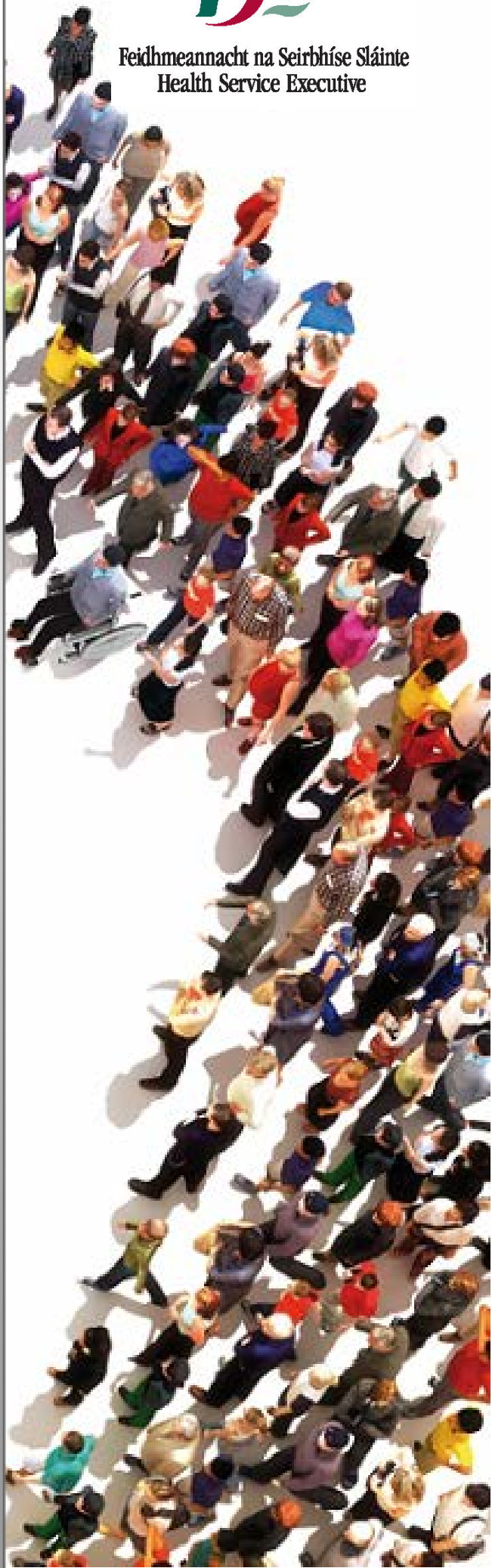
ucc
Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

South/South West Hospital Group

Operational Plan 2016



Vision

A healthier Ireland with a high quality health service valued by all

Mission

- People in Ireland are supported by health and social care services to achieve their full potential
- People in Ireland can access safe, compassionate and quality care when they need it
- People in Ireland can be confident that we will deliver the best health outcomes and value through optimising our resources

Values

We will try to live our values every day and will continue to develop them

- Care
- Compassion
- Trust
- Learning

Goal 1 Promote health and wellbeing as part of everything we do so that people will be healthier

Goal 2 Provide fair, equitable and timely access to quality, safe health services that people need

Goal 3 Foster a culture that is honest, compassionate, transparent and accountable

Goal 4 Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them

Goal 5 Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money

Contents

Executive Summary

Introduction

The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the *Health Act 2004* in line with National Service Plan (NSP) 2016 and allocated Group budgets. In this context each Group will produce a detailed operational plan for 2016 which will be aligned with the Acute Hospitals' Division overarching Operational Plan. The detail of the services which will be delivered at each of the hospitals in the South/South West Hospital Group within the funding allocation is set out in this Group Operational Plans for 2016.

The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the Accountability Framework of the HSE. All targets and performance criteria adopted in the service plan and the divisional Operational Plan will be reported through this framework.

The South/South West Hospital Group comprises of nine acute hospitals operating across the counties of Cork, Kerry, Waterford, Tipperary and Kilkenny. The Group serves a population of approximately 1.2million and provides a wide range of inpatient, day case and ambulatory care services. The group has 2,139 inpatient beds and 382 day beds.
The nine hospitals under the group are:

Acute Services	
2016 Nett Budget €m	
South / South West Hospital Group	€705.7
Full details of the 2016 budget are available in Appendix 1	

Cork University Hospital/Cork University Maternity Hospital
University Hospital Waterford
Kerry General Hospital
Mercy University Hospital
South Tipperary General Hospital
South Infirmary Victoria University Hospital
Bantry General Hospital
Mallow General Hospital
Lourdes Orthopaedic Hospital, Kilcreene

The primary academic partner for the group is University College Cork.

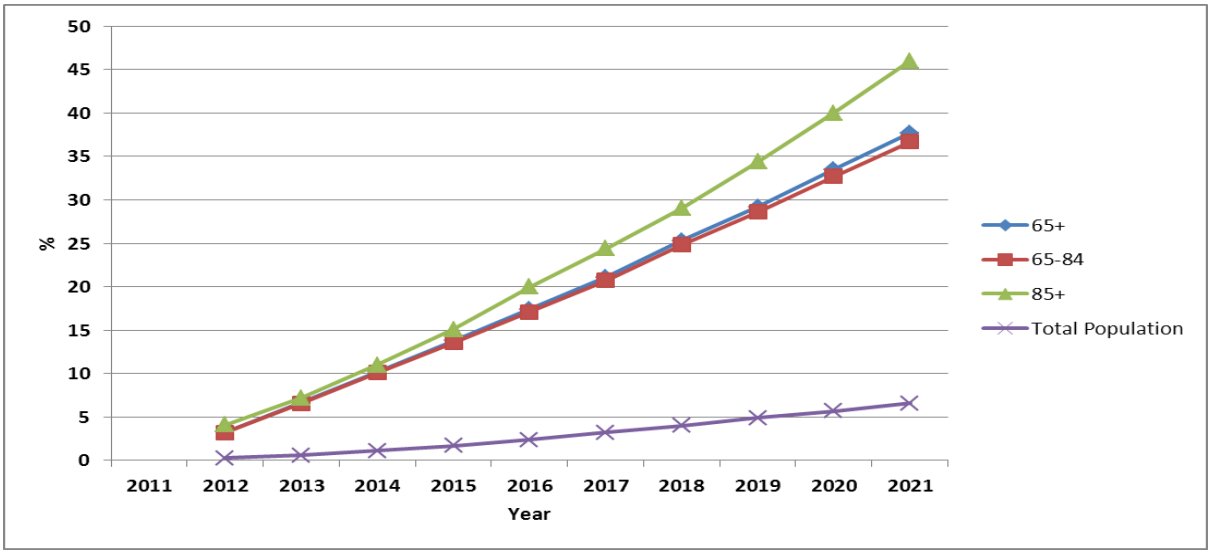
The Group has two major cancer centres in Cork University Hospital and University Hospital Waterford and three trauma centres in Cork University Hospital, University Hospital Waterford and Kerry General Hospital. It has three model three hospitals in Kerry General Hospital, Mercy University Hospital and South Tipperary General Hospital and two elective hospitals in the South Infirmary/Victoria University Hospital and Lourdes Orthopaedic Hospital, Kilcreene. It also has two smaller hospitals in Bantry General Hospital and Mallow General Hospital.

The South/South West Hospital Group has a Chairperson and is awaiting the appointment of an interim Board of Directors. A Group Leadership Team is in place, which is led by the Group Chief Executive Officer.

Impact of Demographics on Hospitals

The demand for acute hospital services continues to increase in line with a growing and ageing population. The overall population growth year on year in Ireland is in the order of 1%. However, the growth of the over 65 year age group is increasing at a steeper rate, and is in the order of 3-4% per year. In 2016 we can expect a projected increase of 32,500 persons in our population, including an increase of 19,400 aged 65 years and over and an increase of 2,900 persons of 85 years and over. Figure 1 below demonstrates the projected cumulative percentage change in 65 years and older population versus total population 2011 – 2021. A steep increase in the older age cohorts is evident.

Figure 1: Projected cumulative percentage change in 65 years and older population versus total population 2011 – 2021



Source: CSO

The *Health Information Paper 2015/2016 Trends and Priorities to Assist Service Planning 2016* outlines the impact of the changing age profile of our population with respect to Inpatient and Day Case activity, some key points include:

- In 2014, adults 65 years and over made up 12.7% of our population but used 53.3% of total hospital in-patient care and approximately 36% of day case care, and this trend is likely to continue.
- In 2014, adults 85 years and over represented 1.4% of our total population but used 13.5% of the in-patient beds.
- The five leading medical and surgical in-patient specialities in adults over 65 years include general medicine 37.2%, general surgery 11.9%, orthopaedic surgery 8.4%, geriatric medicine 8.2% and cardiology 5.6%. General Medicine and Geriatric Medicine combined represent over 45% of all admissions in adults greater than 65 years.
- In adults over 65 it is projected, from 2014 to 2016, that there will be an increase of 3,846 discharges in General Medicine, 1,228 in General Surgery, 875 in Orthopaedics, 853 in Geriatric Medicine and 584 in Cardiology.
- The trend in projected in-patient costs for those over the age of 65 is an increase of 3.4% from 2015 to 2016.

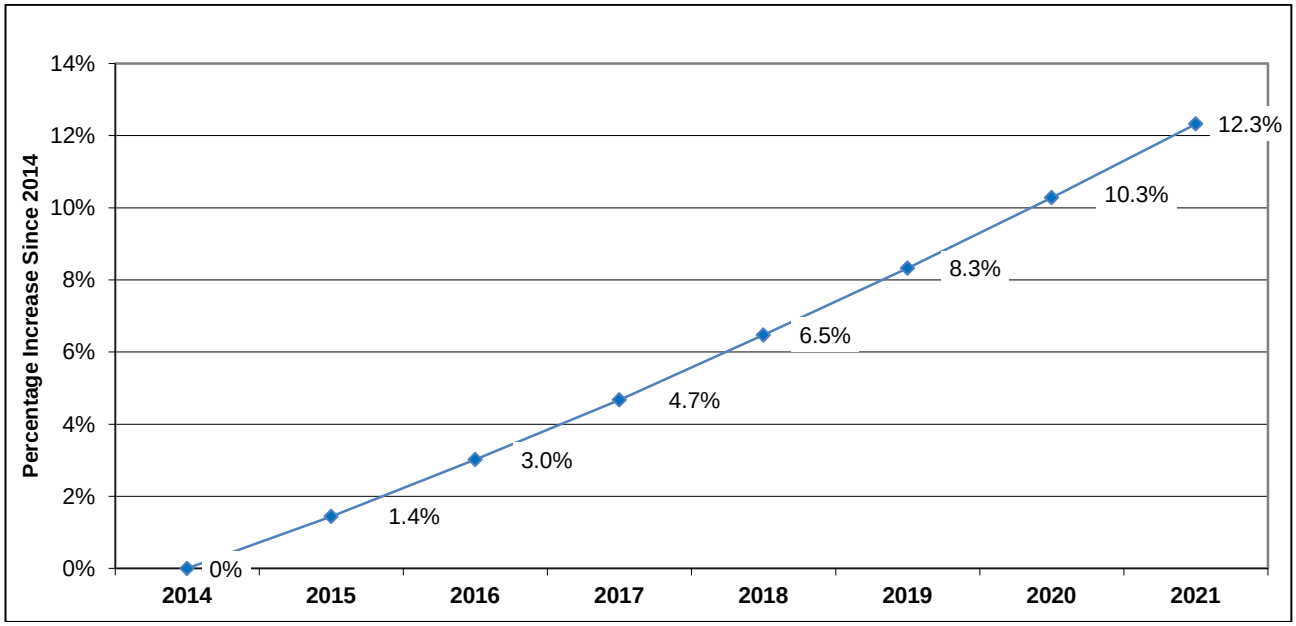
The increase in the population and the higher increase in the population over 65 is putting increasing pressure on hospital resources. Combining in-patient and day case discharges provides a view of total cost pressures

facing publicly funded acute hospitals in managing their in-patient workloads over the period to 2021. This shows average annual demographically driven pressures of around 1.7% for the years from 2014 to 2021 with a rising rate reflecting the acceleration in population ageing over the period.

From 2015 to 2016, demographically driven cost pressures of 1.6% are predicted. Figure 2 below represents total in-patient and day case cost pressures for 2014 to 2021 and shows the trend line in costs in the acute sector based upon CSO data and the use of Hospital Pricing Office (HPO) cost data adjusting for the impact of ageing.

This equates to €64m of the net 2015 allocation to keep up with the demographic pressure. Clearly model of care changes relating to the frail elderly area and chronic conditions are key to addressing this challenge. However in 2016 the pressure will continue to fall directly upon hospitals with limited additional financial provision.

Figure 2: Total in-patient and day case cost pressures, 2014 to 2021.



- *Source: HPO and CSO.*

In the context of developing Activity Based Funding (ABF) as the funding model for the HSE, this plan is also seeking to align activity with costs. Hospital services will be analysed on a diagnosis related groups (DRG) basis which will provide a truer assessment of real performance in 2016. This form of analysis is used internationally to understand the complexity and cost of hospital inpatient and day case activity. The budgets of each Group and their hospitals will reflect the affordable activity level to be provided and the cost associated therewith. This will be presented using the DRG tools available to the HSE.

Developments and Challenges 2016

The services outlined in this operational plan are based on those agreed in the National Service Plan 2016, which aims to deliver an equivalent volume of activity as that delivered in 2015 whilst acknowledging that the financial challenges are significant. Substantial cost control and cost reduction by the Groups and hospitals will be required with a focus on controlling the total pay and non pay costs as well as maximising income. The specific challenges in meeting the financial and activity targets facing the South/South West Hospital Group are detailed within this Group operational plan with an emphasis on delivering safe care at the 2015 volumes.

In summary, when account is taken of the 2015 cost of services, expected cost growths and initial cost saving measures, a preliminary National funding shortfall of €150m remains to be addressed. An interim cash-management based solution to the €50m historic accelerated income collection target has been proposed which reduces this funding shortfall on a once-off basis to circa €100m. This is put forward on the basis that a feasible permanent solution to this €50m issue can be agreed between the HSE and DoH during 2016, in time to be implemented in 2017.

Options to address the remaining €100m funding shortfall have been considered during the service planning process, including aligning activity levels to the funding available, albeit this is considered as very much a last resort. In summary, this view is based on the significant risks inherent in operationalising such an option and more importantly on the negative impacts for patient access to services and for staff morale.

The acute hospital division, with support from the rest of the HSE, will take a number of measures to control costs, reduce waste and improve efficiency aimed at minimising any impact on services.

The targets that need to be achieved in relation to these measures are very challenging and carry significant delivery risk albeit each of the measures represent areas of focus that the Acute Hospital Division would have intended to pursue in 2016 in any event. It is for the Acute Hospital Division and the Hospital Groups to ensure that appropriate management effort and attention is applied to maximising the delivery of savings measures and overall budgetary performance. Thereafter the HSE and DoH acknowledge the shared risks inherent in the extent of the savings targets and the assumptions underpinning them, which have been mutually agreed following extensive engagement in light of the alternative which is service reductions, within the service planning process. This is considered preferable in light of the alternative which is service reductions.With regard to inpatient activity it is recognised that the imperative is to continue to shift to day case activity in terms of enabling optimum access at the most efficient cost. The planned work undertaken by the system will give priority to urgent and complex cases. In terms of activity the division will also seek to optimise existing capacity through reducing length of stay and shifting care to appropriate settings including primary care.

Having regard to the available funding, it is expected that:

- Day case activity will be delivered at 100% of 2015 levels including up to 10,000 cases to be provided within primary care
- Inpatient activity target is to deliver 2015 levels
- Emergency inpatient activity will be delivered at 100% of 2015 levels
- OPD activity will be funded at 100% of 2015 levels
- The target for % of adults waiting < 15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 90% compliance against this target. The projected compliance for 2016 is 95%
- The target for % of adults waiting < 8 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 66% compliance against this target. The projected compliance for 2016 is 70%
- The target for % of children waiting <15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 95% compliance against this target. The projected compliance for 2016 is 95%
- The target for % of children waiting < 20 weeks for elective procedure (inpatient and cay case) was 100% in 2015 and it is expected that the outturn for 2015 will be 55% compliance against this target. The projected compliance for 2016 is 60%

- The target for % of people waiting <15 months for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 90%. The projected compliance for 2016 is 100%
- The target for % of people waiting < 52 weeks for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 85%. The projected compliance for 2016 is 85%

Risks to the delivery of Acute Hospitals plan within funding available

In identifying potential risks to the delivery of this operational plan, it is acknowledged that while every effort will be made to mitigate these risks, it will not be possible to eliminate them in full. Identified risks include:

- Capacity to cap the introduction of drugs and medical devices including transcatheter aortic valve implantations (TAVIs)
- Capacity to control activity volumes to the targeted level under ABF
- Capacity to maintain and collect income
- Capacity to achieve pay and non-pay cost control at the level required while demographic impacts drive demand for services
- Ability to contain activity to 2015 levels for emergency care and urgent and routine elective treatments
- Delayed discharges are not reduced to and maintained at <500 during 2016
- Service risks related to limited capacity in Intensive Care (ICU)
- Continued or accelerated demographic pressures over and above those already planned for in 2016
- The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce
- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system constraints
- Pay cost growth which has not been funded
- Risks associated with the delivery of procurement savings targeted at €9.9M
- Lack of contingency funding to deal with unexpected service or cost issues

Clinical Strategy and Programmes

Clinical Strategy and Programmes will progress the establishment, enablement and delivery of integrated care through five integrated care programmes – prevention and management of chronic disease, older people, patient flow, children and maternity care.

Clinical and Integrated Care Programmes

In 2016 the clinical and integrated care programmes will lead a number of priority programmes to design, develop and progressively implement models of care which will incorporate cross service, multi-disciplinary care and support which will facilitate the delivery of high quality evidence based and coordinated care. The Acute Care Division will collaborate with the clinical and integrated care programmes to ensure the changes implemented are consistent with frameworks, models of care, pathways and guidelines designed by the integrated and clinical care programmes.

Integrated Care Programme for Older Persons

The purpose of the Integrated Care Programme for Older Persons is to augment primary and secondary care services for older people in the community enabling a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older

person. Given the ageing demographics there is an urgent need to build capacity in the provision of healthcare services that can meet this change in the model in both community and acute services. Work is already well established in Cork and Limerick. The priority in 2016 is developing this programme across 4 pioneer sites including Cork University Hospital. The early implementation of the Model of Integrated care programme for Older Persons in 2016 is to be carried out in association with local CHO, Clinical Care Programmes and Social Care Division.

The South/South West hospital Group will support the development of implementation plans for integrated care pathways across all hospitals in the Group.

Conclusion

Notwithstanding the challenges ahead, the South/South West Hospital Group will strive to achieve key service objectives for 2016 which include:

- Sustain access to urgent and planned care by increasing efficiencies, streamlining processes and maximising capacity in hospitals
- Implement integrated care pathways for patients with Chronic Obstructive Pulmonary Disease (COPD), asthma, heart failure and diabetes in the context of the Integrated Programme for Prevention and Management of Chronic Disease
- Improve patient access and experience by the provision of integrated care in collaboration with social care, primary care and mental health services
- Provide high level co-ordination of maternity, gynaecology and neonatal services across the Group through the Women and Infants Health Programme
- Commence implementation of the Maternity Strategy
- Embed robust governance structures within the Group in line with the HSE Accountability Framework
- Build effective managerial and clinical networks within the Group which will provide direct support to the smaller hospitals in the group, in particular
- Develop and improve capacity for quality and patient safety within the Group through the establishment of a defined patient safety and quality framework that will address patient advocacy, complaints, incident management and response, learning systems and service improvement
- Continue with the development of the Hospital Group on an administrative basis in 2016, in advance of legislation
- Phased implementation of Activity Based Funding Model with the use of the *Hospital Inpatient Enquiry system (HIPE)* data to determine the volume of cases required to be undertaken by each hospital in the Group in 2016
- The National Cancer Control Programme (NCCP) will work with the DoH and other stakeholders in the implementation of the National Cancer Strategy 2016-2025. The NCCP will continue to lead on service developments in cancer and performance monitoring against agreed KPIs across all eight designated cancer centres.

Improving Quality and Reforming Service Delivery

Strategic Priorities for 2016

The South/South West Hospital Group places a significant emphasis on the quality of services delivered and on the safety of those who use them and therefore will work in close collaboration with the Acute Hospitals Division, Quality Improvement Division (QID) and Quality Assurance and Verification Division (QAV) to improve the overall quality and safety of services with measurable benefits for patients and service users.

The four objectives which underpin the quality and patient safety programme led by QID and QAV are:

- Services must be relevant to the needs of the population
- Patients and service users must be appropriately encouraged and empowered to interact with the service delivery system
- Health services must work to a set of clear quality and safety standards that are based on international best practice
- Services must be safe and a strong focus must be placed on ensuring quality and safety is improved through a combination of improvement programmes and formal accountability for ensuring safe services

Progress on patient safety, clinical effectiveness and quality improvement continues to enable integrated care and promote services that are appropriate, delivered with the patient / service user at the centre, and are based on best clinical practice and integrated care pathways. In this context the objectives for 2016 include:

Leadership and Governance for Quality and Safety

- Ensure that authority and accountability for the quality and safety of services across all service areas is integrated into operational service management through appropriate leadership, governance, structures, and processes
- Develop capacity for development of quality and patient safety within the Hospital Group whereby each service has a defined patient safety and quality operating model to address service user advocacy, complaints, incident management and response, learning systems, service improvement, and change of culture
- Ensure compliance with all national standards and regulations as they relate to quality and safety of services along with a strong focus on continuous quality improvement of services
- Build capacity and capability for leadership and improvement in quality through formal education and training programmes and supporting staff to implement quality improvement initiatives in their services
- Strengthening the HSE's governance arrangements under the health service Accountability Framework by measuring, monitoring and reporting on the performance of the health service in relation to the quality and safety of care, with a specific focus on identifying and addressing areas of under-performance by recommending appropriate and proportionate action to ensure the improvement of services
- Putting in place an assurance system including measurement, healthcare audit and reviews that seek evidence that quality and safety is prioritised and committed to at all levels of the healthcare delivery system

- Establish positive and effective staff engagement as a keystone of quality improvement and person centred care by partnering with services to develop and test methodologies, build organisational leadership capacity and share learning

Safe Care

- Acting to promote the reduction of risk to the public, staff and healthcare services by adopting a risk based approach to predicting, identifying and responding to service areas where significant performance, quality and safety concerns may exist
- Improve monitoring, investigation and learning processes from serious incidents across all service areas. Progress the implementation of recommendations from major reports and serious incidents across all service areas
- Continue support and commitment to the process of development, implementation and monitoring of National Clinical Effectiveness Committee (NCEC) National Clinical Guidelines and Audit in all appropriate services including Early Warning Systems, Clinical Handover, Healthcare Associated Infections (HCAIs) and Sepsis
- Putting in place an effective system to identify, manage, investigate and implement the learning from serious safety incidents, safety investigations and regulatory investigations and inspections
- Strengthening the HSE's regulatory capacity to fulfil its responsibilities in the area of medical ionising radiation
- Continue the implementation, control and prevention of HCAIs / antimicrobial resistance (AMR) in accordance with HCAI standards across all service areas including decontamination standards
- Reduction in medication errors
- Establish a National Independent Review Panel with an independent Chair and Review Team members as part of the HSE's enhanced arrangements for investigations. The Review Panel will focus on serious incidents that occur in disability services across the HSE and HSE funded services

Effective Care

- Continue to prioritise improvements in the quality and safety of care in maternity and perinatal services
- Prioritise the safeguarding of service users, and support improvements in services in residential intellectual disability services
- Provide leadership and support to enable the services develop capacity and capability to deliver on key national patient safety programmes in primary care, social care and acute settings to address internationally recognised causes of harm to people (including HCAI, medication safety, pressure ulcers, falls prevention and nutrition and hydration)
- Develop a national policy framework for Policies, Procedures, Protocols and Guidelines (PPGs) including education training and support and commence the development of a document control system national repository for PPPGs

Service User Experience

- Listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals
- Conduct a service user and patient experience survey in each hospital (in conjunction with Health Information and Quality Authority- HIQA) and commence patient experience surveys in primary care and community services
- Develop and implement a national person-centred care Programme which engages, enables and empowers people to be at the centre of service delivery

- Continue the development of a patient-centred and improvement culture in the HSE that will deliver on sustainable quality improvement with the implementation of a framework for improving quality which provides a structured approach to improving health and social care service delivery by enabling staff to focus on the key drivers for quality improvement
- Continue to develop access to advocacy for all patients and service users within, Hospital Groups and Ambulance Services; work to ensure that advocacy is available to older people in all settings; and provide advocacy services to patients, including work with Patient Focus
- Leading a national person-centred programme (including listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals)

Health Service Reform

The South/South West Hospital Group will continue to establish and develop its governance structures and management teams in line with the Strategic Plans for the Group which will be finalised early in 2016. The arrangements between the Hospital Group and relevant Academic partners will be consolidated and clinical governance structures defined.

Operational Framework – South/ South West Hospital Group Financial Plan

Introduction

The South/South West Hospital Group has received in 2016 a Gross Budget Allocation of €893.1m and an Income Budget of €187.4m, giving a net allocation of €705.7m, inclusive of funding for LRA and Pay Increments.

	2016 Available Budget €m	2015 Opening Budget €m
SSWHG Hospitals	705.7	694.2
Total Available Funding*	705.7	694.2
*Includes once-off allocation of budget		

This allocation does not include:

- ED Taskforce/Winter Initiative
- Maternity Services Strategy Posts
- Portlaoise Recommendations
- WRC Proposals/INMO Agreement
- Full Year Costs of 2015 Developments
- 2016 Approved Developments

Significantly 2016 is the year when the funding model is migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for public hospital care covering inpatients and day-cases.

Breakdown of the ABF allocation by Hospital is attached at Appendix I.

National Incoming Deficit

In 2015 the National Acute Hospital Division spent some €150m more than their available budget delivering services. While it is acknowledged that the 2016 letter of allocation includes €100m to support this level of service delivery, there is a residual unfunded amount of €50m. The figures are shown below and it is believed that cost containment plans can deliver savings in the region of €33m to €43m against this shortfall.

			Measures to address shortfall – range: stretch to best case	
Opening 2015 Funding Shortfall – Before savings measures proposed	€m		From €m	To €m
Current 2015 funding level	4,011.1			
Winter Plan 2015 funding	9.0			
Provision of 2015 deficit funding in 2016	100.0			
Funding relevant to 2015 spend	4,120.0			

Opening 2015 Funding Shortfall – Before savings measures proposed	€m		Measures to address shortfall – range: stretch to best case	
			From €m	To €m
Projected 2015 spend (excluding waiting list initiative)	4,170.0			
Opening 2016 funding shortfall / measures to address	50.0		32.6	43.5

In order to deliver the same volume of service as 2015, the HSE have discounted the offered prices to hospitals by 2% compared with their existing cost level for 2015. This discount applies before any incremental costs related to 2016 are factored in. This discounted price will pose a clear challenge to the hospitals in the SSWHG as it equates to a figure of approximately €11.4m.

Existing Level of Service / Cost pressures

The cost of providing the 2015 level of service will grow in 2016 due to a variety of factors. Under Activity-Based Funding cost growth is considered under two headings - 'price' and 'volume'.

1. We know that we will have 'price' effects in the following areas. This means that our underlying price will rise, but we will not obtain any additional service for that expenditure:-
    - National pay agreements
    - Public pay policy requirements such as increments
    - Quality and safety requirements
    - New drugs and improved medical technologies
    - Supplier price increases, and potentially some price savings if oil prices translate into our energy bills

2. In addition to the 2015 level of service we know that we will have 'volume' pressures in 2016 due to the nature of our demographic, over 85 population etc. Our challenge in this context is that the ABF targets have been locked with a price to fit within the funding envelope. Those targets are based on the rolling 12 months to the end of October 2015. We do not have funding to exceed that level of service - and in fact we have already discounted by 2% the prices available.

We must not grow volume in 2016 as this will lead to increased non-pay expenditure on bloods, laboratory, medical consumables etc. It can also lead to increased expenditure on variable pay such as overtime. Further to these price and volume pressures, we have a very challenging Income Budget/Target of €187m for 2016. This includes an additional €9.3m challenge that relates to historic income-collection targets which have now been included in the budget.

The Group will ensure that appropriate management effort and attention is applied to maximising the delivery of the savings measures proposed and in the overall budgetary performance of the hospitals. Thereafter the HSE and the Department of Health have acknowledged the shared risks inherent in the extent of the savings.

The Financial Control framework for 2016 will consist of four major components:-

1. Headcount and other pay controls
2. Management of activity∞ volume and clinical non-pay

3. System-wide approach to non-clinical non-pay
4. Maximising delivery of income targets

1. Headcount and other pay controls

Following a number of years of economic recession, the hospital system did fill a range of risk-related posts in 2015 which had been vacant due to the recruitment moratorium. The strategy to deliver the EWTD and efforts to reduce agency premium also involved increases in headcount. It is clear that the financial envelope which is available in 2016 does not allow for any further recovery of vacant posts, and indeed efforts will have to be made to carefully manage staff numbers in line with savings targets - particularly in hospitals which filled significant posts in 2016.

The HSE has already given hospital groups a pay framework for 2016 which will require them to improve the governance of headcount, further specific agency conversion where appropriate and manage expenditure on variable pay at 2015 levels - particularly through controlling activity volumes. This pay framework has been also been given to each hospital within the Group.

2. Management of activity volume and clinical non-pay expenditure

The three critical components of clinical non-pay expenditure are:-

1. Activity volume
2. New drugs and increased volume of existing drugs due to treatment regimes
3. Improved medical technologies

- Increases in workload involve expenditure on consumables, medical and surgical devices, bloods, laboratory etc. The prices which have been offered to hospitals for 2016 under ABF are already discounted by 2% which means that hospitals cannot afford the levels of expenditure already being incurred and must make savings on these. Critically, there is no scope to increase clinical non-pay expenditure by growing volume.

  The monthly performance meetings with the hospitals in the South/South West Hospital Group will focus heavily on the volumes being produced to ensure that these are within the targeted levels for the year which have been locked in place with prices to fit the funding envelope. To the greatest extent practicable and consistent with the safe delivery of services hospitals will deliver services at 2015 levels.

- New drugs are an intrinsic element of hospital systems and good progress has been made in recent years in the area of high-cost cancer drugs supported by the National Cancer Control Program and their protocol-driven reimbursement system. So called 'orphan' drugs such as enzyme replacement therapy can increase expenditure steeply and are among some of the most expensive drugs in the system. Additional funding has been provided in the service plan for this aspect of hospital expenditure.

  Increased volume of drugs is a more difficult issue and can arise due to volume of patients and/or changes in treatment regimes which require more frequent administration of certain chemotherapy drugs. These types of cost will have to be managed carefully in the context of savings targets.

- Improved medical technologies such as the capacity to deliver thrombectomy in stroke care or transcatheter aortic valve implantation can suddenly bring considerable additional costs to the system and these items will have to be isolated and monitored during 2016, given the funding available.

3. System-wide Approach to Clinical Non-pay

   Working with colleagues in other Divisions of the HSE, the Acute Hospital Division and the Hospital Groups will review all areas of non-clinical expenditure to achieve savings.

4. Maximising Delivery of Income Targets

   The changes in legislation in relation to bed designation have allowed the hospital system to increase its income generation. Private patient billing and other income-generation is now supporting service costs to the level of €187m in the South/South West Hospital Group. This is a significant income target and is a considerable increase on the 2015 outturn. The €9.3m accelerated income target is a part of the increased target together with other factors such as an expected 4.55% growth in the private patient market.

   Some hospitals grew their income billing quite significantly in 2015 and the targets set build in a level of this expectation for those hospitals that did not. Work is already taking place to assess the resources and systems available to maximise billing and to share processes and apply resources to assist hospitals to achieve these very stretched targets.

HSE Prioritised Initiatives

A total of €13.1m has been prioritised for new initiatives in 2016 including the opening of newly commissioned units, maternity services, children's hospital developments and blood and organ transplantation. The full year cost of these initiatives in 2017 is €27.3m. This represents an additional investment of €14.4m in 2017 and approval of NSP 2016 is taken as confirmation that these initiatives can be commenced in 2016 on the basis that this additional funding will be provided in 2017.

Furthermore, additional funding has been allocated to NCCP in 2016 - €10m of which €7m is for drugs 2017 FYC €16.4 – which is projected to be available to Acute Hospitals in due course. This additional NCCP funding has been included in table below for completeness.

New Initiatives

	2016 €m	2017 €m	2017 Incremental Funding Requirement €m
Opening of commissioned new units	2.8	5.9	3.1
Maternity services	3.0	9.3	6.3
Hospital service developments	3.0	4.1	1.1
Paediatric service developments	3.8	5.8	2.1
Cancer services	10.0	16.4	6.4
Organ transplantation	0.5	1.9	1.4
Grand Total	23.1	43.4	20.4

Activity Based Funding

As indicated in the Introduction section above, 2016 is the year when we are migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for public hospital care covering inpatients and day-cases. ABF involves a 'revenue' stream being offered to each group/hospital for specified inpatient and day-case activity, together with a block grant for other work. The combined total can be referred to as the budget, but with a very different underlying construction - *if the specified work is not delivered, the ABF revenue will not be paid.* We recognise that we will have to work with exceptions to this principle - for example a serious outbreak in a hospital might prevent them from delivering work; however the core principle is being established:

- A specified price will be paid for each weighted unit of inpatient work and each weighted unit of day-case work up to the limit of the specified activity target
- If specified work is not delivered, ABF revenue will not be paid
- If excess work is delivered further ABF revenue will not be paid

A national envelope of funding has been determined based on the exchequer funding allocation. Inpatient and day case care is being purchased using price and activity volume, with transition adjustments. The remaining activity such as emergency care, out-patients etc will remain in the block grant allocation.

The overarching management approach to ABF within a hospital should be to deliver "efficiency within the financial cap". The Irish health system operates with a financial cap so ABF cannot fund unlimited increases in volume. What it can do, and is doing, commencing in 2016, is to reward those hospitals that clearly have unit costs below the national average.

Conclusion

The South/South West Hospital Group is facing a significant financial challenge in 2016. While we are fully committed to delivering on our service plan targets and fully acknowledge the requirement to operate within the funding envelope provided we are also cogniscent of the demographic, regulatory and other service/risk pressures that we will be faced with in delivering a safe and quality service.

Operational Framework – Workforce Plan

Introduction

The South/South West Hospital Group recognises and acknowledges its people as its most valuable resource and key to service delivery. Recruiting and retaining motivated and skilled staff is a high priority for the Group as specialist skills deficits within health care pose a serious threat to the delivery of services and many workforce planning initiatives are in progress to address these concerns. 2016 will see a focus on the "The People Strategy" which has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. This strategy is underpinned by a commitment to engage, develop, value and support people, thereby creating a culture of high trust between management and employees, supporting the achievement of performance. Through supporting and facilitating continuous professional development and learning, embracing leadership and teamwork and accepting and managing change, service delivery and performance will improve. The South/South West Hospital Group will support the implementation of The People Strategy throughout its hospitals.

The Workforce Position

Government policy requires that the number of people employed in Acute Hospital Services is within the limit of the available funding. The management of funding for human resources in 2016 will continue to be based on the Pay bill Management and Control Framework. Compliance with the framework and the requirement for the Group to operate within the funded pay envelope is a key priority, alongside the management of risk and service implications. This approach sees a transition from moratorium to an accountability framework designed to support creation of annual and multi-annual workforce plans based on models of care that will deliver services within allocated pay resources. Hospital Groups that meet budget targets will have greater discretion and flexibility in how they manage their workforce and payroll costs, while ensuring services are delivered in line with the National Service Plan. The Group is currently working collaboratively with the Acute Hospital Division, National HR and Finance to develop a comprehensive workforce plan into 2016 that is closely aligned to funding projections.

Hospitals Employment Levels

The whole time equivalent numbers employed by the acute sector fell significantly during the years of austerity and by October 2015 had returned to 2009 levels. However, over that period there has been a reconfiguration of the skills mix. The data demonstrates a shift in the mix of staff reflecting an increase in medical staffing while there have been reductions in nursing and support services. All hospitals nationally will need to reduce total staff numbers in 2016 to achieve the financial targets contained within this plan. The specific staff levels are identifed in the Group operational plan. The range of adjustment will vary depending upon the outturn for each group in 2015. Where hospitals are achieving a balanced financial position for 2015 current staff numbers may be affordable. Agency costs reduced in between 2014 and 2015 by over €19.5m nationally and this trend is expected to continue in 2016.

Reducing Agency and Overtime Costs

The South/South West Hospital Group will continue to focus on further reductions in the cost and reliance on agency staff and overtime during 2016. This will involve services developing appropriate plans for agency conversion and reduction in overtime expenditure across all services and staff categories, to deliver appropriate and cost effective services.

The Group will continue to monitor and review agency and overtime costs whilst implementing initiatives to reduce costs, such as redeployment, skill mix review, and changes in work practices including the establishment of staff banks.

2016 Developments

The planning, approval, notification, management, monitoring and filling of service development posts will be in line with the existing process for approved and funded new service developments as specified in National Service Plan. Other workforce additions, not specifically funded at the outset of the year, will be implemented only where offset by funding redirection within the allocated pay envelope.

Public Service Stability Agreements 2013-18

The Lansdowne Road Agreement 2015 will build upon the agreement set out in the Haddington Road Agreement (HRA) until 2018. This includes an extension of the enablers, such as additional working hours, to support reform, reconfiguration and integration of services. This will also involve skill mix initiatives, systematic review of rosters, de-layering of management structures, restructuring and redeployment of existing workforce, new organisation structures and service delivery models. The new agreement includes a strengthened oversight and governance arrangement for dealing with matters of implementation and interpretation in the event of disputes that may arise. The South/South West Hospital Group will implement actions agreed under the Public Service Agreements 2013–2018 through which change is achieved and is a central element of the strategy for recovery and a sustainable future for acute hospital services.

The key enablers, such as additional working hours, that existed under the HRA up to now will remain for the duration of the extended agreement and will continue to assist clinical and service managers to manage their workforce through the flexibility measures contained. These enablers will support the reform, reconfiguration and integration of services and contribute to delivering a workforce that is more adaptable, flexible and responsive to needs of the services, while operating with lower pay expenditure costs and within allocated pay envelopes.

The HRA continues to provide the necessary enablers to allow for:

- Workforce practice changes
- Reviews of rosters, skill mix and staffing levels
- Increased use of productivity measures
- Use of redeployment mechanisms
- Greater use of shared services and combined services focused on cost effectiveness and cost efficiencies

In 2016, as per the Final Agreement for Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement the following tasks will transfer from Medical to Nursing staff in line with associated National Framework and Task Transfer Verification Process (December 17th 2015):

- Peripheral cannulation
- Phlebotomy
- Intra Venous drug administration — first dose; including in the appropriate setting
- Nurse led delegated discharge of patients.

Workforce Planning

The South/South West Hospital Group will engage in high quality workforce planning, ensuring that funded workforce plans are developed that are practical, reasonable and aligned to best practice, at both Hospital Group and Hospital level. This will require ongoing review of skill mix requirements and effective staff deployment to manage workforce changes. The funding for these plans will be managed through the Pay Bill Management and Control framework. This will also address the impact of skills shortages, support improved capacity within acute hospitals by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals. There will also be a focus on workforce design based on service design and delivery, driven by clinical care pathways and efficient and effective staff deployment alongside the development of leadership and management competencies.

European Working Time Directive (EWTD)

Through the forum of the National EWTD Verification and Implementation Group, the South/South West Hospital Group the Division continues to work in consultation with the Acute Hospital Division and collaboratively with Irish Medical Organisation, the Department of Health and other key stakeholders to work collectively towards the achievement of full compliance with the EWTD.

Recruitment

The South/South West Hospital Group in consultation with the Acute Hospitals continues to work with national HR to recruit and retain highly skilled Medical and Nursing staff to approved positions to support services.

The Group will support the work of the HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including:

- Developing an agreed Hospital Group strategy for specialties within each Group to meet demand and demography whilst acknowledging neighbouring group services, recognising established national specialties and matching developing national strategies such as the provision of trauma services
- Developing a statement on shared service division within the relevant specialty
- Compiling information on the precise allocation of available facility resources including, for example, allocation staffed theatre time, protected beds, Outpatients (OPD), endoscopy sessions, Non consultant hospital doctor (NCHD) staffing, specialist nursing, allied health staffing and administrative resources

Attendance and Absence Management

The South/South West Hospital Group will continue to maintain and build upon the progress achieved during the past year in improving attendance levels through the consistent implementation of the Managing Attendance Policy and Procedures. The performance target for 2016, remains at less than or equal to 3.5% staff absence rate. In addition, the Group will continue to support the implementation of an agreed performance management framework. In doing so, managers will receive support to manage absenteeism and performance appropriately.

Employee Engagement

As outlined previously, the South/South West Hospital Group will support the implementation of The People Strategy throughout the Group. Particular emphasis will be placed on the employee experience and increased levels of engagement through ensuring that each staff member is aware of how their role links to the organisational objectives.

Efforts will be made to ensure that the "employee voice" is heard and their views considered with appropriate feedback being given, alongside the further development of people management practices. In this context, the South/South West Hospital Group will continue to actively engage with staff and will continuously seek to identify opportunities to involve more staff in planning and decision making. Mechanisms will also be developed to improve effective internal communications to enable timely responsiveness. In addition, discussions between staff and managers, concerning professional and career aspirations will take place, which will inform learning and development.

Health and Safety at Work

In 2016 there will be a corporate emphasis on: reviewing and revising the Corporate Safety Statement, developing key performance indicators (KPIs) in Health and Safety Management and Performance, launching a new statutory Occupational Safety and Health training policy, and developing and commencing a national proactive audit and inspection programme. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established. Improving staff health and wellbeing is also a key strategic priority and education campaigns will include specific information and supports to help staff improve their own health and wellbeing.

Accountability Framework

Introduction

The HSE's Accountability Framework was introduced in 2015 and has been further enhanced and developed for 2016. It sets out the process by which the National Divisions and Hospital Groups will be held to account for their performance in relation to Access to services, the Quality and Safety of those Services, doing this within the Financial resources available and by effectively harnessing the efforts of its overall Workforce.

The key components of the Performance Accountability Framework for the Health Services 2016 as they relate to the acute hospital services are as follows:

- Continued strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group Chief Executive Officers and the CHO Chief Officers
- Completion of Formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers
- A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance
- Continued cooperation with the National Performance Oversight Group with respect to accountability responsibilities with the focus on the balanced scorecard
- Accountability arrangements will be put in place in 2016 between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Operational Business Plans

Accountability Framework

In the second half of 2015 a review of the operation, effectiveness and application of the Accountability Framework was commissioned and completed. The learning from this and recommendations arising will be taken on board during 2016 as appropriate and the acute hospital division will roll out the associated implementation plan once finalised.

The Letter of Determination for 2016 requested that the National Service Plan should detail how the HSE intends to develop and build on the Framework in 2016 including the changes that are required to improve the process and, in particular, the intervention and support processes in place to address areas of underperformance.

Areas for development and improvement during 2016 include:

- The implementation of Improvement Leads and Improvement Teams.
- Partnering of a high performing hospital or service with a poorer performing service as a 'buddy' arrangement to provide advice and support
- Inclusion of a clearly defined timeframe for improvement over the reporting year for services that fail to improve

- Differentiated approach to underperformance in respect of finance
- The application of sanctions for persistent underperformance

As part of the Performance Accountability Framework 2015 an enhanced Escalation and Intervention Framework and process was developed for implementation during 2016. The HSE's Escalation and Intervention Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels.

Accountability Levels relevant to Acute Hospital Services

The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the accountability framework of the HSE. All targets and performance criteria adopted in the service plan will be reported through this framework.

The five levels of accountability (i.e. who is calling who to account) set out in the Framework are described below:

Level 1 Accountability:	▪ The HSE's accountability through the Directorate to the Minister for Health
Level 2 Accountability:	▪ The Director General's accountability to the Directorate
Level 3 Accountability:	▪ National Director accountability to the Director General
Level 4 Accountability:	▪ Hospital Group CEOs accountability to National Director Acute Hospitals. Monitored monthly through Performance Meetings.
Level 5 Accountability:	▪ Service Managers accountability to the relevant Hospital Group CEO. Two Section 38 funded agencies in the SSWHG, i.e. Mercy University Hospital and South Infirmary-Victoria University Hospital. SLA's are in place between these two voluntary hospitals and the SSWHG/HSE. Monitored monthly through Performance Meetings.

Service Arrangements and Compliance

The HSE Acute Hospitals Division provides funding to 16 Voluntary Hospitals, known as Section 38 Agencies for the delivery of a range of healthcare services. There are 2 Voluntary Hospitals in the South/South West Hospital Group.

These agencies are required to enter into a formal Service Arrangement with the Executive. The Service Arrangement is the contract between the Executive and each individual Provider and comprises the general terms and conditions set out in the Service Arrangement and a number of schedules prepared on an annual basis that specify the services to be delivered, budget, staffing, quality and safety, monitoring requirements, etc. Under the Service Arrangement, Providers are obliged to give certain undertakings in relation to compliance with a range of standards and statutory requirements.

Given the level of investment by the State in services provided by the non-statutory sector, the Provider Board must, in respect of the Service Arrangement for 2016 and subsequent years;

- Submit a formal Annual Compliance Statement
- Adopt and implement core governance standards

Delivery of Services

DELIVERY OF SERVICES

South/ South West Additional Key Priorities and Actions to Deliver on Goals in 2016

The South/South West Hospital Group will deliver the following goals in 2016 in association with the Acute Hospitals team.

Goal 1	Promote Better Health and Wellbeing as part of everything we do so that people will be healthier	
Priority Area	Action 2016	Target/ Date
Healthy Ireland	Promoting healthy lifestyle for patients and staff, reduce incidence of disease and support best management of chronic diseases such as diabetes, COPD and coronary heart disease through the development and phased implementation of hospital group *Healthy Ireland* plans.	
	Complete Healthy Ireland Plan	Q1 – Q3
	Maintain tobacco free campuses across all sites	Ongoing
	Appointment of Healthy Ireland Implementation Plan Lead for the Hospital Group	Q3
	Increase the number of hospital frontline staff trained in brief intervention	Q1 – Q4
	Promoting increased uptake of seasonal flu vaccination by hospital staff.	Q1 – Q4
	Implementation of the HSE Policy on Calorie Posting in all hospitals	Q1 – Q4
Improving Patient and Staff Wellbeing	Build on existing good practices and initiatives, identify areas for improvement and implement actions to improve patient and staff wellbeing	Q1 – Q4
	Implement action plan to meet national standards for Nutrition and Hydration, Breast check, Bowel screen and HCAI of patients across the Group.	Q1 – Q4

Goal 2	Provide fair, equitable and timely access to quality, safe health services that people need	
Priority Area	Action 2016	Target/ Date
Capital Developments	Continuing Capital Developments:	
	Paediatric OPD Project CUH Phase1	Q4
	Blood Science Project, CUH	Q2
	Radiation Oncology, CUH	Ongoing
	Helipad CUH	Q4
	Haematology/Oncology Ward Upgrade, CUH	Ongoing
	Oncology Refurbishment HIQA, KGH	Q2
	Theatre Refurbishment KGH	Q2
	Blood Science Project, KGH	Ongoing

	Palliative Care Development, KGH Gastroenterology Centre, MUH Ophthalmology OPD and Theatres, SIVUH New Mortuary UHW Upgrade of Theatres UHW Decontamination Facility, UHW Palliative Care Development, UHW Radiology Extension, STGH Radiation Oncology Phase 2, CUH	Ongoing Ongoing Ongoing Ongoing Q3 Q2 Ongoing Q3 Ongoing
Winter Initiative	Provide additional capacity in line with Winter Capacity 2015/2016: 18 Transitional Beds- MUH 10 additional beds CUH Expansion of ED South Tipp General Hospital – 4 additional bays Develop CIT in UHW and STGH 15 Transitional beds UHW	 Q4 2015 Q4 2015 Q4 2015 Q1 Q1
Improve and Develop Services	Develop Medical Services : • Rapid Access Lung Clinic – Achieve 95% target • AMAU/MAU – Extend service over 7 days in CUH • Implement Rapid Access Prostate Clinic UHW • Peri-operative Service – Expand use of pre-admission assessment clinics • Peri-operative Service – Develop surgical care programme • NQAIS medicine roll out in MUH • Establish anaesthetic and recovery programme for nurses • Establish foundation theatre education programme for nurses • End of Life Care – Appointment of End of Life Co-ordinator • Appointment of Clinical Nurse Specialist – Sepsis Lead • Support roll out of the National Model for Paediatrics and Neonatology	 Q1 Q1 Q1 Ongoing Ongoing Q1 – Q4 Q2 Q1Q1- Q4 Ongoing Q4 2015 Ongoing
Quality	Review the Quality and Safety functions in each hospital in the Group, identifying areas that require improvement and implementing change where necessary. Standardise the processes for dealing with Serious Reportable events across the Group. Appoint Group Quality and Risk Manager. Based on the findings of the HIQA Portlaoise Report the Group will undertake a risk assessment of clinical and corporate governance in each of our hospitals with a view to identifying and stratifying immediate risks and mitigating actions. Continue to implement the *National Standards for Safer Better Healthcare in all hospitals (NSSBHC)* within the Group. Report and publish monthly hospital patient safety statements Co-operate with Quality Assurance and Verification Division on the roll out of Phase Two of the National Incident Management System. Establish defined patient safety and quality framework in all hospitals that will address: • Patient experience/satisfaction • Clinical Governance and Accountability • Performance Monitoring: Incident Reporting	Q1 Q1 – Q3 Q1 Ongoing Ongoing Q1-Q4 Q1-Q4 Q1-Q4

	• Mortality/Morbidity Review • Complaints Management • Service Improvement	
Maternity Services	Progress Maternity Services Developments in South Tipperary General Hospital as recommended in the Flory Report including. • Appointment of Director of Midwifery • Implement recommendations of midwife staffing report, Birth Rate Plus. • Appoint CMS, CMN2, Social Worker and DOM & Bereavement post • Establish maternity clinical network with CUMH as hub. This will involve the appointment of a Group Clinical Director for Midwifery, with responsibility for both services and budget. Implement Portlaoise Report recommendations including: • Appointment of Risk Managers in BGH and MGH • Strengthen BGH and MGH management teams • Appoint Group Quality & Risk Manager • Conclude HIQA Portlaoise self assessments • Finalise Group ICT Plan Implement Phase 1 of the Maternal and Newborn Clinical Management System at Kerry General Hospital and Cork University Hospital. Report and publish monthly maternity patient safety statements. Implement the Maternity Charter which will be informed by the Maternity Strategy. Plan and develop the provision of equitable access to antenatal anomaly screening in all Maternity Units in the context of emerging clinical maternity networks. Develop bereavement specialist teams in all maternity units.	 Q1 Q1-Q4 Q1-Q4 Q1 Q1 Q1 Q1 Q1 Q1 Q2-Q3 Q1 Q1 Q2-Q4 Q1-Q4
Haemophilia Services	Increase resources for Haemophilia services in Cork University Hospital in order to meet service demands with the following: • One Consultant Haematologist • Clerical Support • Physiotherapy Support	Q2
Unscheduled Care	ED reporting mechanism, maximise use of SBAR tool Implement ED ICT dashboards on all sites in line with Emergency Department (ED) Taskforce report recommendations. Hospital Group Standardised Process Admission, Discharge & Transfer Process Hospital escalation process review to be completed Review functionality of all AMAUs Implement visual hospital across the Group Implement Hospital Group Navigation Hub Ensure that targets for PET are achieved Full implementation of Winter Resilience Plan	Q1 Q1 Q1 Q1 Q2 Q2 Q4 Ongoing Q1 – Q4 Ongoing
Scheduled Care	Implement performance management to improve patient access to scheduled care with an increased focus on smaller hospitals managing routine or planned care locally and more complex care managed in the larger hub hospitals. Reorganise hospital group services with an increased focus on smaller hospitals	Ongoing

	Ensure that all hospitals are up to date with their validation of waiting lists	Ongoing
	Monitoring all hospitals to ensure that routine endoscopies are performed in a timely manner and in accordance with national KPIs	Ongoing Ongoing
	Ensure chronological booking of all patients	
	Ensure that all hospitals adhere to the National KPI targets for inpatients and outpatients in line with Outpatient Services Performance Improvement Programme.	Q1 – Q2 Q1
	Cooperate with new KPIs for monitoring cancellation rates and waiting lists for diagnostics	Q1
	Expand MSK triage lists for Rheumatology and Orthopaedics	
	Increase day of surgery rates in line with the National Clinical Programme	Q1 Q3
Cancer Services	Appoint Consultant Oncology Urologist at CUH	
	Ensure that breast cancer KPI target of 95% is achieved- urgent 2 wks/non urgent 12wks	Q3 Q2
	Ensure that lung cancer KPI target of 95% is achieved – urgent 10 working days	Q2
	Ensure that prostate cancer KPI of 90% is achieved – 20 working days	Q2
	Ensure that radiotherapy KPI of 90% is achieved – 15 working days	Q1 – Q4
Reconfiguration of Services	Transfer of prostate cancer services from MUH to CUH	Q1 – Q4
	Transfer of Rectal cancer services from MUH to CUH	
	Transfer of Ophthalmic Outpatient Services from CUH to SIVUH	
Integrated Care Programme for Older Persons	Transfer of Pain Medicine Service from MUH to SIVUH	
	Continue early implementation of the Model for Integrated Care Programme for Older Persons at Cork University Hospital in association with local CHO, Clinical Care Programmes and Social Care Division	Q1 – Q4
Research	Support the development of implementation plans for integrated care pathways across all hospitals in the Group	Q1 – Q4
	Develop and implement Research Strategy for the Group	Q3 – Q4

Foster a culture that is honest, compassionate, transparent and accountable

Priority Area	Action 2016	Target/ Date
Governance	Embed the hospital Group structures across all hospitals in the Group	Q1 – Q4
	Ensure compliance with SLA with Voluntary Hospitals.	Ongoing
	Comply with recommendations from internal audit	Q1-Q4
	Develop the Group Strategic Plan in consultation with the Acute Hospitals Division	Q2
	Consolidate and develop arrangements with the Group's Academic Partners	Q1– Q4
	Develop and maintain relationships with the Group's key strategic partners	Q1 – Q4
Patient Experience	Implement plans to build the capacity and governance structures needed to promote a culture of patient partnership across the Group	Q1 – Q4
	Undertake patient experience surveys in conjunction with HIQA and DOH.	Q3-Q4
	Implement the Pathway for Management of the acute surgical patient	Q3 – Q4
	Support the implementation of the HSE Open Disclosure National Guidelines	Q1 – Q4
	Establish a Patient Council across the Group	Q1 – Q4

National Clinical Guidelines	Maternal and Child Health Services – Implement Children first recommendations Establish Children First Group Implementation Team Continue to support the implementation of the Major Response function in the Group Continue with the implementation of the National Clinical Guidelines • Communication (clinical handover) in Maternity Services, No. 5 • Communication (clinical handover) in Acute Hospital Services, No.11 • Sepsis Management No.6 Develop self audit schedules and follow up action plans in each hospital for • NEWS – National Early Warning Score • IMEWS – Irish Maternity Early Warning Score • PEWS – Paediatric Early Warning Score	Q2 Q1 – Q4 Q1 – Q4 Q1 – Q4 Q1 – Q4
Accountability	Foster a culture of honesty, compassion and patient centred care across the Group. This will be done through: - The ongoing education and training of staff - The audit of care provided - All incidents must be investigated and any learning from outcomes implemented - Timely and appropriate responses to complaints made Develop a performance management framework within the Group Implement the policy on Safe-guarding Vulnerable Persons at Risk of Abuse in conjunction with Social Care Division.	Q1 – Q4 Q1 – Q4 Q1- Q4

Goal 4	Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	
Priority Area	Action 2016	Target/ Date
People Strategy 2015 - 2018	Implement the People Strategy 2015 – 2018 within the Group Develop Staff engagement programmes which aim to involve staff in service delivery planning. Support improved capacity within acute hospitals by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals with current resources. Support the National HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including: • Develop an agreed strategy for specialties within each Group • Develop a statement on shared service division within the relevant specialty • Compile information on the precise allocation of available facility resources for consultant services. Continue to work with National HR on Nursing Recruitment and Retention initiatives. Ensure that health education campaigns will include specific information and supports	Q1 – Q4 Q1-Q4 Q1-Q4 Q1- Q4 Q1- Q4 Q1- Q4

	to help staff improve their own health and wellbeing. Implement the Healthy Workplace Policy and support initiatives to encourage staff to look after their own health and wellbeing. Participate on Working Group to oversee the implementation of the strategy for People with Disabilities as it applies to the HSE. Support the implementation of an agreed performance framework as outlined in the People Strategy 2015 - 2018 Continue the roll out of the Clinical Directorate structure	 Q1- Q4 Q1- Q4 Q1 – Q4 Q1 – Q4
EWTD	Ensure compliance with the EWTD within the Group	Q1 – Q4
Education, Research and Innovation	Further growth and development of Clinical Research in conjunction with UCC and continued work with the Health Innovation Hub Appoint joint Professor of Clinical Nursing – HSE and UCC	Ongoing Q2 - Q3
Learning and Development	New communication initiatives with staff throughout the group to ensure staff are informed regarding the group and directorate activities, opportunities and developments Implement staff engagement initiatives in line with the People Strategy 2015 – 2018 Promote the learning and development of staff in line with the People Strategy 2015 – 2018	Q1 – Q4 Q1 – Q4 Q1 – Q4
Communication	Appointment of a Communication Officer for the group Development of a communications Strategy for the group	Q1 – Q2 Q1 – Q2
Nursing Services	Monitor and report through the Office of Nursing and Midwifery Services: • The number of nurses registered to prescribe medicinal products • The number of nurses registered to prescribe ionising radiation. • The number of ED and AMAU nurses who received clinical skills and competence education to improve patient flow. • The number of overseas nurses who completed a mandatory adaptation programme. Undertake review of Nursing Documentation in conjunction with UCC	Q1-Q4 Q1-Q4

Goal 5	Manage resources in a way that delivers best health outcomes improves people's experience of using the service and demonstrates value for money	
Priority Area	Action 2016	Target/ Date
Green Flag	Expansion of Green Flag programme across the group	Q1 – Q4

Activity Based Funding	Move to the next phase of transition to an Activity based funding model of hospital activity with an initial focus in inpatients and day cases	Q1 – Q4
	All hospitals to complete HIPE coding within 30 days of patient discharge.	Q1 – Q4
Pay—Bill Management and Control	Establish a Pay-Bill management and control framework within the Group and ensure compliance across all hospitals in the Group	Q1 – Q4
Surgery Improvements NQAIS	Continue to use NQAIS to monitor and measure surgical activity across the Group	Q1 – Q4
Acute Medicine NQAIS	Continue to support the development and implementation of NQAIS medicine Support the continuing pilot at Mercy University Hospital	Q1 – Q4 Q1
Health Business Services	Continue to collaborate with Health Business Services to embed and adapt the HBS customer relationship model	Ongoing
ICT	Appoint Group Chief Information Officer – funded through National Chief Information Officer Office	Q2
PSA/HRA/LRA	Continue with implementation and realisation of benefits and enablers under the HRA/LRA national agreements e.g. roster reviews	Q1-Q4
	Establish Local Implementation Group which will oversee the implementation of the Final Agreement of the *Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement December 17th 2015.*	Q2-Q4

Appendix 1: Hospital Group Budget

Table 1: Net 2016 Budget

Hospital Group	ABF Revenue (note 1)	Special Purpose Payments (Note 2)	Income Targets	Total
	€ 000s	€ 000s	€ 000s	€000s
Cork University Hospital	247,418	92,753	-80,481	259,690
Mallow General Hospital	12,980	7,080	-3,850	16,210
Bantry General Hospital	0	19,812	-2,645	17,167
Kerry General Hospital	62,953	25,321	-15,293	72,981
Mercy University Hospital	68,630	24,630	-27,104	66,156
South Infirmary/Vic Univ Hosp	54,688	12,966	-16,927	50,727
University Hospital Waterford	128,614	55,186	-30,112	153,688
South Tipperary General Hospital	42,584	18,340	-9,962	50,962
Kilcreene Orthopaedic Hospital	0	7,709	-1,006	6,703
SSWHG	0	11,440	0	11,440
Total	617,867	275,237	-187,380	705,724

Notes

1. ABF Revenue in this table includes total of DRG based revenue plus adjustments for tertiary referral, specialist paediatric , high cost oncology drug ,agency pay ,transition plus block grant.

2. Special purpose payments include LRA, ED/Winter Plan 2016 and new prioritised initiatives

Appendix 2: HR Information

Hospital Group	WTE Dec 14	WTE Dec 15	Medical/ Dental	Nursing	Health and Social Care Professionals	Management/ Admin	General Support Staff	Patient and Client Care
Cork University Hospital	3462	3611	539	1494	501	432	507	138
Mallow General Hospital	214	224	25	95	17	33	7	47
Bantry General Hospital	237	244	22	100	23	25	20	54
Mercy University Hospital	1000	1008	142	384	121	158	107	96
South Infirmary/Vic Univ. Hospital	738	752	73	288	68	177	108	38
Kerry General Hospital	899	962	130	418	100	133	149	32
University Hospital Waterford	1674	1772	293	693	224	297	202	63
South Tipperary General Hospital	686	732	112	321	63	115	94	27
Kilcreene Orthopaedic Hospital	69	70	9	35	-	5	21	-
SSWHG	14	12	-	-	-	12	-	-
Total Acute Services	8993	9387	1345	3828	1117	1387	1215	495

Appendix 3: Performance Indicator Suite

System-Wide

System-Wide				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Budget Management including savings Net Expenditure variance from plan (within budget) Pay – Direct / Agency / Overtime	M	≤ 0%	To be reported in Annual Financial Statements 2015	0.33%
Non-pay	M	≤0%		0.33%
Income	M	≤ 0%		0.33%
Acute Hospitals private charges – Debtor Days – Consultant Sign-off	M	New PI 2016	New PI 2016	90% @ 15 days by 31/12/16
Acute Hospitals private income receipts variance from Actual v Plan	M	New PI 2016	New PI 2016	≤ 5%
Capital Capital expenditure versus expenditure profile	Q	New PI 2016	New PI 2016	100%
Audit % of internal audit recommendations implemented by due date	Q	New PI 2016	New PI 2016	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received	Q	New PI 2016	New PI 2016	95%
Service Arrangements / Annual Compliance Statement % of number of Service Arrangements signed	M	100%	100%	100%
% of the monetary value of Service Arrangements signed	M	100%	100%	100%
% of Annual Compliance Statements signed	A	100%	100%	100%
HR % absence rates by staff category	M	3.5%	4.19%	≤ 3.5%
% variation from funded staffing thresholds	M	New PI 2016	To be reported in Annual Report 2015	≤ 0.5%
EWTD < 24 hour shift (Acute and Mental Health)	M	100%	96%	100%
< 48 hour working week (Acute and Mental Health)	M	100%	78%	95%

System-Wide				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	New PI 2016	New PI 2016	15% increase
Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	M	75%	75%	75%
Serious Reportable Events % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	M	New PI 2016	New PI 2016	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	62%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	New PI 2016	New PI 2016	90%
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	New PI 2016	To be set in 2016

Hospital Care

Service Area	New/ Existing KPI	Reporting Frequency	Projected Outturn 2015
Activity			South/ South West Hospitals Group
Beds Available Inpatient beds **	Existing	Monthly	2,139
Day Beds / Places **	Existing	Monthly	382
Discharges Activity∞ Inpatient Cases	Existing	Monthly	120,480
Inpatient Weighted Units	New PI 2016	Monthly	118,750
Day Case Cases∞	New PI 2016	Monthly	202,988
Day Case Weighted Units	New PI 2016	Monthly	197,076
Total inpatient and day case Cases∞	New PI 2016	Monthly	323,468
Shift of day case procedures to Primary Care	New PI 2016	Monthly	To be confirmed (National Target – Up to 10,000)
Emergency Care - New ED attendances	Existing	Monthly	190,383
- Return ED attendances	Existing	Monthly	22,032
- Other emergency presentations	Existing	Monthly	22,318
Inpatient Discharges *(Note this section previously detailed Inpatient Admissions but has been modified to align with HIPE data which is discharge)* Emergency Inpatient Discharges	New	Monthly	80,149
Elective Inpatient Discharges	New	Monthly	21,812
Maternity Inpatient Discharges	New	Monthly	18,518
Outpatients Total no. of new and return outpatient attendances	Existing	Monthly	579,649
Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	New PI 2016	Monthly	1 : 2
Births Total no. of births	Existing	Monthly	12,748

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Inpatient, Day Case and Outpatient Waiting Times % of adults waiting < 15 months for an elective procedure (inpatient and day case)	Existing	Monthly	90%	95%
% of adults waiting < 8 months for an elective procedure (inpatient and day case)	Existing	Monthly	66%	70%
% of children waiting < 15 months for an elective procedure (inpatient and day case)	New PI 2016	Monthly	95%	95%
% of children waiting < 20 weeks for an elective procedure (inpatient and day case)	Existing	Monthly	55%	60%
% of people waiting < 15 months for first access to OPD services	New PI 2016	Monthly	90%	100%
% of people waiting < 52 weeks for first access to OPD services	Existing	Monthly	85%	85%
Colonoscopy / Gastrointestinal Service % of people waiting < 4 weeks for an urgent colonoscopy	Existing	Monthly	100%	100%
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	Existing	Monthly	52%	70%
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within 6 hours of registration	Existing	Monthly	67.8%	75%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	Existing	Monthly	81.3%	100%
% of ED patients who leave before completion of treatment	Existing	Quarterly	<5%	<5%
% of all attendees at ED who are in ED < 24 hours	New PI 2016	Monthly	96%	100%
% of patients 75 years or over who were admitted or discharged from ED within 9 hours	New PI 2016	Monthly	New PI 2016	100%
Patient Profile aged 75 years and over % of patients attending ED > 75 years of age **	Existing	Monthly	12.6%	13%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 6 hours of registration **	Existing	Monthly	32.0%	95%
Acute Medical Patient Processing % of medical patients who are discharge ed or admitted from AMAU within 6 hours AMAU registration	Existing	Monthly	65.5%	75%
Access to Services % of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	Existing	Monthly	79.8%	90%
Ambulance Turnaround Times % of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	New 2015	Monthly	New 2015	95%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Health Care Associated Infections (HCAI) Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used	Existing	Quarterly	0.054	< 0.055
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	Existing	Quarterly	2.1	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	Existing	Bi- Annual	86.4	80
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	Existing	Bi- Annual	28	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	Existing	Bi- Annual	87.2%	90%
Hospital acquired S. Aureus bloodstream infection/10,000 BDU **	New PI 2016	Monthly	New PI 2016	<1
Hospital acquired new cases of C. difficile infection/ 10,000 BDU **	New PI 2016	Monthly	New PI 2016	<2.5
Percentage of current staff who interact with patients that have received mandatory hand hygiene training in the rolling 24 month **	New PI 2016	Monthly	New PI 2016	100%
Percentage of patients colonized with multi-drug resistant organisms (MDRO) that can not be isolated in single rooms or cohorted with dedicated toilet facilities as per national MDRO policy **	New PI 2016	Monthly	New PI 2016	0%
Adverse Events Postoperative Wound Dehiscence – Rate per 1,000 inpatient cases aged 16 years+ **	Existing	Monthly	Data not available Q4 2015	TBC
In Hospital Fractures – Rate per 1,000 inpatient cases aged 16 years+ **	Existing	Monthly	Data not available Q4 2015	TBC
Foreign Body Left During Procedure – Rate per 1,000 inpatient cases aged 16 years+ **	Existing	Monthly	Data not available Q4 2015	TBC
Activity Based Funding (MFTP) model HIPE Completeness – Prior month: % of cases entered into HIPE	Existing	Monthly	93%	> 95%
Average Length of Stay Medical patient average length of stay (contingent on < 500 delayed discharges)	Existing	Monthly	7.2	7.0
Surgical patient average length of stay	Existing	Monthly	5.5	5.2
ALOS for all inpatient discharges excluding LOS over 30 days	Existing	Monthly	4.6	4.3
ALOS for all inpatients **	Existing	Monthly	5.5	5.0
Outpatients (OPD) New attendance DNA rates **	Existing	Monthly	12.9%	12%
Dermatology OPD No. Of new Dermatology patients seen **	Existing	Monthly	41,732	41,700

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
New: Return Attendance ratio **	Existing	Monthly	1:2	1:2
Rheumatology OPD No. Of new Rheumatology patients seen **	Existing	Monthly	13,818	13,800
New: Return Attendance ratio **	Existing	Monthly	1:4	1:4
Neurology OPD No. Of new Neurology patients seen **	Existing	Monthly	16,994	16,900
New: Return Attendance ratio **	Existing	Monthly	1:3	1:3
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit **	Existing	Quarterly	67.8%	50%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	Existing	Quarterly	12.1%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	Existing	Quarterly	53.7%	50%
Heart Failure Rate (%) re-admission for heart failure within 3 months following discharge from hospital **	Existing	Quarterly	6.7%	20%
Median LOS for patients admitted with principal diagnosis of acute decompensated heart failure **	Existing	Quarterly	7	6
% patients with acute decompensated heart failure who are seen by HF programme during their hospital stay **	Existing	Quarterly	85.8%	80%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Existing	Quarterly	83%	85%
% of reperfused STEMI patients (or LBBB) who get timely PPCI	Existing	Quarterly	68.4%	80%
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	Existing	Monthly	69.4%	75%
% day case rate for Elective Laparoscopic Cholecystectomy	Existing	Monthly	38.3%	> 60%
Reduction in bed day utilisation by acute surgical admissions who do not have an operation **	Existing	Monthly	10% Reduction	5% Reduction
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	Existing	Monthly	84.5%	95%
Surgery Scheduled waiting list cancellation rate **	New PI 2016	Monthly	New PI 2016	New PI 2016
Hospital Mortality	Existing	Annual	Not Yet Reported	TBC

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition **				
Re-admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	Existing	Monthly	10.8%	10.8%
% of surgical re-admissions to the same hospital within 30 days of discharge	Existing	Monthly	2.0%	< 3%
% of all medical admissions via AMAU **	New PI 2016	Monthly	New PI 2016	35%
Medication Safety No. of medication incidents (as provided to the State Claims Agency) in acute hospitals reported as a % of bed days	Existing	Quarterly	0.12%	≤0.12%
Patient Experience % of hospital groups conducting annual patient experience surveys amongst representative samples of their patient population	Existing	Annual	Not yet reported	100%
Dialysis Modality Haemodialysis patients Treatments Δ **	Existing	Bi-Annual	271,638-275,226	288,096 - 295,428
Home Therapies Patients Treatments **	Existing	Bi-Annual	86,300 -87,161	90,647-93,259
Delayed Discharges No. of bed days lost through delayed discharges	Existing	Monthly	225,250	< 183,000
No. of beds subject to delayed discharges	Existing	Monthly	577	< 500
HR – Compliance with EWTD European Working Time Directive compliance for NCHDs - < 24 hour shift	Existing	Monthly	98%	100%
European Working Time Directive compliance for NCHDs - < 48 hour working week	Existing	Monthly	75%	95%
National Early Warning Score (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	Existing	Quarterly	100%	100%
% of all clinical staff who have been trained in the COMPASS programme	Existing	Quarterly	63.6%	> 95%
Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with full implementation of IMEWS	Existing	Quarterly	100%	100%
% of hospitals with implementation of IMEWS for pregnant patients	Existing	Quarterly	78%	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning Score) **	New PI 2016	Quarterly	New PI 2016	100%
Clinical Guidelines % of maternity units / hospitals with implementation of the guideline for clinical handover in maternity services	New PI 2016	Quarterly	New PI 2016	100%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
% of acute hospitals with implementation of the guideline for clinical handover	New PI 2016	Quarterly	New PI 2016	100%
National Standards % of hospitals who have commenced second assessment against the NSSBH	New PI 2016	Quarterly	New PI 2016	95%
% of hospitals who have completed first assessment against the NSSBH	Existing	Quarterly	80%	100%
% maternity units which have completed and published Maternity Patient Safety Statements and discussed at Hospital Management Team each month	New PI 2016	Monthly	New PI 2016	100%
% of Acute Hospitals which have completed and published Patient Safety Statements and discussed at Hospital Management Team each month **	New PI 2016	Monthly	New PI 2016	100%
No. of nurses prescribing medication	New PI 2016	Annual	New PI 2016	100
No. of nurses prescribing ionising radiation (x-ray)	New PI 2016	Annual	New PI 2016	55
COPD Mean and median LOS (and bed days) for patients admitted with COPD **	Existing	Quarterly	7.6 5	7.6 5
% re-admission to same acute hospitals of patients with COPD within 90 days **	Existing	Quarterly	27%	24%
No. of acute hospitals with COPD outreach programme **	Existing	Quarterly	15	18
Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	Existing	Bi- Annual	27 Sites	33 Sites
Asthma % nurses in secondary care who are trained by national asthma programme **	New PI 2016	Quarterly	New PI 2016	70%
No. of asthma emergency inpatient bed days used **	New PI 2016	Quarterly	New PI 2016	3% Reduction
No. of asthma emergency inpatient bed days used by <6 year olds **	New PI 2016	Quarterly	New PI 2016	5% Reduction
Diabetes Number of lower limb amputations performed on Diabetic patients **	Existing	Annual	Not Yet Reported	≤488
Average length of stay for Diabetic patients with foot ulcers **	Existing	Annual	Not Yet Reported	≤17.5 days
% increase in hospital discharges following emergency admission for uncontrolled diabetes. **	New PI 2016	Annual	New PI 2016	≤10%
Epilepsy Reduction in median LOS for epilepsy inpatient discharges **	New PI 2016	Quarterly	New PI 2016	2.5
% reduction in the number of epilepsy discharges **	Existing	Quarterly	11.4%	10% Reduction
Blood Policy No. of units of platelets ordered in the reporting period **	Existing	Monthly	21,000	21,000
% of units of platelets outdated in the reporting period **	Existing	Monthly	<5%	<5%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
% usage of O Rhesus negative red blood cells **	Existing	Monthly	<14%	<14%
% of red blood cell units rerouted to hub hospital **	Existing	Monthly	<4%	<4%
% of red blood cell units returned out of total red blood cell units ordered **	Existing	Monthly	<1%	<1%
Reportable events % of hospitals that have processes in place for participative engagement with patients about design, delivery & evaluation of health services **	New PI 2016	Annual	Data not due to be reported until Q2 2016	100%
Outpatients (OPD) % of Clinicians with individual DNA rate of 10% or less **	New PI 2016	Monthly	New PI 2016	70%
Ratio of compliments to complaints **	New PI 2016	Monthly	New PI 2016	TBC
National Cancer Control Programme				
Symptomatic Breast Cancer Services No. of patients triaged as urgent presenting to symptomatic breast clinics	Existing	Monthly	16,800	16,800
No. of non urgent attendances presenting to Symptomatic Breast clinics **	Existing	Monthly	23,500	24,000
Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals **	Existing	Monthly	16,100	16,000
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals	Existing	Monthly	96%	95%
Number 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. offered an appointment that falls within 12 weeks) **	Existing	Monthly	19,300	22,800
% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)	Existing	Monthly	82%	95%
Clinic Cancer detection rate: no. of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer **	Existing	Monthly	>1,100	>1,100
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer	Existing	Monthly	11%	>6%
Lung Cancers No. of patients attending the rapid access lung clinic in designated cancer centres	Existing	Monthly	3,300	3,300
Number of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres **	Existing	Monthly	2,800	3,135
% of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	Existing	Monthly	86%	95%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Clinic Cancer detection rate: Number of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer **	Existing	Monthly	>825	>825
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer	Existing	Monthly	29%	>25%
Prostate Cancer No. of centres providing surgical services for prostate cancers **	Existing	Monthly	8	7
No. of patients attending the rapid access clinic in cancer centres	Existing	Monthly	2,600	2,600
Number of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres **	Existing	Monthly	1,630	2,340
% of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres	Existing	Monthly	62%	90%
Clinic Cancer detection rate: Number of new attendances to clinic that have a subsequent diagnosis of prostate cancer **	Existing	Monthly	>780	>780
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of prostate cancer	Existing	Monthly	38%	>30%
Radiotheraphy No. of patients who completed radical radiotherapy treatment (palliative care patients not included) **	Existing	Monthly	4,900	4,900
No.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 **	Existing	Monthly	4,153	4,410
% 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)	Existing	Monthly	84%	90%
Rectal No. of centres providing services for rectal cancers **	Existing	Monthly	13	8

** *KPIs included in Divisional Operational Plan only*

∞*Discharge Activity in Divisional Operational Plan target 2016 are based on ABF and weighted unit (WU) activity supplied by HPO. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU*

Δ *Dialysis data includes all hospitals, contracted units and Home therapies*

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that were completed in 2014 / 2015 but not operational, projects due to be completed and operational in 2016 and also projects due to be completed in 2016 but not operational until 2017

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
South / Southwest Hospital Group									
Cork University Hospital	Reconfiguration of existing paediatric outpatients department (OPD) to provide additional isolation facilities in adjacent ward; provision of new paediatric OPD and medical education facility (funded by University College Cork); dedicated leukaemia and cystic fibrosis units within this development.	Q3 2016	Q4 2016	0	6	3.00	5.12	0	0.00
	Extension and refurbishment of existing pathology laboratory to facilitate management services tender [blood science project].	Q4 2016	Q4 2016	0	0	1.00	2.20	0	0.00
South Infirmary Victoria University Hospital, Cork	Refurbishment and upgrade of accommodation to facilitate relocation of ophthalmic surgery from Cork University Hospital.	Q3 2016	Q4 2016	0	0	0.70	2.19	0	0.00
St. Mary's Orthopaedic Hospital, Cork	Upgrade existing ward to facilitate the relocation of OPD, Mercy University Hospital to OPD, St. Mary's Orthopaedic Hospital.	Q3 2016	Q4 2016	0	0	0.70	1.00	0	0.00
University Hospital, Waterford	New decontamination facility for the day unit (endoscopy).	Q2 2016	Q3 2016	0	0	1.00	1.44	0	0.00
	Provision of replacement interventional (angiography) radiology room.	Q1 2016	Q2 2016	0	0	0.50	1.00	0	0.00
Kerry General Hospital, Tralee, Co. Kerry	Extension and refurbishment of existing pathology laboratory to facilitate management services tender [blood science project].	Q3 2016	Q4 2016	0	0	0.30	0.70	0	0.00
Mercy University Hospital, Cork	Provision of 18 transitional care beds [Winter capacity initiative].	Q4 2015	Q4 2016	0	0	0.20	1.00	0	0.90
Bantry General Hospital, Co. Cork	Provision of a MAU to enable reconfiguration of acute hospital services.	Q4 2015	Q1 2016	0	0	0.10	1.15	0	0.00
South Tipperary General Hospital	Provision of 4 additional ED treatment places [Winter capacity initiative].	Q4 2015	Q1 2016	0	0	0.10	0.40	0	0.15
	Extension of the radiology department to accommodate a CT (purchased) and future MRI.	Q3 2016	Q3 2016	0	0	1.46	1.96	0	0.00

Appendix 5: Group Activity Targets

Hospital	Inpatients		Daycases	
	Cases	Weighted Units	Cases	Weighted Units
Waterford	20,597	22,607	38,076	44,012
South Tipperary	12,714	9,384	7,656	8,421
Mercy	11,101	13,164	22,850	23,436
South Infirmary-Victoria	5,718	7,904	31,802	34,849
Mallow	4,734	2,513	4,123	5,423
Cork University	45,039	46,608	76,017	57,946
Kerry	15,361	11,804	18,751	18,319
ABF Totals	**115,264**	**113,984**	**199,275**	**192,406**
Bantry	4,323	2,964	2,331	2,585
Kilcreene	893	1,802	1,382	2,085
Non-ABF Totals	**5,216**	**4,766**	**3,713**	**4,670**
SSWHG Totals	**120,480**	**118,750**	**202,988**	**197,076**