual Planning & Budgeting and AFS cycles is that a very significant amount of additional / annual work is concentrated into the months of October to February. This is not without its implications on the ongoing financial reporting cycle and should not be sustained going forward. Implications include delays in production of monthly reports typically in December and January, a preference in some instances to exclude the month of December from forecasting efforts and at least a perceived risk that there is insufficient capacity to focus on decision support in respect of the performance in the months of October to January.

[28] As per Chartered Institute of Management Accounting (CIMA)

II. **Current financial reporting is overly focused on "simple breakeven" – an essential hygiene factor but not sufficient in itself**

Prioritising the delivery of safe services within the available resources can be considered to be the 1st priority for the HSE in any given year. Accordingly if financial breakeven is not achieved then any assessment of performance must, generally, deliver a negative rating. However delivering financial breakeven, essential though it is, remains very much a "hygiene factor". An equally or more important question is did we deliver the quality and quantity of service expected for the money provided? If expenditure is 1% below budget but only 80% of the expected volume of services have been provided then clearly there is a performance or budget setting concern.

If 100% - 110% of the expected volume was delivered within the budget but there are significant quality concerns over 30% of that volume then clearly there are performance concerns. At present, within our financial reports, there is not a uniform approach to making sure any analysis of budget versus actual takes into account these factors. The information may well be more or less visible in other reports presented at the same time etc. but that is not sufficient for the future.

III. **Current financial reporting is overly focused on inputs, with limited output based reporting**

Traditionally, public sector financial reporting has been input focused i.e. has concentrated on controlling the total costs of staff, supplies, services and other "input costs" that are used in the provision of services or "outputs". The current prominence, in both internal and external health service financial reports, of actual, budget and variance reporting in relation to pay costs, non-pay costs, gross costs, income and net costs, confirms that this remains very much the case. Consequently there is insufficient focus within our reports on the outputs and, ultimately, the outcomes, delivered by the services (treatments, residential places, visits etc.) which supports the point made above about the over focus on "simple breakeven".

This continued over focus on inputs is in part a result of the lack of development of costing systems and methodologies and the general lack of the clinical and operations information systems that costing typically relies upon. This is despite some good progress in recent years, including in relation to Hospital Activity Based Funding and Fair Deal costing. In acknowledging this progress it is important to also flag the significant level of effort these costing processes take to maintain and operate. This hampers their mainstreaming and alignment into the normal ongoing planning, budgeting and performance reporting workload, their sustainable extension and improvement in their own right and the extension of the underlying methodologies to other areas of health service provision.

IV. **Current financial reporting has a general absence of Price / Volume analysis, for inputs and outputs**

Despite the over focus on input based reporting, current reporting tends not to be comprehensive. Current input focused reports do not as a general rule meet the good practice of analysing all movements or variances in pay and non-pay costs as between:

1. changes in the volume of the units of labour hours, supplies or services and
2. changes in the price per unit of each of those inputs.

V. **Current financial reporting is overly retrospective focused – need more and better forecasting supported by standard tools and models**

Current reporting in many cases gives more prominence to assessing what has happened to-date and, often to a lesser extent, why that was the case, rather than seeking to predict future trends and scenarios. The understanding of current and recent performance is important to good financial reporting and indeed needs to be generally improved (see comments re price / volume above etc.). However, in keeping with the overarching purpose of financial reporting, i.e. to support decision making leading to necessary actions, it is important that all financial reports, as standard, give significant prominence to forecasting.

When forecasts are included, they are often input cost only forecasts and based predominantly on largely "simple extrapolation" of past costs. Forecasting also, despite some notable exceptions, tends to be high level and is often top-down in nature. This top-down predominance does not reflect best practice and is in part reflective of the complexity, time, capacity and other constraints inherent in a truly combined bottom up and top down approach to forecasting in as large an organisation as the health system. This is particularly challenging in the absence of a common platform, process and toolset to support and partly automate this.

VI. Current financial reporting is generally not focused on the wider control environment, cash / working capital etc.

Best practice would indicate that ongoing financial reporting should include reporting in relation to cash and working capital management and also in relation to what we refer to generally as governance and compliance i.e. the operation of the overall system of internal financial control. This is not currently a consistent feature of financial reporting at all levels within the health service.

VII. Current financial reporting is generally not focused on Value i.e. Economy, Efficiency and Effectiveness

The "Value for Money and Policy Review Initiative Guidance Manual", published by the Department of Public Expenditure and Reform (DPER) in 2007 (chapter 3), in effect summarises the formal central public sector view of how public value should be defined and evaluated in the Irish context. The evaluation criteria cover rationale, efficiency, effectiveness, impact and continued relevance and are aligned with the usual shorthand of value for money represented by economy, efficiency and effectiveness. See Appendix 10 on page 27 for how the DPER VFM guide can be linked to the Institute for Healthcare Improvement (IHI) Triple Aim and the Institute of Medicines (IOM) 6 Aims for Improvement i.e. Value in Healthcare context = Quality!

In the DPER guide:

- Economy (securing the best price per unit of input, consistent with appropriate quality) is a subset of
- Efficiency (optimising the ratio of inputs to outputs, consistent with appropriate quality).
- Effectiveness encompasses an assessment of outcomes against the strategic objectives of any expenditure programme.

The general absence of assessment as to the economy, efficiency and effectiveness of services from our current financial reports is a key limitation of our current reporting albeit it is a predictable enough outcome given the other constraints previously outlined. Its absence makes it more difficult to either drive value internally or demonstrate value externally and this hampers our capacity to secure necessary additional investment. This absence also in part explains the lack of focus in our current reporting on prompting decisions and actions i.e. a lack of focus on true decision support.

Appendix 2 – HSE Directorate Hierarchy of Priorities for implementation of NSP 2019

Overarching priority

The HSE's hierarchy of priorities in terms of the implementation of NSP 2019 is as follows:

1. The over-riding requirement is to prioritise the delivery of safe services within the available resources (budget, WTE, facilities etc.). It is acknowledged that for certain services this this will involve a balanced judgement including the application of the HSE's integrated risk management policy where appropriate.)

2. Thereafter, maximise the delivery of the volume, access, quality improvement and other targets as set out in the NSP, without jeopardising the 1st priority. This requires maximisation of the effectiveness, efficiency and economy of services.

There are areas of potential risk to safety which may result from resource limitations. These limitations may have an impact on our ability to meet all the demands on services. Points to be considered include:

1. The quantum of services to be provided must be limited to what the budget will support.

2. In deciding which services to provide within the available budget, and to whom, prioritisation should be based on clinical need and effectiveness.

3. Eliminating waste in all forms in healthcare expenditure has the potential to enable higher levels of service provision.

4. It may be necessary to redirect resources from one service to another when addressing known or emerging risks.

Every organisation has a unique risk profile. The HSE's Integrated Risk Management Policy sets out the process for the identification and assessment of risk. The risk matrix identifies 3 levels of risk, that is red (not tolerable), amber (tolerable) and green (acceptable). Key decisions relating to patient safety should be subject to risk assessment to inform management decision making.

The reasons for selecting "prioritise the delivery of safe services" as part of the 1st priority are self-evident. Delivering financial breakeven i.e. "within the available resources" is also included within that 1st priority primarily on the basis that it meets the legal obligation of the HSE and is considered to be in the medium to long term best interests of the patients and service users who rely on our services, and the staff who work in them. This is predicated on the view that securing additional investment in public health services, having greater flexibility over the application of that investment, and ideally having multi-annual funding plans with certainty as to future annual "real" funding increases, is best served by demonstrating that the health service can operate within the level of resource provided to it each year.

The medium to long term benefits, of demonstrating and sustaining, this internal discipline, and the consequent external credibility with our funders and the wider public, is seen as outweighing any perceived short term disadvantage in any one year. In summary, delivering financial breakeven, is seen as fully aligned with the legal objective of the health service as set out in section 7(1) of the Health Act 2004 i.e. "to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public".

For the avoidance of doubt, "just" delivering fully on both of these essential aspects of the 1st priority is not considered sufficient to represent acceptable or good performance. However, if either aspect of the 1st priority is not met, then regardless of other areas of performance, any assessment of overall performance must, generally, be considered in the negative.

Once the 1st priority is fully delivered, the focus of any overall performance assessment will be on the extent to which services provided meet the various volume and other targets set out in the NSP.

In assessing whether an accountable officer, or other budget holder, including a funded voluntary provider, has met the financial breakeven aspect of the 1st priority in any given year, consideration will be given to whether actions taken in the current year have created unsustainable financial pressures in the following year. Put simply, budget holders cannot enter into arrangements in the current financial year that are likely to cause underfunded costs in the following year(s) e.g. recruiting staff late in the year, or approving recurring expenditures for which they only have once-off funding such as time related savings from other funded developments.

Appendix 3 – Further detail in relation to section 3.4 Additional design principles and objectives for health service financial reporting:

General

All process design work (financial processes, procurement processes and HR / Payroll processes) will give significant priority to the need to maximise the daily and weekly completion of all core work, including reconciliations, in order to absolutely minimise the requirement for any additional month end or year-end tasks and related staff time. In addition, and to the extent consistent with the timeline requirements above, the potential for IFMS to support relevant daily and weekly operational financial reporting to facilitate local service management, will be fully explored.

I. Emphasis on phased reporting improvements pending implementation of new systems including IFMS

The implementation of IFMS, and a single national HR and Payroll system (NISRP), will be essential to the full realisation of this reporting strategy, as will the phased development of clinical and operational systems, including the National Electronic Health Record (EHR). In the interim, and fully aligned with the desired future state, there will be a significant focus on foundational work and on phased practical improvements within the context of the existing legacy systems available to us. As more and better systems and information become available our challenge is to have done the preparatory work in advance to be ready to quickly bring the benefits of those improvements to the decision makers who use financial reports.

II. Mitigating the typical financial management risk associated with public health and social care provision

The planning and budgeting process constructed as part of the implementation of this reporting strategy needs to assist in delivering on the hierarchy of priorities including the 1st priority i.e. prioritising the provision of safe services within the available resources. This will be mean effectively managing the typical financial management risks associated with public health and social care service provision in many countries. These financial management risks include:

- ✓ the unavoidable nature of certain health service activity, regardless of funding availability;
- ✓ the challenge that in certain years the cost of the level of certain services desired by health service funders may exceed the level of funding they have available for that service; or
- ✓ the risk that the provider system will have insufficient capacity or capability, in a single year, to bridge any funding gaps caused by the prevailing financial risks, despite focused efforts around realistic improvement measures or prioritisation / de-prioritisation of resources and services.

III. Balance sheet and working capital reporting

Will be required for all legal entities i.e. currently HSE and s38 / s39s. It will also be an immediate requirement for all hospitals, hospital groups, CHOs, larger sub-CHO entities (tbc e.g. National Forensic Mental Hospital), NAS, HBS, HSE Centre and PCRS, regardless of legal entity status or otherwise.

IV. Control and compliance reporting

This will be required as a standard feature of routine monthly / quarterly financial reporting. This will include IFMS supported reporting in relation to the compliance levels with core financial controls built into our core processes, as well as reporting on the implementation of recommendations from internal audit, external audit and similar reports.

V. Cash and commitment based reporting

These will be a standard requirement along with accrual based reporting.

VI. Internal transactions

It is expected that the utilisation of funding flows to promote adherence to quality, integration and other service specification requirements, will be an ongoing and most likely growing aspect that our financial reporting will need to appropriately cater for (i.e. payments in addition to "normal budgets" from the centre to provider entities e.g. CHOs, Hospital Groups etc.).

Current examples include the reimbursement of certain drug costs between PCRS / NCCP and hospitals, the payments issued internally in relation to the Fair Deal scheme (NHSS) and aspects of the work done by hospitals in respect of screening services.

Building on the outputs from the recent review of the accounting for internal income, a standard set of processes will be designed and embedded within IFMS to cater for this so that the appropriate service and entity level views of such transactions can be reported with appropriate removal of duplicate expenditure or income upon consolidation.

VII. Grants to s38 & s39 bodies who are operating IFMS

The IFMS will have the capacity to show at least 2 views of the s38 / s39 organisations funded by the HSE that are utilising IFMS. The "HSE Centre View" will report the funding provided by the HSE to these organisations as HSE grant expenditure within non-pay. The "Consolidated Health Service view" will report the pay and non-pay expenditure, and income, of these organisations as part of the overall expenditure and income of the consolidated health service.

Appendix 4 – Further supporting text in relation to - Work Area 1 - Governance, Capacity and Capability

It is intended that the following (at 1 and 2 below) will be in place before, during and after implementation of IFMS i.e. they will be an ongoing feature of our financial reporting infrastructure:

1 Representational decision making informed by wide consultation and engagement

The key decisions as to how financial reporting will be designed and operated will be made through the process governance model. Each process council will have responsibility for the aspects of reporting relevant to their own end to end processes. Overall co-ordination will be via the Financial Planning and Analysis process council. The output of these decisions must be validated by the Process Standardisation Unit (PSU) as fully consistent with the Financial Management Framework, including this financial reporting strategy and will be ratified by the Finance Reform Steering Committee, chaired by the Chief Financial Officer.

2 Capacity to support decision making and decision implementation

The supports to the reporting decision making body will also be similar to those outlined in relation to the process governance model. This will be coordinated by the PSU with input from the Finance Business Intelligence and Reporting team (FBI&R). Significant inputs will be required from the Cost Accounting and Funding, Acute / HPO, Corporate Planning and Performance and other teams.

3 Assessment of the level and mix of financial staff across the health service

An externally supported assessment, including of the level, mix and location of financial staff needed to support the delivery and full realisation of the benefits from the phased improvement in financial processes, financial reporting and decision support will be commissioned by the CFO and coordinated by the Corporate Development Team. This assessment will take account of, amongst other things:

- The current level, grade mix, skill sets, location and qualification mix of existing financial staff,
- The intended future state of financial management in terms of the design and delivery of financial processes, financial reporting and decision support as detailed in the financial management framework, including this reporting strategy, and other foundational documents.
- The appropriate role and development of non-financial staff

4 Developing staff capability in relation to comprehensive financial reporting

A significant programme of staff development will be designed and implemented to support both finance and non-finance staff to fully participate in the journey towards best practice financial reporting as set out in this strategy. This will be led by the Corporate Development Team and will follow on from the output of the assessment at 3 above.

Appendix 5 – Further supporting text in relation to Work Area 2 - Service Engagement to inform financial reporting improvement

The financial reporting needs of service colleagues at local, regional and national level, coupled with the development, by relevant accounting staff, of a strong understanding of the cost and costing related objects and concepts supported by SAP S4 HANA, must inform the different reporting views that are built into our financial reporting models.

Service needs from financial reporting will be defined via the reporting strategy governance model outlined in work area 1 above. Service colleagues, in addition to their finance support teams, need to be involved directly in the discussion as to how they want to see their services represented within financial reports, recognising that there will inevitably be a need for more than one view of most if not all services. This process will include supporting service colleagues, via workshops and other engagement, to answer key questions including:

I. How do you describe and conceptualise your service and those services its needs to integrate with, both today and in the future (the next 3 to 10 years). What do you see as its different components or moving parts and how do these fit together. What are its key inputs, activities and outputs (activities are those things that convert inputs into outputs e.g. the activity called "theatre operations" converts inputs (theatre staff hours and medical / surgical supplies) into outputs (completed patient operations). What are the key high level indicators of safety and quality now and likely in the future?

II. What significant changes do you see as certain, likely or possible, over the next 3 to 10 years, including in terms of how your service is designed, organised, funded, delivered or managed?

III. What are the key finance or cost related questions you would like to be able to answer, better answer or more readily answer today and in the future (the next 3 to 10 years) in order to help you improve how you plan for, design, fund and manage your services. What are the key high level and detailed outputs that you are interested in being able to understand the costs of?

IV. What do the answers to I to III above indicate to you about how you would like to see your service represented in financial reporting terms. What different "views" of your service would be helpful from a financial reporting perspective in order to improve how you plan for, pursue resource for, allocate resource for and performance manage?

It is expected that some of the "future issues" that will emerge from this dialogue with service colleagues will include:

a. The need for better costing of activities and outputs as well as improved input based reporting and the move away from the current overly "provider / accountable unit" and "input" focus to financial reporting.

b. The Individual Health Identifier (IHI) programme and the move over time to patient and service user level costing for both community and hospital service users.

c. The desire to understand the cost of keeping populations well, including at the small area level, including counties, networks, DED's, supported perhaps by the IHI and geocoding.

d. The introduction of personalised budgets into disability services

e. Getting ready for bundled payments to support population level commissioning within which activity based payment / funding for episodic care will feature

While much of the items at a. to e. above may not be, or may not be fully, within the scope of IFMS, it is worthwhile considering them at a high level in designing the underlying architecture of the system.

In advance of / in parallel with the work at I to IV above, the IFMS team and other finance colleagues, will engage in a process to develop a strong understanding of the cost and costing related objects and concepts supported by SAP S4 HANA.

This will include understanding how cost allocation and cost assignment is organised within SAP and the extent to which costing processes are best operated within SAP versus within separate but interfaced specific costing systems. It will also include examining the service areas where costing is already established e.g. hospital activity based funding and fair deal, in order to determine the extent to which existing processes can be improved, or intended developments facilitated, by utilisation of SAP S4 HANA.

The bringing together of these two important work-streams will inform, amongst other things:

I. The various views required of each service and delivery entity.

II. The reporting, cost collection and costing architecture to be designed and configured within the national build of IFMS in SAP S4 HANA. This will include the finalisation of the enterprise structure and chart of accounts.

III. The extent to which existing costing systems and processes currently in operation should remain outside of SAP or be incorporated within it.

IV. The initial high level output based reporting that can be delivered without application of significant costing methodologies in service areas where costing is as yet undeveloped. This work is within the core scope of the IFMS programme (see Appendix 8 on page 24 below).

V. The longer term detailed output based reporting to be pursued in the services. This work is outside of the core scope of the IFMS programme albeit within the scope of the Finance Reform programme (see Appendix 9).

Appendix 6 – Further supporting text in relation to Work Area 3 – IFMS Analysis, Forecasting, Planning and Budgeting via SAP Consolidation Tool(s)

Given the scale and complexity of the Irish public health system, as evidenced, inter-alia, by its wide scope and many levels, there is an urgent requirement to implement an automated consolidation tool within SAP to support integrated local, regional and national variance analysis, forecasting, planning, savings reporting and budgeting (SAP Business Planning & Consolidation or similar)

This tool(s) will be used as a vehicle to bring about and embed the necessary standardisation and improvement, including in relation to trend and variance analysis, forecasting, financial reporting commentary, planning, budgeting, savings measure proposal and reporting. The various improvements outlined in this reporting strategy can be designed and implemented on a phased basis and, incorporated into the consolidation tool as they become available, starting with basic monthly analysis and forecasting. The consolidation tool will, for example:

Enable all levels of the health system on IFMS to receive each month, and comment within the system, on exceptions regarding actual, budget or variance figures. These exceptions would be flagged automatically by IFMS in response to agreed rule sets. Analysis and commentary would be entered at any level by appropriate users which would facilitate production of their minimum local reporting requirements. All analysis and commentary would also be consolidated to meet the initial minimum requirements of the next level within the health system and so on thereby meeting the agreed monthly minimum reporting requirements without requiring this to be completed outside of the financial system. This will be how the 5 working day close **and report** will be delivered in practical terms.

Similarly the system will generate each month, and make available for analysis and commentary, automated forecasts based on agreed models and rule sets. All forecasts will be for 18-24 months ahead. The system will flag exceptions thrown up by these forecasts and enable local users at all levels to provide analysis, structured commentary and suggested adjustments to these forecasts based on local knowledge and insight. Having completed their analysis and commentary of the latest figures inside the tool, financial staff will be well placed to assess the automated base forecast each month. Through the consolidation process the forecasts, along with commentary and adjustments, for each level of the system will be aggregated thereby converting an initial top down base forecast into a bottom up consolidated forecast with the link between the two maintained for review by all levels.

The same principle will be applied to the submission and reporting on savings measures.

The consolidation tool will also be used as part of the annual planning process to set out a baseline level, top-down, ELS (existing level of service) forecast for the following year and enable this to be rapidly converted into a bottom up ELS requirement within the "10 working day of quarter end" timeline as set out above. Similarly development funding requests may be able to be captured via the consolidation tool.

The processes outlined above, if embedded as routine within the health system will be a key enabler to meeting the mandatory financial reporting timelines set out at 3.2above. This includes the monthly 5 working day close and report and the requirement to have the annual planning and budgeting process completed by the end of the 2nd week in December for the subsequent year as outlined. Achieving these in a sustainable way with the likely level of financial staffing resource that will be available will not be practical without the implementation of such a tool.

There will be an agreed set of topics to be routinely addressed within monthly and quarterly financial reports, to be reported from local to national level via the consolidation tool. These will include:

I. Input based assessment – including trend and variance analysis, price and volume etc.

II. Output based assessment – including trend and variance analysis, price and volume etc.

III. Value Assessment i.e. of economy, efficiency and effectiveness

IV. Budget utilisation assessment - in context of budgeted quantity of service and minimum quality level (Broader than budget V actual).

V. Cash and Working capital assessment

VI. Assessment of future periods - Forecasts to end of year and following year - (across I to V).

VII. Compliance and Governance Assessment

VIII. Decisions and actions that are prompted by I to VII

Improved standard operating procedure for forecasting: This will require the implementation of best practice which includes:

1. Creation of an actual model that routinely forecasts "to end year" and "to end next year".
2. Using activity and related non-financial (output) data to drive / inform the forecast(s)
3. Documented and detailed assumptions underpinning the forecast model, and any alternative scenarios within same, including price and volume of inputs and outputs
4. Routine assessment of actual against the previous forecast to understand the basis for variation and improve future forecasting.
5. A combination of top down and bottom up forecasting to arrive at as much of a consensus as practical via an obligation to evidence model assumptions, and respectful challenge
6. Adoption of a single integrated software platform / tool to support the integrated forecasting process at local, regional and national level in adherence to the core principle of "enter data once and use it many times". This is the consolidation tool referenced above (SAP BPC or similar).

Financial reporting, to be truly effective in the medium to longer term, needs to bring together, into one place / report, financial and relevant non-financial data, including data relating to:

I. The unit price and volume of all units of staff and non-staff inputs

II. The unit price and volume of all units of output along with

III. Sentinel measures and indicators of safety, efficiency, quality and ultimately outcomes, related to those outputs.

Accordingly, **budgets as maintained on IFMS** will, over time move progressively away from the current "simple" focus on total high level input costs, and move towards including all of the elements at I to III above.

The data at I to III above will also become core components of our efforts at forecasting and planning that precede the creation of budgets on IFMS and our efforts at variance and trend analysis that form part of the subsequent performance management processes, i.e. *"did we provide the expected level and quality of outputs*

for the money provided"? rather than *"did we simply breakeven when we compare the money spend to the money provided"?.*

Appendix 7 – Further supporting text in relation to Work Area 4 – Enhanced Input based reporting – enables assessment of economy

There is a mandatory goal of 100% of all non-pay expenditure to be underpinned by unique material or service codes, including, for example, pharmacy and grant expenditure. This is a pre-requisite to enable the required best practice of being able to readily analyse any movement (over time), or variance (against budget), in non-pay expenditure as between changes in the volume of units purchased versus changes in the price per unit. This will make assessment of the economy or otherwise of non-pay expenditure readily available within financial reports, thereby facilitating the recommendation of economy related decisions and actions, where the assessment indicates that is appropriate.

There is a similar mandatory goal within pay and staffing i.e. a formal requirement to be able to readily track and report on the individual units of labour **hours** and the specific price per unit of labour hours within any given amount of actual or planned (budgeted) pay expenditure. This mandatory goal must include agency hours and costs and will enable assessment of the extent to which any pay expenditure movement (over time), or variance (against budget), is due to changes in the volume, grade mix or unit price of the labour hours used within any service.

Pay Bill Management is an essential feature of overall financial management and reporting, and will be supported by:

- Intelligent Pay budgeting and funds tracking
- Consistent Pay activity information
- Standardised Payroll Processes
- Employee level costing

The pay bill management section of the overall financial management framework sets out further detail in this regard, including the following components and key design principles:

i. Master data between IFMS and NISRP must be fully integrated

ii. The requirement for simplicity and standardisation in terms of pay related data and processes

iii. Consistency of approach and process

iv. Controlling and reporting of master data, grade drift and position based funding

v. Completeness of coverage i.e. all statutory services, all s.38s plus appropriate s.39s

There is a similar mandatory requirement in relation to income in terms of being able to track unit price movement versus volume movements across the various income headings.

Appendix 8 – Further supporting text in relation to Work Area 5 - Enhanced High Level Output based reporting => enables assessment of efficiency and effectiveness.

High Level Output based reporting, by maximising the potential of financial reporting – There will be a phased expansion of routine financial reporting to include output based reporting (treatments, visits, residential places) in addition to the intended improvement in input (pay, non-pay) based reporting flagged above. Financial reporting in relation to outputs exists on a spectrum. At one end of this spectrum, high level output based reporting can be achieved with no or minimal application of costing methodologies (cost assignment, cost allocation etc.). At the other end of this spectrum detailed output based reporting requires the application of specific costing methodologies.

Example 1: Through careful use of cost centres, unique material codes, service codes and other basic cost collection objects it is practical to construct financial reports on the direct costs of providing different types of residential accommodation for people with disabilities. Let's assume, for this example, that service colleagues advise that there are up to 6 different types or "bands" of residential accommodation, each with different service user, staffing and overall cost profiles at a "whole house / unit of accommodation" level. These different types of accommodation would represent **high level outputs** that could be reported on i.e. the number of accommodation units and the total number of places provided within them, at whatever cost, over a period.

This "lining up" of "buckets of costs" against "high level outputs", to deliver high level output based reporting will be adopted as a stepping stone to more detailed output based reporting, and is a core part of IFMS, including in the preparatory stages, pre deployment.

This would not provide us with a cost per individual client, which would involve application of costing methodologies and is beyond the scope of what is referred to here as high level output based reporting, and therefore beyond the scope of IFMS.

Example 2: Take any given "community based team" e.g. Adult Mental Health teams. Let us assume the engagement with services gives rise to a detailed enterprise structure that has a cost centre per community team including one for each adult mental health community team. Once sufficient data clean-up is done, pre-deployment, to ensure all relevant staff and non-pay costs are routinely charged to the correct adult mental team cost centre, we will know the actual cost of each team for any given period. That "bucket of cost" can then be lined up against the current "bucket of data" collected in respect of each team i.e. XA referrals received per month, XB referrals accepted, XC assessment carried out, XD service users in active caseload and XE service users discharged from the team. This will tell us the total cost of that total range of activity for the team in question and how that compares to other teams. It won't tell us the cost of each individual element of activity as that would require a separate costing project and determination of the relative utilisation of team resource of each individual element of activity.

To the greatest extent practical, once the detail of the enterprise structure including cost centre detail is known, the strong preference will be to make as much of this preparatory change within legacy systems. This is in order to secure the benefits of same earlier and also lower the change impact associated with deployment of IFMS. This is consistent with the overall approach set out within the financial management framework, including at section 1.4 Realistic Ambition on page 5.

Appendix 9 – Further supporting text in relation to Work Area 6 - Enhanced detailed output based reporting (requires costing - not core IFMS work– parallel to IFMS and core to Finance Reform)

The "lining up" referred to in Appendix 7 above, which represents a significant improvement on where we are today in many services, can be provided with no or minimum application of costing methodologies. However, it does not provide us with any insight into the detailed cost for different **categories** of service users or for **individual** service users.

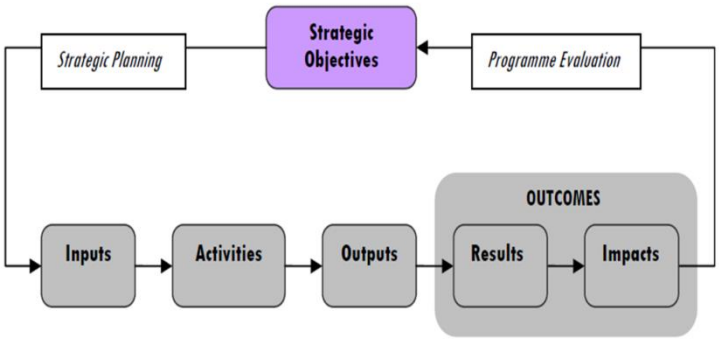
The work to implement detailed output based reporting will build on the work already underway in relation to hospital activity based funding and the strategic framework for community costing.

Example: Returning to the example above, let's assume, that service colleagues advise that, based on the adoption of a standard assessment tool, there are 10-12 different categories of service user in terms of the complexity of their accommodation needs and the resource intensity of same. The 10-12 categories of service user can be accommodated in sub-sets of the 6 different types of residential accommodation. We will need to adopt appropriate costing methodologies to assign the costs of running the individual units of accommodation in some relative proportion to the different categories of service user staying in each unit. This would allow us to arrive at an average accommodation cost for each of the 10-12 **categories** of service user. If we have access to more specific and detailed costing information we can arrive at **individual** service user costs (the hospital equivalent of patient level costing).

Appendix 10 – Diagnosis – DPER VFM Guide and link to Institute of Medicine 6 Aims for Improvement and IHI Triple Aim

All of this is systematically and visually represented by a Programme Logic Model and map which is shown below:

Figure 1: Programme Logic Model



Within the evaluation of economy and efficiency, the DPER guide makes clear that the relevant criteria include throughput, timeliness, quality and cost of outputs as well as securing the best price for inputs and minimising the ratio of inputs to outputs.

Some definitions are useful in this context:

I. Effectiveness = Whether the outputs deliver the required objectives in both the short term i.e. safety & quality indicators, and the medium to long term i.e. outcome measures

II. Efficiency – Whether the lowest practical ratio of inputs to outputs has been achieved without compromising the quality of outputs / outcomes?

III. Economy - Whether the lowest practical price per unit of each input has been achieved without compromising quality of outputs / outcomes? (economy is a subset of efficiency)

IV. Overall Value (comprised of I, II and III above)

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

- safe care (do no harm)
- effective care (evidence based care and only if likely to benefit patient)
- Efficient care (avoids waste, including of time)
- timely care (reduces waits and harmful delays)
- patient centred care (takes account of patient preferences and values)

Equitable care (quality constant regardless of socioeconomic status, geography, gender etc.). These six aims for improvement are in effect descriptors, in the view of the IOM, as to what would be the characteristics of a high quality healthcare system and they can be readily mapped to what DPER describes as Value (economy, efficiency and effectiveness).

Both the IOM report and the DPER guide can also be readily mapped to the "Triple Aim" as first promulgated by the Institute of Healthcare Improvement (IHI including Don Berwck) in 2007, which has become a globally adopted set of strategic organising principles for health systems across the Western world. It too can be seen to define value in terms of quality with quality being represented by:

Aim 1: **Care:** Improving the individual experience of care

Aim 2: **Health**: Improving the health of populations

Aim 3: **Cost**: Reducing the per capita cost of care for populations.

Appendix 11 – Examples of Master Data within IFMS and NiSRP – illustrative only and not a priority list

Inputs – describing types of cost

- General Ledger A/C Codes – Finance
- Cost Elements – Finance
- Commitment Items – Finance
- Material Codes – Procurement
- Pay Scale - HR
- Job - HR
- Position - HR

Inputs – describing the organisation

- Controlling areas – Finance
- Business areas – Finance
- Cost Centres and Cost Centre Groups – Finance
- Profit Centres and Profit Centre Groups – Finance
- Plant - Procurement
- Purchasing Group – Procurement
- Personnel Area – HR
- Personnel Sub-area – HR
- Cost Centre – HR
- Employee Group - HR
- Employee Sub-Group - HR
- Payroll Area – HR
- Organisational Unit – HR

Outputs – describing what the inputs produce

- Internal Orders – Finance
- Project / Programme – Finance
- WBS / Work Order – Finance
- DRG – HIPE / ABF
- Bed Days – PAS
- Discharges – PAS

Appendix 12 – Finance Reform Board Members

Paul Reid, HSE Chief Executive Officer, HSE
Jim Breslin, Secretary General, DoH
Greg Dempsey, Deputy Secretary, DoH
Stephen Mulvany, Chief Financial Officer, HSE
Liam Woods, National Director of Acute Operations, HSE
Fran Thompson, Chief Information Officer (Acting), HSE
Paul Bolger, Director, Scheduled & Unscheduled Care Performance Unit, DoH
Ronnie Downes, Assistant Secretary, DPER

Appendix 13 – HSE ICT Business Case Benefits

Appendix 10 contains the benefits approved in the Finance Reform HSE ICT Business Case Executive Summary. In April 2015, the Finance Reform Board approved the Finance Reform ICT Project Business Case for submission to the Office of the Government Chief Information Office (OGCIO). The OGCIO approved the Business Case in October 2015 to progress the implementation of a new Finance Operating Model for the entire Health Sector.

ICT Business Case - Business Outcomes and Benefits

1. Integration of processes to allow for clear line of sight across the system and efficient consolidation.
2. Standardisation and improvement of processes.
3. Develop reporting processes and mechanisms that support decision making, service delivery and statutory requirements.
4. Increased granularity and consistency of information.
5. Capability to support decision making and resource planning.
6. Improved access to best practice services.

ICT Business Case - Organisational Benefits

7. Joined up governance, accountability and responsibility.
8. Clear definition of roles, responsibilities and capabilities.

ICT Business Case - Records and Data Management Benefits

9. Period end close will be automatic and timely.
10. Month end reports will be circulated to budget holders very soon after period close.
11. Finance, HR and Procurement will all be integrated.
12. Statutory and voluntary providers will operate on the one system which will make consolidation easier.
13. Financial management practices will improve significantly due to embedded system rules and controls and the line on sight provided by the single integrated system.
14. Patient level costing will support service line reporting and operational budgetary control.
15. Data ownership will be clearly defined and data is respected as a corporate asset.
16. A common CoA will be in place.

17.A data dictionary will be created so that definitions are consistent.
18.Coding structures developed for core feeder systems will be aligned and integrated.
19.Standard reports for management accounting purposes will be prescribed.

ICT Business Case - Operational Benefits

20.Productivity and efficiency gains in transaction processes.
21.ERP support productivity and efficiency gains from move to managed service.
22.General efficiency gains outside of Income and Accounts Payable process efficiencies in Finance and also ICT.

ICT Business Case - Internal Impacts to HSE

23.Defined ownership of the system and accountability assigned accordingly.

ICT Business Case - External Impacts to HSE

24.Support the five key objectives of the Public Service ICT Strategy.
25.Component of the HSE ICT agenda that is aligned to pan government ICT reform.

Appendix 14 – Version Control Table

Date	Member	Description	Version
11/01/2018	Michael Morrow	Feedback and comments	V1.3
12/01/2018	Eilish Hardiman	Feedback and comments	V1.3
15/01/2018	Tadgh Costello	Feedback and comments	V1.3
15/01/2018	Raymonde O' Sullivan	Feedback and comments	V1.3
16/01/2018	Michelle Brennan	Feedback and comments	V1.3
17/01/2018	Simon Moores	Feedback and comments	V1.3
17/01/2018	Jim O' Sullivan	Overall comment	V1.3
18/01/2018	Brian Long	Feedback and comments	V1.3
18/01/2018	Rosarii Mannion	Feedback and comments	V1.3
18/01/2018	Miriam Keegan	Feedback and comments	V1.3
18/01/2018	Tom Laffan	Feedback and comments	V1.3
18/01/2018	Paul Quinn	Feedback and comments	V1.3
18/01/2018	Donal Foran	Feedback and comments	V1.3
18/01/2018	Damien McCallion	Feedback and comments	V1.3
19/01/2018	Damian Casey	Feedback and comments	V1.4
26/01/2018	John Cregan	Feedback and comments	V1.51
26/01/2018	Simon Moores	Feedback and comments	V1.52
30/01/2018	CFO	Updated document	V1.53
05/02/2018	Brian Long	Feedback and comments	V1.6
05/02/2018	Chris Kenny	Feedback and comments	V1.6
05/02/2018	Jim O'Sullivan	Feedback and comments	V1.6
05/02/2018	HG CFOs (Declan Lyons)	Additional time required to compile feedback. Anthony Baynes, Chris Kenny, John Cowhey, Joseph Campbell, Noelle Dineen, Valerie Plant	V1.6
05/02/2018	David Walsh	Feedback and comments	V1.6

Date	Member	Description	Version
06/02/2018	CHO HOF (Michael Morrow)	Combined feedback from Paraic Casey, Liam Fogarty, Anthony Floyd, Julie Hallahan, Edward Meaney, Grainne Hannon, Anne Kennedy, and Michael O'Keefe.	V1.6
06/02/2018	Paul Quinn	Feedback and comments	V1.6
07/02/2018	Pat Leavy	Feedback and comments	V1.6
09/02/2018	Kevin Conlon	Feedback and comments	V1.6
09/02/2018	Damian Casey and Sean Redmond	Feedback and comments	V1.6
16/02/2018	HG CFOs	Feedback and comments	V1.61
16/02/2018	PA Consulting	Feedback and comments	V1.61
25/02/2018	CFO	Addition of Section 4	V1.7
27/02/2018	CFO	Addition of Introduction	V1.71
28/02/2018	Orla Dooley	Feedback and comments	V1.71
28/02/2018	Kevin McConville	Feedback and comments	V1.71
01/03/2018	Greg Dempsey	Feedback and comments	V1.71
05/03/2018	CFO	Addition of Section 3.8 and Process 6	V1.72
14/03/2018	FRP PMO	Amalgamation of comments received from iteration 1 and 2	V1.73
15/03/2018	CFO	Final updates to document for circulation	V1.74
12/04/2018	CFO	Addition of Workshop comments to document	V1.75
23/04/2018	James Furlong	Addition of info graphics to document and text amendments	V1.75
23/04/2018	Michael Morrow	Addition of text to section 1.4	V1.75
25/04/2018	James Furlong	Addition text amendments	V1.75
02/05/2018	CFO	Additional text for next iteration of document	V1.76
12/06/2019	Colum Maddox	Additions of chapters 12, 14 and 15	V1.77
12/06/2019	Tom Laffan	Addition of Chapter 6.2	V1.77
12/06/2019	Kevin McConville	Addition of Chapter 6.4	V1.77

Date	Member	Description	Version
12/06/2019	CFO	Addition of Chapter 5	V1.77
06/01/2020	PSU	Changes to Chapter 6.1.6 from Change Team	V1.78
06/01/2020	PSU	Changes to Chapter 6.3.4 from CoE, HPSA	V1.78
06/01/2020	PSU	Changes to Chapter 6.4 from CoE, HPSA	V1.78
06/01/2020	FRP PMO	Updates to Steering Committee and Finance Reform Board membership	V1.78