Acute Hospitals Division

Operational Plan 2014

Contents

Introduction

The implementation of the Government's decision to re-organise the acute hospitals system will be guided by the Department of Health's *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015*. The Health Service strategic reform programme aims to move from the current hospital centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity which is safe, timely, efficient, and as close to home as possible. The opportunities for development of the acute hospital system will focus not only on the development of acute hospital services but also on maximising staff potential within the hospital sector.

Acute hospitals will be required in 2014 to meet the full value of cost containment plans amounting to €56.5m which were put in place in 2013 in order to address the incoming deficit issues. A 2014 *Haddington Road Agreement* target of €60m and a reconfiguration target of €7.5m have also been applied. However, provision for an additional €50m for acute hospitals has been made in 2014, to meet the full year costs of the demand for services which emerged in 2013.

Acute Hospitals Division

The remit of the newly established Acute Hospitals Division covers both acute hospitals and palliative care. Leading, supporting and embedding the transformation of the current hospitals system into Trusts represents one of its main responsibilities. By way of transition, and going hand in hand with continuous improvement in quality and patient safety, a key priority for 2014 will be the establishment of Hospital Groups on a sustainable footing. The development of the National Paediatric Hospital will also be a key focus in 2014 and beyond.

The Division will use the *National Standards for Safer Better Healthcare* in conjunction with key reports, such as the HSE-commissioned and HIQA reports on Improvements in Maternity Services, as catalysts for change.

As we move to a commissioning environment, clinical governance and operational management of all secondary and more complex mental health services need to come within the remit of the mental health division. For most mental health services on acute hospital sites, this is already the case. Where it is not, the mental health and acute hospital divisions will continue to work collaboratively with relevant hospital groups to plan for and implement any necessary changes. It is expected that there will be agreed local joint governance arrangements around clinical interfaces, shared facilities, shared services and other practical interfaces.

The Acute Hospitals Division, working with the other Divisions, with key internal partners (including Clinical Strategy and Programmes, Quality and Patient Safety, and the National Cancer Control Programme) and with external stakeholders, will continue in 2014 to work toward an integrated and "joined up" approach to the complex challenges facing the system, in areas such as the introduction of generic models of care, the improvement of waiting times for hospital services and optimum standards of infection control and hygiene.

Clinical Strategy and Programmes

The National Clinical Programmes are a joint initiative between the HSE, the Forum of Irish Postgraduate Medical Training Bodies and the professional representative bodies of Nurses and Health and Social Care Professionals.

Clinical Strategy and Programmes (CSP) play a vital role in improving and standardising patient care throughout the organisation by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of the health services. This will be achieved *inter alia* by designing standardised models of care, guidelines, pathways and associated strategies for the delivery of integrated clinical care in acute hospitals and in the community. Additional CSP actions for 2014 will be found particularly in the Primary Care Operational Plan.

National Cancer Control Programme

Since its establishment in 2007, the National Cancer Control Programme (NCCP) has been steadily implementing cancer policy as outlined in *A Strategy for Cancer Control in Ireland 2006* using a programmatic approach to the management of hospital and community based cancer services across geographical locations and traditional institutional boundaries. Accountability for service delivery and expenditure will continue to rest with the designated cancer centres and the NCCP will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally.

Palliative Care

Responsibility for palliative care services lies with the National Director for Acute Services. Palliative Care is an approach that improves the quality of life of patients - children and adults - who are facing the challenges associated with life-limiting illness, and of their families. A considerable proportion of specialist palliative care services is provided by the voluntary sector and in 2014 the HSE will continue to improve the quality of its Service Level Arrangements with these providers.

Reforming our Services

Establishment of Hospital Groups

Further to the publication in May 2013 of the report *"The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts"*, all hospitals will participate in, and co-operate with, all relevant projects, initiatives and developments required to progress the implementation of the report's recommendations, including the establishment of the new Hospital Groups and the associated governance and management arrangements.

The HSE will proceed with the recruitment of hospital group CEOs as a first and significant step toward the formal development of hospital groups. Chairpersons and associated Board members will also form part of the initial setup and development phase.

Each Hospital Group will be required to develop a Strategic Plan for its future services by the end of the first year of operation, taking account the requirement to meet the National Standards for Safer Better Healthcare. This

plan will demonstrate:

- the formation of a single coherent Hospital Group structure and organisation
- reorganisation of services within the Group to ensure optimal care provisions to the population served
- provision of safe effective, efficient and relevant patient services within budget
- maximum integration and synergy within the Group and with other Hospital Groups and all other Health Services, particularly primary and community care services

The Acute Division will target a saving of €7.5m for reconfiguration and reorganisation plans for 2014.

Specific performance targets have been set based on the new hospital groups and these are outlined in Appendix 1. This includes both expected levels of activity for the defined hospital groups as well as the performance targets that hospital groups must achieve over 2014.

Further implementation of Clinical Programmes

The HSE will continue its ongoing implementation of the National Clinical Programmes with a number of programmes moving toward full implementation in 2014. Since their foundation in 2010, the National Clinical Programmes have been one of the most significant positive developments in the Irish Health Service. Their success is due to the close collaboration between the HSE and the forum of post graduate training bodies working in partnership with patients, nursing and allied health leads. The clinical programmes have changed and continue to change how care is delivered using evidence based approaches to system reform. Clinical leadership is central to ensuring that reform is a success.

The Programmes have proven to be an extremely valuable change model. Their governance and configuration adapts to:

- The priorities of the 'Future Health'
- The formation of the new HSE Directorate and the merging five care group Divisions responsible for operational management
- The implementation challenges emerging from existing clinical programmes and clarity of ownership of the Implementation Phase
- The growth in the range of individual programmes and the capacity of the system to resource both the design and implementation phases

Implementation of Money Follows the Patient

From the 1st January 2014 Phase I of the Money Follows the Patient (MFTP) approach to hospital funding will be implemented in the country's 38 hospitals participating in the casemix system. The programme will be implemented over a number of years. A shadow funding exercise was undertaken for a number of selected hospitals (one from each Hospital Group) to compare actual 2013 activity against target activity and to assess variance. A communication and engagement process with hospitals was undertaken in December 2013, with a key input being learning from the shadow funding exercise.

The key goal of MFTP Phase 1 is the phased introduction in 2014 of MFTP within hospitals currently part of the casemix system. A Steering Group has been established and is overseeing the implementation plan, key elements of which are:

- Action plan to ensure delivery of MFTP Phase 1 at hospital level
- Design of rule set, approach to funding and activity targets for MFTP 2014
- Developing the strategy and plan for MFTP Phase 2 for the period 2015-2016

A Healthcare Pricing Office has been established on an administrative basis and will have responsibility for the pricing / tariff function.

Review of Maternity Services

The HSE will be working closely with the Department of Health on a Review of Maternity Services and development of a new National Maternity Strategy. The HSE will be implementing, with all hospitals, the recommendations from a number of key reports on Maternity Services. The HSE will publish progress on these reports during 2014.

Cancer Services

Accountability for service delivery and expenditure will continue to rest with the Designated Cancer Centres and the NCCP will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally. Progressive implementation of commissioning models and performance contracts is planned for 2014.

Healthy Ireland – A Framework for Improved Health and Wellbeing

During 2013 the government published a major policy, *Healthy Ireland, a Framework for Improved Health and Wellbeing 2013-2015*. *Healthy Ireland* sets out a whole of government and cross sectoral approach to addressing the challenges of an ageing population, together with the demands being placed on health services resulting from the growth in the incidence of chronic illness. The Division will work with the Health and Wellbeing Division to develop a 3 year health service implementation plan for *Healthy Ireland*.

Key Priorities

Acute Hospitals

Key Priorities with Actions to Deliver in 2014

- Ensure **patient safety and quality** in acute hospitals.
  - Using the *National Standards for Safer Better Healthcare*, ensure hospitals undertake related self-assessments as a necessary measure for continuous quality improvement.
  - Ensure the National Early Warning Score (NEWS) system is fully implemented across all acute hospitals.
  - Continue initiatives enabling optimum standards of infection control and hygiene (Healthcare Associated Infections).
  - Progress quality indicators in relation to Medication Management and Safe Surgery practices.
  - Develop organ donation and transplantation services and address additional need in the Donor and Transplantation Programme. **(€2.92m and 19 WTEs)**
- Ensure **access** to services.
  - Ensure access to services in relation to waiting time targets for emergency or unscheduled care, and scheduled care in public hospitals, including outpatient and diagnostic services.
  - Progress Outpatient (OPD) Quality Improvement Programme, particularly in relation to necessary data integrity and operational control.
  - Target additional capacity and capability in areas which continue to experience increased service demand, particularly in the areas of access across ED, inpatient day care and OPD services. **(€30m)**
  - Special Delivery Unit will continue supporting and enabling performance improvement particularly in relation to unscheduled care access.
  - Provide a service to undertake bilateral cochlear implants (sequential and simultaneous implants). **(€3.22m and 14.5 WTEs)**
  - Address children's needs in respect of narcolepsy. **(€0.57m)**
- Implement a model of integrated care through **strategic reform**.
  - Full implementation of seven Hospital Group constructs:
    - Dublin North East
    - Dublin Midlands
    - Dublin East
    - South / South West
    - West / North West (already established)
    - University Limerick Hospitals (already established)
    - Children's Hospital Group (already established)
  - Direct development of necessary Group service reconfiguration and integration plan.
  - Continue to implement the Small Hospitals Framework.

- Progress development of new children's hospital with particular focus on necessary integration of paediatric services.
- Target necessary patient centred improvements in maternity care, using the Health Service and Galway HIQA reports. **(€1.48m and 6.5 WTEs)**

- Utilise best models of **financial allocation** and **human resource planning**.
  - Continue implementation of all elements of the *Haddington Road Agreement* to ensure maximum value for money and cost reduction opportunities.
  - Develop and implement a sustainable approach to NCHD recruitment and progress toward compliance with the European Working Time Directive (EWTD). **(€3.1m)**
  - Begin the phased implementation of a 'money follows the patient' approach to funding acute hospitals as part of the preparatory step for Universal Health Insurance (UHI) implementation.

National Clinical Strategy and Programmes

- Further implement **national clinical models of care** to improve quality, optimise patient flow, integrate chronic disease prevention and management and address demographic pressures.
  - Acute Medicine Programme
    - Support Acute Medical Assessment Unit (AMAU) functions towards 24 / 7 in model 4 hospitals.
    - Implement the National Early Warning Score (NEWS) and associated COMPASS training programme.
    - With the national surgery and older people's programmes, agree patient flow and hospital capacity models to facilitate sustainability of clinical access standards and care quality.
  - Older People
    - Develop a necessary national model of care document that complements the acute model of care in relation to the management of the frail elderly pathway in primary care.
  - Obstetrics
    - Develop necessary National Model of Obstetric Care delivery
  - Surgery
    - Roll out access to NQAIS (National Quality Assurance Intelligence System) to all acute hospitals.
    - Provide support and guidelines for management of day cases, minor operations and OPD procedures.
  - Chronic Diseases
    - Develop a chronic disease framework.
    - Progress cross border paediatric congenital cardiac surgery and cardiology services.

Laboratory Services

- establishment of a national governance Structure for Clinical Microbiological Reference Laboratory services
- establishment of an Implementation Group to ensure progression of recommendations of the Microbiological Reference Laboratory Group

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Palliative Care Service

Palliative care is an approach that improves the quality of life of patients, and their families, facing the challenges associated with life-limiting illness.

The Health Service will continue to work towards the implementation of the recommendations contained in national policy / strategic documents. In 2014 we will remain engaged with the voluntary sector to address the gaps identified in home care and specialist inpatient services.

The vision for the future is that palliative care will be a gradual and natural increasing component of care from diagnosis to death. We will ensure that patients with a life-limiting condition, and their families, can easily access a level of high quality palliative care service that is appropriate to their needs, regardless of age, care setting, or diagnosis.

Key Priorities with Actions to Deliver in 2014

- Ensure service provision for **adult palliative care** by addressing service gaps.
  - Ensure improved capacity and capability for Dublin North East in relation to palliative care ambulatory and inpatient services, specifically staged opening and usage of St. Francis Hospice, Blanchardstown (24 beds). **(€1m)**
- Develop the **quality, efficiency and effectiveness** of generalist and specialist palliative care services through process and quality improvements.
- Develop and integrate **community based paediatric palliative** care services.

National Cancer Control Programme (NCCP)

Since its establishment in 2007, the NCCP has been steadily implementing cancer policy as outlined in *A Strategy for Cancer Control in Ireland, 2006* using a programmatic approach to the management of hospital and community based cancer services across geographical locations and traditional institutional boundaries.

Finance	2014 Budget €m
	11.0
Excludes €3.8m for National Medical and Haemato-Oncology Programmes, which is included in the Acute budget for 2014	

Key Priorities with Actions to Deliver in 2014

- Implement the **National Medical and Haemato-Oncology Programmes**. **(€3.8m)**
  - Implement the national medical oncology and haemato-oncology programme comprising multidisciplinary human resources, evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery, technology review processes for oncology drugs, and related molecular tests and the introduction of a nationally funded oncology drug budget. Develop and support a national plan for treatment-related molecular testing.
- Develop a **National Cancer Drug Management Programme** including predictive molecular oncology tests.
- Strategic review of **new developments and technologies** relating to cancer, including policy with regard to European wide specialisation and how best to make full use of centralisation in the interests of resource utilisation and service quality.
- Support the **Hereditary Cancer** Programme.
  - Support access to identification of genetic risk and surveillance in well population at risk. Agree appropriate referral pathways from primary care for patients considered at increased hereditary risk of breast, bowel or ovarian cancer. Develop GP referral guidelines to support these pathways, consulting with the ICGP, and disseminate to all GPs in the country, make available online, incorporate into e-learning modules.
- Further support the **Eight Designated Cancer Centres** and Letterkenny Satellite within current resources.
  - Centralise oncology surgical services in line with national policy to maintain continued improvements in diagnosis, surgery and multi-disciplinary care. Support existing national networks for site specific cancers and develop networks for gynaecological and neuro-endocrine tumours and for sarcomas.
  - Support capacity / capability requirements in relation to Dublin Midlands Gynaecological Services.

- Address **Quality and Safety Standards** and **Deliver Quality Care in the Community**.
  - Progress the work of national expert Tumour Groups comprising expert leads in relevant clinical disciplines to develop and promulgate national clinical practice guidelines. Collaborate with all stakeholders to ensure public, patient, and professional policies, safety, and standards are nationally developed and maintained across the scope of cancer services.
  - Develop professional staff knowledge, through education, research and collaboration with relevant colleges and educational bodies. Develop primary care skills in prevention, diagnosis, care, and follow up to facilitate safe, high quality care in the community. Progress the development of GP referral guidelines and pathways to facilitate early diagnosis of cancer. Participate in national groups to address chronic disease and health promotion initiatives. Develop a comprehensive **survivorship** programme to address communication issues and information needs of both cancer survivors and healthcare professionals.

Summary of Service Quantum

Acute Hospitals

There are 48 hospitals in the Irish public hospital system with a bed complement of 13576 (11513 of which are inpatient and 2063 of which are day care designated)

In terms of clinical activities

- there are over 1.1 million attendances at 33 adult Emergency Departments each year
- over 1.4 million people receive either inpatient or day care treatments each year
- there are over 2.5 million attendances at hospital outpatients departments each year
- across the 19 maternity units, there are nearly 70,000 births each year

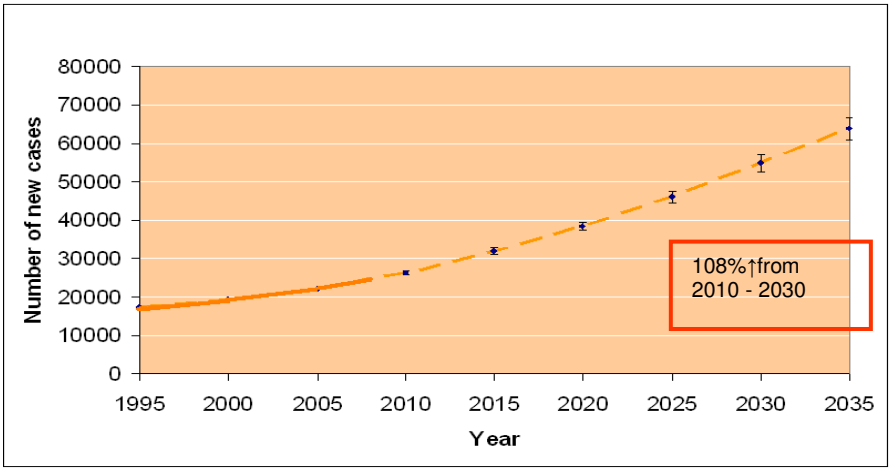
Palliative Care

During 2014, it is anticipated that we will provide, as a minimum:

- 156 palliative care inpatient beds
- community / home care specialist palliative care teams in every county
- specialist palliative care day care services in 9 locations
- specialist palliative care services in 34 acute hospitals
- palliative care support beds in 70 locations.
- a service to approximately 94% of people within seven days of their referral to specialist in-patient services and 82% within seven days of their referral to specialist home care

NCCP

The National Cancer Registry of Ireland (NCRI) predicts that a total of 22,360 people will be treated for cancer in 2014. On average 80% of these people will be treated in the public system.



Service Area	2014 Act Activtyivity	Service Area	2014 Activity
Number of Attendances Breast RACs Urgent	13,900	Radiotherapy Patients Treated	9,400
Number of Non Urgent Attendances Breast RACs	25,200	Radiotherapy treatments delivered	142,500
Number of new Attendances at Prostate RACs	2,970	Training for nurses (primary, secondary and community care -including disability services) in Cancer care education	1,000
Number of new Attendances at Lung RACs	2,700	People at high risk of hereditary cancer tested (in partnership with NCMG) for genetic mutation.	800
		Active treatment of patients with cancer drugs (both oral drugs delivered in the community and delivered by injection in hospital settings)	33,000 Over 90,000 day case chemotherapy treatments will be delivered.

Quality and Patient Safety

Acute Hospitals

The Acute Hospitals Division recognises its role in maintaining the quality and safety of the services it provides to the forefront of service delivery and in promoting continuous quality improvement. It will continue to develop a culture of accountability, quality and patient safety that translates into a positive patient experience and clinical services that are evidence based, within the resources available.

There has been considerable work with definite progress in improving the quality and safety of health services. The Division continues this improvement by working with Clinical Strategy and Programmes, with Quality and Patient Safety and with the Regulator on the quality initiatives detailed in this plan.

With the support and expertise of Quality and Patient Safety, the Acute Hospitals Division will prioritise in 2014 the initial round of self-assessment by hospitals against the new National Standards, followed by the implementation of Quality Improvement Plans. The strengthening of clinical governance structures and processes at Group level will be supported and front line staff will continue to be engaged in service improvement.

The Division will ensure that the National Early Warning Score system is implemented within hospitals, in accordance with the *HSE Guiding Framework and Policy for the National Early Warning Score System to Recognise and Respond to Clinical Deterioration*.

Hospitals will retain a focus on Health Care Acquired Infections (HCAI) initiatives to ensure that optimum standards of infection control and hygiene are in place and maintained.

The Acute Hospitals Division will promote use of the Safe Surgery and Open Disclosure policies. The development of Organ Donation and Transplantation services will continue to be progressed. The HSE will continue to develop and report on new quality indicators and mortality measurement will be advanced.

St. Luke's Radiation Oncology Network (SLRON) has established a Network wide integrated governance structure which includes Clinical Governance and Audit, Clinical Risk Management, Quality Assurance Radiation Therapy and Radiation Protection. There is regular review and audit of policies, procedures and guidelines with monthly monitoring of incidents.

Using the support and expertise of Quality and Patient Safety, hospitals will promote systems and structures for engagement with patients in Hospital Groups, measuring patient experience in a real time fashion, disseminating learning and improving the patient experience.

Palliative Care

The Acute Hospitals Division, Palliative Care Clinical Programme and Quality and Patient Safety will continue to strengthen the quality, safety, effectiveness and governance of palliative care services in 2014. A number of key priorities will drive improvements through the implementation of evidence based sector wide initiatives including:

- The dissemination of a model of care, guidelines, pathways and protocols
- The Competence Framework, which will provide management and staff with baseline competences for disciplines across all settings
- The development of national policy on advanced care planning
- Engagement with the IHF in initiatives such as the Hospice Friendly Hospital, Design and Dignity, End of Life Audit Tool and the recommendations from reports including *Palliative Care for All* report and *Palliative Care for Children with Life-limiting Conditions*
- Dissemination of *Towards Excellence in Palliative Care – Self Assessment Tool*, which will help services complete an initial round of self-assessment against the new National Standards, followed by the implementation of Quality Improvement Plans.

NCCP

Quality and patient safety are key components in the delivery of an integrated cancer control programme. The NCCP has established a number of quality and safety initiatives to improve the delivery of cancer care which will continue during 2014.

- Since 2010 the NCCP has delivered annual Audit Quality & Risk (AQR) forums for breast cancer. This was further extended in 2013 and breast, prostate, lung and pancreas AQR forums will be held in 2014.
- Tumour groups: Five national expert tumour groups (breast, lung, prostate, gastrointestinal and gynaecological cancers) have been established to drive and guide the development of national evidence based clinical practice

guidelines. The work of the groups has been developing well with some groups already approaching completion of recommendations for national adoption. This work will continue for the next number of years.

- Audit and annual reports: National specialist cancer services including pancreatic, upper gastro-intestinal and neuro-oncology services are required to produce annual reports outlining performance and activity within the services.
- The NCCP has also introduced a national oncology drug management system which is directly linked to the development of nationally agreed drug protocols.
- A national oncology drug safety review of all 26 hospitals which administer chemotherapy was completed in 2013. The next step will be progressed in 2014 with the development of national policies for safe administration of chemotherapy agents.
- National treatment protocols have been developed for all new cancer drugs introduced since 2012 and national protocols are in development for existing oncology drugs

Improving Performance Management

The Acute Hospitals Division will continue to use the CompStat process as a key performance management tool in 2014. We will seek to develop the CompStat process by introducing further measures related to increased performance. Such additional measures will be in the area of EWTD compliance and OPAT uptake rates.

Performance management structures will also be developed by an approach based on audit and inspection.

Performance management at national level has a dual purpose of providing assurance to the Director General and Minister and as an escalation process for addressing underperformance. The National Director for Acute Hospitals will participate in the National Planning, Performance and Assurance Group established by the Director General. One new feature of the HSE's performance management approach will be the ability of the National Director and/or the COO/ Deputy DG to formally initiate interventions in underperforming services.

The performance management process will be managed at Hospital Group, regional and national levels. Performance management will be a day to day activity between the Hospital Group CEOs/ primary and community services area Managers and the Regional Directors for Performance and Integration.

At its monthly meeting, the Directorate, as the governing body for the HSE, will consider the final draft of the Monthly National Performance and Assurance Report. Once approved, the appropriate reports will be formally submitted to the Secretary General, Department for Health.

In Clinical Strategy and Programmes, improvements in patient care are designed through the clinical programmes. The implementation of these improvements takes place in the services. Clinical Strategy and Programmes will engage in an evaluation cycle, reviewing the impact of its strategies (e.g. through data analysis on key indicators of performance), modifying products or processes as appropriate and sharing learning and good practices across the services, to improve patient care.

The NCCP monitors a number of Key Performance Indicators (KPIs) relating to cancer activity and access each month. A number of these are published in the HSE Quarterly Performance Assurance Reports and all KPIs are reviewed monthly at the NCCP Executive. Remedial action to address any performance issues is undertaken in conjunction with the relevant designated cancer centre.

In addition, during 2014, the NCCP will develop and introduce a new performance indicator for wait times for elective cancer surgeries from all hospitals to indicate performance in relationship to accessing surgical services. Full reporting of this indicator is expected in 2015.

Performance Scorecards

Acute Hospital

Performance Indicator	Expected Activity / Target 2014
Macro-environment **Activity** Expected no. of inpatient discharges*	591,699
Expected no. of day case discharges	797,328
Emergency Care - New Emergency Department attendances - Return Emergency Department attendances - Other presentations	 1,093,187 89,371 108,490
Expected no. of emergency admissions**	402,202
Elective Inpatient Admissions***	99,973
Outpatient Attendances	2,571,115
New: Return Ratio	1:2
Expected no. of births	67,889
Access **Inpatient and Day Case Waiting Times** - No. of adults waiting > 8 months for an elective procedure (inpatient) - No. of adults waiting > 8 months for an elective procedure (day case) - No. of children waiting > 20 weeks for an elective procedure (inpatient) - No. of children waiting > 20 weeks for an elective procedure (day case)	0
Colonoscopy / Gastrointestinal Service quality indicator - No. of people waiting > 4 weeks for an urgent colonoscopy - No of people waiting > 13 weeks following a referral for routine colonoscopy or OGD	0
Emergency Care - % of all attendees at ED who are discharged or admitted within 6 hours of registration - % of all attendees at ED who are discharged or admitted within 9 hours of registration - Reduction of trolley waits	 95% 100% 10%
HIQA Tallaght Report - No. of patients who re-attend the ED with the same clinical condition within 7 days - No. of patients being cared for in inappropriate location - % of patients who leave the ED without completing their treatment	 < 5% < 5% < 5%
Outpatients (OPD) No. of people waiting longer than 52 weeks for OPD appointment	0

Performance Indicator	Expected Activity / Target 2014
Acute Medical Patient Processing % of medical patients who are discharged or admitted from Acute Medical Assessment Unit (AMAU) within 6 hours AMAU registration	95%
In-house processing **ALOS** Medical patient average length of stay	5.8
Surgical patient average length of stay	5.3
ALOS for all inpatients	5.6
ALOS for all inpatient discharges excluding LOS over 30 days	4.5
Stroke Care % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	50%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	85%
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%
Hospital Mortality Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	National average or lower
Re-Admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%
% of surgical re-admissions to the same hospital within 30 days of discharge	< 3%
Medication Management % of medication errors causing harm / no harm / death reported to CIS – as a % of bed days or population	Hospital variance with national baseline
Delayed Discharges - Reduction in bed days lost through delayed discharges - Reduction in no. of people subject to delayed discharges	10% reduction

* Same day discharges as reported in 2013 are not included in the total for 2014 ** The number of hospitals reported in this category has increased for 2014
*** does not include obstetric related admissions

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Quality and Patient Safety **Healthcare Associated Infections** Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	< 0.057	**Operational Control** **Compliance with EWTD** - < 24 hour shift - < 48 hour working week	 100% 100%
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5	**National Early Warning Score (NEWS)** % of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	95%
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	83		
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	25	% of all clinical staff who have been trained in the COMPASS programme	> 95%
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	90%	**National Standards** % of hospitals who have commenced first assessment against the NSSBH	95%
Patient Experience % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	100%	**MFTP** % of HIPE coding episodes completed within 30 days of discharge	> 95%
Finance Variance against Budget: Income and Expenditure	< 0%	**Finance** Variance against Budget: Revenue and Capital Vote	< 0%
Variance against Budget: Income Collection	< 0%	**Human Resources** Absenteeism rates	3.5%
Variance against Budget: Pay	< 0%	Variance from approved WTE ceiling	< 0%
Variance against Budget: Non Pay	< 0%		

Additional quality and patient safety indicators in development – please see Appendix 3 of the National Service Plan 2014

Palliative Care Service

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Inpatient Units - Waiting Times Specialist palliative care inpatient bed provided within 7 days	94%	**Day Care** No. of patients in receipt of specialist palliative day care services	331
Community Home Care - Waiting Times i). No. of patients in receipt of specialist palliative care in the community ii). Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non-Acute hospital)	 3,050 82%	**Paediatric Services** Total number of children in the care of the Children's Outreach Nursing service	New PI 2014
Finance Variance against Budget: Income and Expenditure	< 0%	**Finance** Variance against Budget: Revenue and Capital Vote	< 0%
Variance against Budget: Income Collection	< 0%	**Human Resources** Absenteeism rates	3.5%
Variance against Budget: Pay	< 0%	Variance from approved WTE ceiling	< 0%
Variance against Budget: Non Pay	< 0%		

National Cancer Control Programme (NCCP)

Performance Indicator / Activity	Expected Activity / Target 2014	Performance Indicator / Activity	Expected Activity / Target 2014
Symptomatic Breast Cancer Services No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals.	13,200 95%	**Prostate Cancers** No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	2,673 90%
Lung Cancers No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre	2,565 95%	**Radiotherapy** No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	4,546 90%
Finance Variance against Budget: Income and Expenditure	< 0%	**Finance** Variance against Budget: Revenue and Capital Vote	< 0%
Variance against Budget: Income Collection	< 0%	**Human Resources** Absenteeism rates	3.5%
Variance against Budget: Pay	< 0%	Variance from approved WTE ceiling	< 0%
Variance against Budget: Non Pay	< 0%		

The Funding Position

It should be noted that in addition to the savings measures outlined in the National Service Plan 2014 hospitals will be also be required to meet the full value of cost containment plans amounting to €56.5m which were put in place in 2013. A further €80m related to the Haddington Road Agreement is being held centrally, in the first instance, and will be allocated to individual services including Acutes following an assessment of the most appropriate allocation of the savings across each service location.

The table below illustrates the budget movement within the acute sector for 2014. Provision for an additional €50m for acute hospitals has been made, to meet the full year costs of the demand for services which emerged in 2013.Budgets have been set by taking account of directly controllable factors within the acute system and excluding key risk areas which were beyond the direct control of hospital managers in 2013.The 2014 budget for Hospital Groups is €3.700 billion ***(Table 2).*** This budget incorporates budgetary adjustments detailed in ***Table 1***.

The Acute Hospital Division also has an allocation of €7.7m for demographic pressures and €38.4m for the maintenance and expansion of critical services.

Hospitals will be required to deliver on cost containment plans in addition to a focus on improvements in the area of income collection as a priority in 2014.

Acute Financial Allocation

In developing the Service Plan 2014 a multi faceted approach to budget management was adopted in order to protect core services. The principal focus is to continue to deliver the same level of frontline services with a reduced budget while at the same time ensuring that quality and safety is not compromised in any way.

Table 1 Acute Services Budget Framework

Acute Budget Adjustments	€m
2014 Budget Adjustments	
2014 Haddington Road Agreement Budget Reduction	-60.0
New entry consultants	-2.6
Consultants – historic and current rest day arrangements	-3.0
Incentivised career break	-3.2
Reduction in management grades	-0.5
Employment Control Framework	-11.2
Legislation to charge all private patients in public voluntary hospitals	-30.0
Nurse Bank	-12.0
Net total – 2014 funding adjustments	**-122.5**

The specific elements of this multi faceted approach to budget management includes:

1. A reduction in the lump sum provision for pensions which will be used to offset, in part, the incoming deficits from 2013.
2. Making use of savings which will accrue from the phased implementation of new developments during 2014.
3. Additional savings targets in areas such as procurement, shared services, value for money initiatives, hospital reconfiguration, energy efficiency savings. Included also is the full delivery of cost containment plans of €56.5m for hospitals.
4. Specific actions in respect of additional savings target include pay and flexibility reductions which include Haddington Road

In determining the budget allocations for 2014 with a view to ensuring sustainable budgets in the hospital sector, the HSE has in its National Service Plan based allocations on projected spend requirements rather than historic budgets. The approach adopted in the Service Plan places priority on rebasing hospitals in budgetary terms and aims to ensure that hospitals can meet its challenge given its incoming deficit and cost challenges from 2013.

Arising from this the HSE has taken further actions to address this carry forward deficit by providing an additional €50m in funding to provide budgets for hospitals to support activity levels and the cost increases due to demographic, technology and clinical advancements.

Table 2 Hospital Group 2014 Budgets

	Budget 2014
Hospital Group	**€m**
Dublin North East	616.769
Dublin Midlands Hospital Group	734.446
Dublin East Hospital Group	699.827
South/South West Hospital Group	625.759
West/North West Hospital Group	598.087
University of Limerick Hospital Group	234.861
National Children's Hospital Group	190.334
Acute Hospitals Total	**3,700.08**

Notes to Hospital Group Table

1. The 2014 budget for hospital groups does not include €38.4m which will be invested in a number of new critical service developments and €7.7m for initiatives to meet demographic pressures in the acute hospitals and Regional Acute Support Services.
2. Hospital budget figures are stated net of 2014 hospital income targets. NSP 2014 Acute budgets are stated gross before deduction of income targets.

Palliative Care Financial Allocation

The budget for palliative care in 2014 is €72.88m. Additional Demographic funding of €1m is being allocated for the phased opening of 24 specialist in-patient beds located in St Frances Hospice Blanchardstown.

The Workforce Position

Employment Control

The challenge in 2014 is to achieve the overall reduction in staff numbers in a managed way, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed. The indicative employment ceiling in the acute services (acute hospitals, cancer services, palliative care) is expected to decrease to 46,612 in December 2014. The continuing reduction in employment in 2014 will be pursued through natural turnover (retirements and resignations) and other targeted measures.

There will be a focused approach to the management of the staffing resource in order to deliver on the service objectives of this plan, while controlling payroll and related costs. The *Public Service Stability Agreement 2013 -2016* or *The Haddington Road Agreement (*HRA) is the key enabler to further reduce the cost of labour, deliver cost reductions and payroll savings and to manage the change agenda in 2014. Some of the mechanisms contained in the Agreement are: Nursing/Midwifery Graduate Programme, Redeployment, Performance management and work practice changes. Eighty million relating to the Haddington Road Agreement is being held centrally pending the outcome of an assessment, currently underway, which will guide the appropriate allocation of the savings across each service location. Once the assessment is finalised savings targets will be applied proportionately across all Divisions to meet the savings target of €80m.

Accountability for an employment control ceiling will be assigned to each budget-holder in order to ensure that there is clarity on the level of reduction to be achieved in the course of the year.

Reconfiguration and integration of services, maximum utilisation of additional contracted hours as provided for in the HRA, reorganisation of existing work and redeployment of current staff will need to underpin the employment control framework in order to implement Government policy on public service numbers and costs within budgetary allocations.

Staff Breakdown by Category

	Medical /Dental	Nursing	Health &Social Care Professionals	Management/ Admin	General Support Staff	Other Patient & Client Care	Total WTE (31/12/2013)	Ceiling (31/12/2013)
Dublin East	1,295	3,915	1,168	1,449	1,236	621	**9,684**	**9,194**
Dublin Midlands	1,140	3,407	1,405	1,394	878	888	**9,112**	**8,919**
Dublin NorthEast	984	2,768	827	1,106	965	455	**7,106**	**6,830**
Dublin Paediatric	322	1,029	439	422	207	119	**2,539**	**2,418**
South/South West	1,159	3,628	973	1,253	1,177	410	**8,600**	**8,442**
University of Limerick	360	1,268	306	450	242	348	**2,974**	**2,943**
West/North West	1,047	3,044	872	1,203	893	566	**7,624**	**7,402**
National Hospital Services	2	2	2	15			**21**	**31**
Palliative Care	28	245	66	61	84	112	**595**	**571**
Total	**6,308**	**19,062**	**5,993**	**7,294**	**5,597**	**3,407**	**48,254**	**46,750**

Note[1]:the above indicative ceilings are subject to revision and are for guidance only.

Note[2]:Tallaght do not disaggregate out paediatrics services & WTE for this hospital is shown as part of Dublin Midlands

Employment Ceilings

The table below sets out the (indicative) employment ceiling for each hospital group for 2014.

	Total WTE (31/12/2013)	(Indicative) Ceiling 2014	Additional Posts 2014
Dublin East	9,684	9,167	
Dublin Midlands	9,112	8,893	
Dublin NorthEast	7,106	6,810	14.5
Dublin Paediatric	2,539	2,411	
South/South West	8,600	8,417	
University of Limerick	2,974	2,934	
West/North West	7,624	7,380	
National Hospital Services	21	31	25.5
Palliative Care	595	569	
Total	48,254	46,612	40

Public Service Reform

The Acute Division will participate in the planned structural reforms as set out in *Future Health*. The aim and process of such reforms are to have:

- Appropriate governance arrangements in place at all times during the reform process
- Structural reforms will not lead to duplication or the creation of unnecessary management tiers or numbers. However, development of leadership and management capacity will be crucial
- A clear focus of the reforms will be on the development and improvement of frontline services
- The regions will remain important throughout the reform process and beyond. While the role of the regional offices will transform through the process, the Government sees strong regions playing a major role in performance management/improvement
- There will be a high level of collaboration and consultation with stakeholders including other Government Departments, the delivery system and staff associations on the design and implementation of the health structures
- The National Clinical Programmes support the reform measures which underpin the delivery of a more integrated, efficient and effective health service as outlined in the *Public Service Stability Agreement 2013 – 2016* (the Haddington Road Agreement)
- The National Clinical Programmes expect that efficiencies will be maximised and productivity in the use of resources greatly increased through revised work practices and other initiatives
- The role of Clinical Strategy and Programmes includes challenging (where appropriate) the work practices and systems in place in order to drive innovation and cost containment within the system for the benefit of patients.

Recruitment

- The Acute Hospitals Division will develop an effective approach to non-consultant hospital doctor (NCHD) recruitment to ensure a more sustainable focus on NCHD numbers into the future. The development of hospital groups presents a unique opportunity to match NCHD training requirements with service organisations and this will be an important focus in 2014
- The Division will be working with Nursing and Midwifery to ensure the continued availability of trained and skilled critical care nurses. Developing our critical care capacity into the future is an important strategic priority. Development of such capacity enables appropriate responses during surge periods but also facilitates the re-organisation of services in line with policy objectives
- The Acute Division will also be focusing on the development of the role of Advanced Nurse Practitioners, particularly in key service priority areas.

Absence Management

2014 will see a continuing focus in acute hospitals on proactive absence management, including training for managers and the implementation of revised sick leave arrangements due to come into force once the legislation has been enacted.

Agency and Overtime Policy

The Acute Division will implement all HSE policies on agency and overtime. The development of hospital groups will assist in ensuring greater uniformity and consistency in application of agreed policies.

There will be tight control of the use of higher-cost staffing arrangements and in particular the use of agency staffing and overtime working.

A graduate nurse employment programme initiated in 2013 will be further rolled-out, involving the recruitment of up to 1,000 nurses on two-year contracts and a similar scheme for Support Staff. These will provide these staff with frontline working experience and professional development opportunities while at the same time providing additional capacity at service level to offset reliance on use of more costly agency and overtime.

There will be a particular focus on the achievement of full compliance with the European Working Time Directive amongst the non-consultant hospital doctor (NCHD) workforce, by the end of 2014.

Cost Containment 2014

Acute hospital services deficits against budgets will be carried into 2014 and will be addressed in year.

Cost containment plans to the value of €56.5m were put in place in 2013. Additional measures to these will be implemented during 2014. This is in addition to a 2014 Haddington Road Agreement target of €60m and a reconfiguration target of €7.5m which have also been applied.

There will be a range of cost containment measures implemented by hospitals over 2014.
€80m relating to the Haddington Road Agreement is being held centrally pending the outcome of an assessment, currently underway, which will guide the appropriate allocation of the savings across each service location. Once the assessment is finalised savings targets will be applied proportionately across all Divisions to meet the savings target of €80m.

Other challenges include addressing the growth in demand for drugs fuelled both by increased cancer incidence and growth in prevalence and addressing the increasing cost of new technologies and personalised medicine. There are also challenges in meeting the increase in patient and societal expectations in an environment of diminishing funding.

Governance and Accountability

Governance and accountability structures in Acute Hospitals for 2014 will be dependent on our timetable for development of hospital groups. Governance within the acute hospitals will also be partially dependent on the broader governance arrangements and changes within the health services.

The Acute Hospital's Division will also be working closely with RDPIs to ensure that performance management arrangements are more fully developed.

Governance and accountability for new Hospital Groups

The Government's decision to re-organise the acute hospitals service through the establishment of new hospital groups was informed by two 2013 reports - *The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts* and *The Framework for Development – Securing the Future of Smaller Hospitals*. This strategic reform aims to move from a hospital centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity that is safe, timely, efficient, and as close to home as possible. The establishment of Hospital Groups will introduce new governance and accountability arrangements for the future.

Hospital services will be provided by the hospitals in each group, on the basis of population need. Each group of hospitals will work together as a cohesive entity, to provide acute care for patients in their area, integrating with community and primary care. This will maximise the amount of care delivered locally, whilst ensuring that complex care is safely provided in larger hospitals. Seven hospital groups will be established in total, of which three are already in place: West/North West, University of Limerick (previously the Midwest) and the Children's Hospital Group. The remaining four groups will be established by 2014: Dublin North East; Dublin Midlands; Dublin East and South/South West.

Each group will comprise between six and eleven hospitals and will include at least one major teaching hospital and a primary academic partner. Patients, their families and staff will benefit from the group objectives, which are to achieve:

- Stronger governance and management structures at the hospital level
- Managed competition which will lead to more cost effective care and the removal of duplicated services
- A concentration of complex services at particular hospitals in order to ensure quality
- Efficiencies through the avoidance of duplication in areas such as HR and finance.

Each Hospital Group will have a single management team, with responsibility for overall performance within a clearly defined budget.

Robust clinical governance structures and processes will form a key element in ensuring quality improvement and patient focus. The next steps are as follows:

- Board members to be appointed
- Group Hospital CEO's and Management Teams to be appointed through the Public Appointments Service
- An overarching policy framework to guide overall hospital services reorganisation is to be put in place by the Department of Health
- National Strategic Advisory Group (now appointed by the Minister)
- Strategic plan to be developed by each Group within one year of formation.

Initially, the Hospital Group Boards will be established on a non-statutory administrative basis. These Boards will not have specific status in legislation and pre-existing Hospital Boards will continue to retain their existing legal responsibilities until the Hospital Group Board is given the necessary standing in legislation to accept the formal transfer of legal responsibilities. Therefore, while the Voluntary and Joint Board Hospitals will necessarily continue to maintain their legal governance structures, it is expected that they will fully co-operate with the Hospital Group Boards and the HSE and / or its successor in supporting effective decision making by Hospital Groups.

Clinical Strategy and Programmes

The National Clinical Programmes are a joint initiative between the HSE, the Forum of Irish Postgraduate Medical Training Bodies and the professional representative bodies of Nurses and Health and Social Care Professionals.

Clinical Strategy and Programmes has established common clinical governance structures on a national and regional basis for all programmes.

Clinical programmes are approved by the HSE Leadership Team. The National Director for Clinical Strategy and Programmes appoints national clinical leads to each programme, following an expression of interest process and interview with the relevant colleges. The clinical lead is responsible and accountable for the development of a model of care or programme initiative. National clinical leads are supported by a Clinical Advisory Group convened by the relevant college and chaired by a member of the college.

While the principle of optimum patient flow and pathway integration should be embedded in all solutions, the Programmes have also developed to such an extent that they collaborate on work practices across closely related programmes to allow for appropriate and effective programme management.

At regional, hospital group and local level, named individuals provide support and are a vital communication link to ensure that the models of care and programme initiatives are understood and that implementation plans are developed and monitored. Accountability for local implementation of individual aspects of cclinical programmes lies with the senior accountable officer operationally.

With System Reform, new governance arrangements will seek to build on the very solid foundations in the current model but clearly build on alignment between Programmes and the Acute Hospitals Division and the HSE Directorate. These arrangements will also allow for appropriate prioritisation across Programmes and within the Workstreams of each Programme. Clear and workable governance arrangements will support programme commissioning, prioritisation and implementation.

NCCP

The NCCP collaborates with the designated cancer centres and other acute hospital providers of cancer care to monitor access and performance in the diagnosis and treatment of cancer patients.

Key performance indicators are published quarterly and the NCCP works closely with the hospital groups and CEOs to both implement new programmes and to instigate remedial solutions where problems arise. In addition, the NCCP senior managers meet regularly with the CEOs/hospital managers of the cancer centres as well as liaising with the National Director for Acute Hospitals.

Key Challenges to Service Deliveries

The most significant challenge to delivery is the availability of appropriate capacity and capability across the Hospital Division

- necessary recruitment and retention of clinical staff
- necessary implementation / roll out of Models of Care and Programmes to support service redesign
- move from hospital centric delivery to community centric delivery
- Internal resource competition Unscheduled Care .v. Scheduled Care

Overall very major change requirements, which despite significant challenges presented, are not optional for progression

Actions 2014

Priority Area	Action 2014	End Q
Improving hospital governance and accountability while driving efficiencies and better outcomes		
Patient Safety and Quality	Commence hospitals undertaking **Self-Assessment against National Standards,** to be followed by the development of Quality Improvement Plans	Q2
	Continue implementation of the **National Early Warning Score** in accordance with the *HSE Guiding Framework and Policy for the National Early Warning Score System to Recognise and Respond to Clinical Deterioration*.	Q2
	Continue implementation of the maternity early warning scoring system (iMEWS)	Q4
	Implement the plan for the National Organ Donation and Transplantation Office **(€2.92m and 19 WTEs)**	Q4
	Collect, report on and monitor the National Quality and Safety Indicators	Q1-Q4
	Commence implementation of The Patient Charter and implement Patient Feedback processes in the Hospital Groups	Q4
	Continue to ensure that initiatives which enable optimum standards of infection control and hygiene are maintained.	Q4
Improving access to services	Target additional capacity and capability in areas which continue to experience increased service demand, particularly in the areas of access across ED, inpatient day care and OPD services. (€30m)	Q1-Q4
	Progress Outpatient (OPD) Quality Improvement Programme, particularly in relation to necessary data integrity and operational control.	Q1-4
	Establish national narcolepsy paediatric service **(€0.57m)**	Q4
	Ensure access to services in relation to waiting times for emergency or unscheduled care, and scheduled care in public hospitals, including outpatient and diagnostic services	Q1-4
	Provide cochlear implants service at Beaumont Hospital **(€3.22m and 14.5 WTEs)**	Q1-4
	Special Delivery Unit will continue supporting and enabling performance improvement particularly in relation to unscheduled care access	Q1-4
Strategic Reform	Full implementation of seven Hospital Group with direct development of necessary Group service reconfiguration and integration plan.	Q1
	Progress development of new children's hospital with particular focus on necessary integration of paediatric services.	Q4
	Implement quality and safety governance arrangements and Clinical Directorates in line with national guidance from the Clinical Directors programme and the Quality and Safety (Clinical Governance) development programme.	Q1-4
	Continue implementation of the Small Hospitals Framework	Q1-4
	Maternity Services: target key improvements in maternity care using the HSE and HIQA reports: ▪ Pursue implementation of all relevant report recommendations from the HSE review ▪ Pursue implementation of HIQA report and recommendations where appropriate **(€1.48m and 6.5 WTEs)** ▪ Develop necessary National Model of Obstetric Care delivery in conjunction with Department of Health	Q2
National Clinical Programmes	**Acute Medicine Programme** ▪ Support extension of AMAU function towards 24/7 in Model 4 hospitals ▪ Deliver requisite business plans using nationally agreed demand capacity and risk stratification models ▪ Support the implementation of an interim software solution to enable reporting of AMAU PETs in National KRA suite ▪ Implement the National Early Warning Score and associated COMPASS training	Q1-Q4 Q3-Q4

Priority Area	Action 2014	End Q
	Older People ▪ Develop an education programme to support roll out of the model of care ▪ Develop a model of care document that complements the acute model of care in relation to the management of the frail elderly pathway in primary care ▪ Develop a model of care for integrated community care for older people	Q2-Q4
	National Transport Medicine ▪ Implement phase 1 of retrieval system for neonate, paediatrics and adult	Q4
	TPOT (Productive Theatre) ▪ Provide expert training and coaching to establish showcase TPOT hospitals and support the implementation of TPOT in the 14 sites that have commenced the programme. Additional sites will be selected in 2014 following evaluation of submissions from hospitals. ▪ Assignment of 6 Process Improvement Nurse Practitioner Mentors full time (at CNM3 level one per hospital group), to mentor all TPOT hospitals in the group.	Q2-Q4
	Surgery ▪ Develop Surgery Programme AvLOS (average length of stay) Hospital Report Packs using the latest approved HIPE figures ▪ Roll out access to NQAIS (National Quality Assurance Intelligence System) to all acute hospitals ▪ Provide on-going implementation support to hospital sites involving site visits, teleconferences, etc. ▪ Provide support and guidelines for management of Day Cases, Minor Operations and OPD Procedures ▪ Select three hospitals to work in partnership with the NCPA and the TPOT National Team to establish showcase TPOT hospitals committed to implementing the programme and acting as exemplars. Ensure the creation of TPOT Governance Teams at these selected hospitals to support the implementation of the programme ▪ With the Anaesthesia Programme, guide and track the progress of the TPOT sites that have commenced their programme, to continue their implementation	Q2-4
	Anaesthesia ▪ Develop per admission model of care ▪ Develop pathway of care for critically Ill patients in Obstetrics & Gynaecology ▪ Develop national model of care for access to hyperbaric chamber ▪ Develop national audit tool for anaesthesia ▪ Continue site visitation programme	Q4
	Chronic Diseases ▪ Develop a chronic disease framework in consultation with the Divisions ▪ Progress cross border paediatric congenital cardiac surgery and cardiology services	Q3
	Laboratory Service ▪ Establishment of a national governance structure for Clinical Microbiological	Q2

Priority Area	Action 2014	End Q
	Reference Laboratory Services	
	▪ Establishment of an implementation group to ensure progression of recommendations of the Microbiological Reference Laboratory Group	Q2
National Cancer Control Programme	**Medical Oncology**	Q1-Q4
	▪ Continue the implementation of the national medical oncology and haemato-oncology programme **(€3.8m)**.	
	▪ Implement the National Cancer Drug Management Programme, in collaboration with PCRS and cancer hospitals, including the Oncology Drugs Management System and the cancer drug budget.	
	▪ Address pathology service pressures relating to molecular testing including development of a national plan for treatment-related.	
	Radiotherapy	
	▪ Expand and renew radiotherapy facilities and equipment to accommodate growth in demand and the introduction of new technologies, including the expansion of national brachytherapy and stereotactic services.	
	▪ Progress service planning for expansion of radiotherapy services in Dublin to meet future service demands	
	Genetics:	
	▪ Expand access to identification of genetic risk and surveillance in well population at risk	
	Quality & Safety Standards	
	▪ Continue to progress the work of national expert Tumour Groups comprising expert leads in relevant clinical disciplines to develop and promulgate national clinical practice guidelines.	
	Community Education & Training	
	▪ Continue to develop professional staff knowledge, through education and research and collaboration with relevant colleges and educational bodies. Develop primary care skills in prevention, diagnosis, care, and follow up to facilitate safe, high quality care in the community	
	Survivorship	
	▪ Develop a comprehensive cancer survivorship programme to address communication issues and ongoing information needs of both cancer survivors and health care professionals.	
Palliative Care	**Adult service provision (€1.0m).**	
	Staged opening of St. Francis Hospice, Blanchardstown	Q4
	Process and quality improvements	
	• Progress the implementation of a standardised model of access, assessment and referral to specialist palliative care services.	Q1-4
	• Develop national policy to support advance care planning	2015
	• Progress the implementation of the Palliative Care Competence Framework	Q1-4
	• Continue to work with the Irish Hospice Foundation on the Design and Dignity Grants Scheme	Q1-4
	• Disseminate and support the use of *Towards Excellence in Palliative Care - A Self Assessment Tool*	Q4
	• Develop and disseminate a best practice model of palliative care	Q4
	• Work in partnership with the Irish Hospice Foundation to implement the recommendations within the *Palliative Care for All* report	Q4
	• Work in collaboration with the IHF to conduct an assessment of the *End of Life Audit Tool* and develop an implementation plan as appropriate	Q4
	• Work in partnership with the Emergency Medicine Programme to support a demonstration project focused on developing a best practice model of palliative care in the ED setting	Q4
	• Develop and implement evidence based guidelines / clinical pathways for generalist and specialist palliative care practitioners in order to improve quality of care, access to, and resource utilisation within services	Q1-4
	• Implement a strategic plan for effective, efficient and high quality utilisation of palliative care support beds based on the findings of the national review finalised in 2013.	Q1-4
	• Commence collection of data on quality performance indicators from specialist	Q3

Priority Area	Action 2014	End Q
	inpatient units. **Community based paediatric service provision** • Extend the provision of co-ordinated care to children with life-limiting conditions, and their families. • Undertake an evaluation of the joint HSE / IHF outreach programme for children with life-limiting conditions • Provide a range of education and training programmes that will support staff to meet the needs of children with life-limiting conditions, and their families • Develop a strategic plan for a children's 'Hospice at Home' service model	 Q1-4 2015 Q1-4 Q4
Utilise best models of financial allocation and human resource planning	Continue implementation of all elements of the **Haddington Road Agreement** to ensure maximum value for money and cost reduction opportunities within services	Q2
	Develop and implement a sustainable approach to **recruitment** and progress toward compliance with the **European Working Time Directive** **(€3.1m)**	Q2
	▪ Establish a Strategic Project Board necessary for the development of a prospective patient case based payment model for money follows the patient approach to funding ▪ Identify system steps / actions necessary to enable delivery of a funding and data model as a live system in 2014 with all Hospital / Hospital Group participation potential ▪ Identify criteria for selection of specific Hospitals / Hospital Groups as pilots for money follows patient model's advancement in 2013 / 2014 ▪ Continue to develop capacity / capability readiness assessment criteria for all Hospitals / Hospital Groups prior to entry	Q2

Appendix 1: Performance Indicators

Acute Hospital including Clinical Strategy and Programmes											
				Expected Activity / Target 2014							
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2013	Projected Outturn 2013	Dublin North East Hospital Group	Dublin Midlands Hospital Group	Dublin East Hospital Group	South / South West Hospital Group	West / North West Hospital Group	University of Limerick Hospital Group	Children's Hospital Group	Expected Activity / Target 2014
Bed Complement In-patient beds	AND Acute Services Quarterly	-- --	**13,576** 11,513	2,005 1,642	2,619 2,294	2,666 2,271	2,621 2,238	2,247 1,868	935 797	483 403	**13,576** 11,513
Day Beds / Places		--	2,063	363	325	395	383	379	138	80	2,063
Discharges Activity Inpatient	AND Acute Services Monthly	600,887	594,791	88,840	96,545	119,609	115,084	102,211	46,521	22,889	591,699
Day Case		830,165	821,988	102,782	193,979	154,757	144,972	134,717	40,101	26,021	797,328
Emergency Care - New ED attendances		---	1,093,187	157,735	176,212	235,330	182,330	178,758	54,274	108,548	1,093,187
- Return ED attendances		---	89,371	13,046	12,675	23,167	22,428	8,124	4,531	5,399	89,371
- Other emergency presentations		---	108,490	9,339	3,190	7,894	32,785	17,969	37,000	313	108,490
No. of emergency admissions		380,090	402,202	59,908	66,426	74,913	73,595	82,150	29,506	15,704	402,202
Elective Inpatient Admissions*		New PI 2014	103,065	10,792	14,547	18,777	24,982	14,524	11,758	7,685	99,973
No. of outpatient attendances		New PI 2014	2,747,826	355,285	412,859	595,032	453,530	465,674	190,390	98,346	2,571,115
Outpatient Attendances		1:2	1:2.6	1:2	1:2	1:2	1:2	1:2	1:2	1:2	1:2

- New: Return Ratio											
Births Total no. of births	AND Acute Services Monthly	71,096	67,899	14,436	10,153	15,151	13,197	10,231	4,732	-	67,899
Inpatient and Day Case Waiting Times No. of adults waiting > 8 months for an elective procedure (inpatient)		0 by 30th June	1,463 Based on Sept. static performance only	0	0	0	0	0	0	0	0
No. of adults waiting > 8 months for an elective procedure (day case)		0 by 30th June	2,810 Based on Sept. static performance only	0	0	0	0	0	0	0	0
No. of children waiting > 20 weeks for an elective procedure (inpatient)		0	588 Based on Sept. static performance only	0	0	0	0	0	0	0	0
No. of children waiting > 20 weeks for an elective procedure (day case)		0	431 Based on Sept. static performance only	0	0	0	0	0	0	0	0

*** Elective in-patient admissions excludes obstetric related admissions**

Acute Hospitals including Clinical Strategy and Programmes				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2013**	**Projected Outturn 2013**	**Expected Activity / Target 2014***
Colonoscopy / Gastrointestinal Service No. of people waiting > 4 weeks for an urgent colonoscopy	AND Acute Services Monthly	0	0	0
No. of people waiting > 13 weeks following a referral for routine colonoscopy or OGD		0	1,482	0
Emergency Care % of all attendees at ED who are discharged or admitted within 6 hours of registration		95%	68%	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration		100%	82%	100%
Reduction of trolley waits		New PI 2014	New PI 2014	10%
HIQA Tallaght Report No. of patients who re-attend the ED with the same clinical condition within 7 days	AND Acute Services Quarterly	New PI 2014	New PI 2014	< 5%
No. of patients being cared for in inappropriate location		New PI 2014	New PI 2014	< 5%
% of ED patients who leave before completion of treatment		< 5%	4.1%	< 5%
Outpatients (OPD) No. of people waiting longer than 52 weeks for OPD appointment	AND Acute Services Monthly	0	84,423 Based on Sept. static performance only	0
Acute Medical Patient Processing % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	Clinical Lead Monthly	95%	Not reported 2013	95%
Average Length of Stay ALOS for all inpatients	AND Acute Services Monthly	5.6	5.6	5.6
ALOS for all inpatient discharges excluding LOS over 30 days		4.5	4.5	4.5
Medical patient average length of stay		5.8	6.8	5.8
Surgical patient average length of stay		5.3	4.6	5.3
Outpatients (OPD) New attendance DNA rates	AND Acute Services Monthly	12%	15.6%	12%
Dermatology OPD No. of new dermatology patients seen	Clinical Lead Monthly	40,000	40,296	40,000
New: Return Attendance ratio		1:2	1:1.8	10% reduction

Acute Hospitals including Clinical Strategy and Programmes

Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2013	Projected Outturn 2013	Expected Activity / Target 2014*
Rheumatology OPD	Clinical Lead			
No. of new rheumatology patients seen	Monthly	12,400	12,376	12,400
New: Return Attendance ratio		1:4	1:4	1:4
Neurology OPD	Clinical Lead			
No. of new neurology patients seen	Monthly	15,404	16,994	15,400
New: Return Attendance ratio		1:3	1:2	1:3
% Discharges which are Public	AND Acute Services			
Inpatient	Monthly	80%	80.2%	80%
Day Case		80%	85.0%	80%
Stroke	Clinical Lead			
% acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Quarterly (6 months in arrears)	50%	62.5%	50%
% of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis		9%	11.8%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		50%	59.6%	50%
Heart Failure	Clinical Lead			
Rate (%) re-admission for heart failure within 3 months following discharge from hospital	Quarterly	25%	Data not available 2013	20%
Median LOS for patients admitted with principal diagnosis of acute decompensated heart failure		7	7	6
% patients with acute decompensated heart failure who are seen by HF programme during their hospital stay		70%	70%	80%
Acute Coronary Syndrome	Clinical Lead			
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Quarterly	70%	81.9%	70%
% reperfused STEMI patients (or LBBB) who get timely				
a) PPCI or		70%	68.4%	75%
b) thrombolysis		70%	30.0%	75%
Medial LOS and bed days for				
a) STEMI		4	4	Stemi: 4
b) Non-STEMI pts		6	4	Non-stemi: 6

Acute Hospitals including Clinical Strategy and Programmes

Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2013	Projected Outturn 2013	Expected Activity / Target 2014*
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	Clinical Lead Monthly	85%	66%	85%
% of surgical re-admissions to the same hospital within 30 days of discharge		< 3%	2%	< 3%
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)		95%	83%	95%
Hospital Mortality Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	AND Acute Services Annually	New PI 2014	New PI 2014	National average or lower
Emergency Care % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	AND Acute Services Monthly	9.6%	10.7%	9.6%
Medication Management % of medication errors causing harm / no harm / death reported to CIS – as a % of bed days or population	AND Acute Services Quarterly	New PI 2014	New PI 2014	Hospital variance with national baseline
Dialysis Modality Haemodialysis patients	National Renal Office Bi-annually	1,669 – 1,714	1,602	1,644 – 1,712
Home Therapies patients		251 – 260	246	258 – 273
Total no. of dialysis patients		1,920 – 1,974	1,848	1,902 – 1,985
Delayed Discharges Reduction in bed days lost through delayed discharges	AND Acute Services / AND Older People Monthly	10% reduction	247,777	10% reduction
Reduction in no. of people subject to delayed discharges		10% reduction	658	10% reduction
COPD Mean and median LOS (and bed days) for patients with COPD	Clinical Lead Quarterly (in arrears)	7.8 5	7.5 5	7.8 5
% re-admission to same acute hospitals of patients with COPD within 90 days		24%	25%	24%
No. of acute hospitals with COPD outreach programme	Clinical Lead Bi-annually	15	13	15
Access to structured Pulmonary Rehabilitation Programme in Local Health Area		63%	50%	20 / 32 63%
Access to structured Pulmonary Rehabilitation Programme in acute hospital services		25 sites	25 sites	28 sites
Asthma % nurses in primary and secondary care who are trained by national asthma programme	Clinical Lead Quarterly	90%	20%	70%

Acute Hospitals including Clinical Strategy and Programmes

Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2013	Projected Outturn 2013	Expected Activity / Target 2014*
No. of asthma inpatient bed days used	Quarterly (in arrears)	10% Reduction	10,907	10% Reduction
No. of deaths caused by asthma annually	Annually	10% reduction	39	< 50
Diabetes % change in lower limb amputation from Diabetes	Clinical Lead Annually	40% reduction	2.27%	40% reduction
% of registered Diabetics invited for retinopathy screening		90%	Data not available in 2013	90%
Epilepsy % reduction in median LOS for epilepsy inpatient discharges	Clinical Lead Quarterly	10% reduction	0%	10% reduction
% reduction in the number of epilepsy discharges		New PI	7,807	10% reduction
Blood Policy No. of units of platelets ordered in the reporting period	ND Quality and Patient Safety Monthly	21,178	187	21,178
% of units of platelets outdated in the reporting period		< 8%	171	< 8%
% usage of O Rhesus negative red blood cells		< 11%	13,200	< 11%
% of red blood cell units rerouted to hub hospital		< 5%	1,063	< 5%
% of red blood cell units returned out of total red blood cell units ordered		< 1%	395	< 1%
Health Care Associated Infections Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	ND Quality and Patient Safety Quarterly	< 0.060	0.06	< 0.057
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used		< 2.5	2.4	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	ND Quality and Patient Safety Bi-annually	83.7	85	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used)		25	25	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool		90%	87%	90%
Patient Experience % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	AND Acute Services Annual	New PI 2014	New PI 2014	100%
HR – Compliance with EWTD < 24 hour shift < 48 hour working week	AND Acute Services Monthly	New PI 2014	New PI 2014	100% 100%

Acute Hospitals including Clinical Strategy and Programmes				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2013**	**Projected Outturn 2013**	**Expected Activity / Target 2014***
National Early Warning Score (NEWS) % of Hospitals with full implementation of NEWS in all clinical areas of acute Hospitals and single specialty hospitals	Quarterly	New PI 2014	New PI 2014	95%
% of all clinical staff who have been trained in the COMPASS programme		New PI 2014	New PI 2014	> 95%
National Standards % of Hospitals who have commenced first assessment against the NSSBH	Quarterly	New PI 2014	New PI 2014	95%
% of Hospitals who have completed first assessment against the NSSBH		New PI 2014	New PI 2014	95%
MFTP % of HIPE coding episodes completed within 30 days of discharge	Monthly	New PI 2014	New PI 2014	> 95%

* Expected activity / Target will apply across all (relevant) hospitals and hospital groups unless stated otherwise

Palliative Care Services								
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2013	Projected Outturn 2013	Expected Activity / Target 2014				
				DML	DNE	South	West	Total
Inpatient Units Waiting Times i) Specialist palliative care inpatient bed provided within 7 days	AND Acute Services Monthly	92%	94%	88%	88%	100%	97%	94%
ii) Specialist palliative care inpatient bed provided to patients within 1 month		98%	98%	100%	100%	100%	100%	100%
No. of patients in receipt of treatment in specialist palliative care inpatient units		340	346	108	40	66	143	357
No. of new patients seen or admitted to the specialist palliative care service (reported by age profile)		173	2,264	662	373	444	806	2,285
No. of admissions to specialist palliative care inpatient units		2,892	2,868	653	577	834	934	2,998
Community Home Care Waiting Times i) Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non-Acute hospital)	AND Acute Services Monthly	82%	81%	81%	72%	82%	91%	82%
ii) Specialist palliative care services in the community provided to patients in their place of residence within 1 month (Home, Nursing Home, Non-Acute hospital)		99%	98%	100%	100%	100%	100%	100%
No. of patients in receipt of specialist palliative care in the community		2,948	2,953	665	587	848	950	3,050
No. of new patients seen or admitted to specialist palliative care services in the community (reported by age profile)		664	8,155	2,136	1,560	2,222	2,262	8,180
Day Care No. of patients in receipt of specialist palliative day care services	AND Acute Services Monthly	331	324	85	73	98	75	331
No. of new patients in receipt of specialist palliative day care services		848	864	243	177	245	183	848
Community Hospitals No. of patients in receipt of care in designated palliative care support beds	AND Acute Services Monthly	149	131	42	7	53	29	131
No. of new patients in receipt of care in designated palliative care support beds		New PI 2014	New PI 2014	---	---	---	---	New PI 2014
Paediatric Services Total no. of children in the care of the Children's Outreach Nursing service / Specialist Paediatric Palliative Care Team	AND Acute Services Monthly	New PI 2014	New PI 2014	---	---	---	---	New PI 2014
Total no. of new children in the care of the Children's Outreach Nurse / Specialist Paediatric Palliative Care Team		New PI 2014	New PI 2014	---	---	---	---	New PI 2014
Acute Hospitals (from Q2) Total no. of new referrals seen by the Specialist Palliative Care Team in the	AND Acute Services	New PI 2014	New PI 2014	---	---	---	---	New PI 2014

Palliative Care Services								
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2013	Projected Outturn 2013	Expected Activity / Target 2014				
				DML	DNE	South	West	Total
acute hospitals (inpatient and outpatient)	Monthly							
Waiting Times (from Q2) Specialist Palliative Care services provided in the Acute setting to new patients and re-referrals within 2 days	AND Acute Services Monthly	New PI 2014	New PI 2014	---	---	---	---	New PI 2014

National Cancer Control Programme				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2013**	**Projected Outturn 2013**	**Expected Activity / Target 2014**
Symptomatic Breast Cancer Services No. of urgent attendances	NCCP Quarterly	13,900	14,847	13,900
No. of non urgent attendances		25,200	24,012	25,200
No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals *(No. and % offered an appointment that falls within 2 weeks)*		13,200 95%	14,476 > 95%	13,200 95%
No. and % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals *(No. and % offered an appointment that falls within 12 weeks)*		23,940 95%	23,075 > 95%	23,940 95%
Lung Cancers No. of attendances at rapid access lung clinic		2,700	2,916	2,700
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre		2,565 95%	2,624 90%	2,565 95%
Prostate Cancers No. of centres providing surgical services for prostate cancers		7	8	7
No. of attendances at rapid access prostate clinics		2,970	2,895	2,970
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre		2,673 90%	1,563 54%	2,673 90%
Rectal Cancers No. of centres providing services for rectal cancers		8	12	8
Radiotherapy No. of patients who completed radical radiotherapy treatment in the preceding quarter (palliative care patients not included)		To be determined	4,905	5,052
No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)		90%	3,972 81%	4,546 90%

Appendix 2: Capital Projects

This appendix outlines capital projects that were completed in 2012 / 2013 and are due to become operational in 2014 and also those projects due to be completed in 2014, irrespective of whether they become operational in 2014 or 2015

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
Acute Division										
Dublin North East Hospital Group	Beaumont Hospital, Dublin	Provision of a second catheterisation laboratory	Q2	Q3	1	1	1.54	1.54	0	0
		Renal transplant unit (phase 1)	Q4	Q1 2015	0	0	3.70	5.00	0	0
	Connolly Hospital, Blanchardstown, Dublin	Acute medical assessment unit (MAU)	Q2	Q2	0	8	0.45	0.65	0	0
	Rotunda Maternity Hospital, Dublin	Electrical distribution system upgrade and completion of the boundary wall, stabilisation works and mortuary upgrade	Q1	Q1	0	0	0.50	1.30	0	0
	Our Lady of Lourdes Hospital, Drogheda	Refurbishment of the former nurses home, purchased from the METR allocation in 2011, to provide a medical education centre	Q1	Q4	0	0	1.00	1.60	0	0
Dublin Midlands Hospital Group	St. James's Hospital, Dublin	Campus wide electrical infrastructure upgrade	Q1	Q1	0	0	0.90	3.60	0	0
	Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital, Tallaght (AMNCH)	Emergency department (ED) expansion and upgrade	Q4	Q4	0	0	2.60	4.50	0	0
		Upgrade of Reverse Osmosis (RO) water system for the renal unit	Q4 2013	Q1	0	0	0.25	5.00	0	0
	Temple Street Hospital, Dublin	Interim works including an ECG room, an admissions unit and cochlear implant / audiology facility	Q1	Q3	0	0	0.85	4.00	0	0
Dublin East Hospital Group	Wexford General Hospital	Construction of a new obstetrics unit and delivery suite	Q1	Q2 / Q3	1	0	1.52	16.82	0	0
		Fire alarm upgrade	Q1	Q1	0	0	0.25	1.25	0	0
	National Maternity Hospital, Holles Street, Dublin	Construction of a new neo-natal intensive care unit (ICU)	Q4	Q1 2015	0	25	3.00	5.00	0	0
	Our Lady's Hospital, Navan	Upgrade of existing facility to provide ED and urgent care accommodation	Q2	Q2	0	0	0.65	0.85	0	0
	St. Luke's Hospital, Kilkenny	Construction of new ED, MAU, day service including endoscopy (including medical education unit)	Q2	Q3	11	14	6.47	28.50	0	0
South / South-West	Waterford Regional Hospital	Campus wide hospital infrastructure upgrade	Q1	Q1	0	0	0.60	1.60	0	0
	Cork University Hospital	MRI and CT project	Q4	Q4	2	0	0.38	2.72	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
		Construction of a new helipad	Q4	Q1 2015	0	0	1.40	1.80	0	0
		Provision of a temporary decant ward (50 bed) to facilitate future ward upgrade programme	Q4	Q4	0	50	3.75	4.05	0	0
South / South-West Hospital Group *contd.*	Cork University Hospital	Acute respiratory care and cystic fibrosis inpatient unit	Q3	Q4	0	15	0.26	0.61	0	0
	South Infirmary / Victoria University Hospital, Cork	Ophthalmology outpatient department (OPD) relocation	Q4	Q1 2015	0	0	0.75	2.00	0	0
	Bantry General Hospital, Co. Cork	Construction of new MAU	Q4	Q4	8	0	1.00	1.15	0	0
West / North-West Hospital Group	Letterkenny General Hospital, Co. Donegal	Emergency works (following flooding) *(Costs to be recouped from insurance company)*	Phased completion throughout 2014	Phased opening from 2014	0	0	1.90	4.36	0	0
		OPD expansion (orthopaedics, ante-natal and pharmacy)	Q1	Q2	0	0	1.00	1.24	0	0
		Construction of medical education and training facility	Q4	Q4	0	0	0	0	0	0
	Mayo General Hospital, Castlebar	Renal unit refurbishment and upgrade	Q1	Q1	0	0	0.10	1.80	0	0
	Merlin Park University Hospital, Galway	School of podiatry (phase 2), the provision of a minor procedures unit	Q1	Q1	0	0	0.20	11.80	0	0
		Rehabilitation unit	Q4	Q4	0	25	1.20	1.20	0	0
	University College Hospital, Galway	Upgrade of campus wide utility infrastructure to facilitate other major developments	Q4 2013	Q1	0	0	0.80	4.59	0	0
		Modular ward block (75 beds)	Q4	Q4	0	75	8.00	8.00	0	0
		Clinical research facility	Q4	Q4	0	0	0.85	0.85	0	0
	Roscommon General Hospital	Provision of endoscopy unit	Q4	Q1 2015	0	2	2.29	3.10	0	0
	Sligo General Hospital	Construction of medical education and training facility	Q4	Q4	0	0	0	0	0	0
University of Limerick Hospital Group	University Hospital, Limerick	Completion of ED (shell space construction with fit out commencing early 2014)	Q4	Q1 2015	3	0	4.00	8.00	0	0
		Infrastructural upgrade (including electrical distribution system) to facilitate present and future developments	Q1	Q1	0	0	0.30	8.50	0	0
	Nenagh Hospital, Co. Tipperary	New theatre block	Q1	Q2	2	0	0.66	5.60	0	0
Acute Division – National Cancer Control Programme										
Dublin North East Hospital Group	Mater Misericordiae university Hospital, Dublin	Relocation of the oncology day unit and drug compounding facility	Q1	Q2	0	0	1.50	2.75	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
West / North –West Hospital Group	Letterkenny General Hospital, Co. Donegal	Oncology day unit expansion*	*	*	0	1	1.90	4.36	0	0
		*Plans for relocation of oncology day ward, Letterkenny delayed arising from recent flooding of ED. It is not possible at this time to indicate when the relocation will be completed.								
Acute Division – Palliative Care										
West / North-West Hospital Group	Ballina District Hospital, Co. Mayo	Provision of a level II (2 bedded) palliative care facility (co-funded by the Roscommon Mayo Hospice Group)	Q2	Q3	2	0	0.08	0.33	0	0