UL Hospitals
Oispidéil OL

Operational Plan 2014

Caring, Courteous and Professional

Contents

Mission Statement

''All of the staff of this hospital will work together in a respectful, caring and professional way to deliver the best possible patient experience in a safe and clean environment and in the most effective and efficient way possible. We are committed to achieving this each and every day''

Statement of Values

''Caring, Courteous and Professional''

Statement of Vision

''To be ranked among the top three Irish university hospitals by 2018''

- To treat each patient as we would wish to be treated ourselves
- To provide safe, quality, excellent clinical services equitably
- To foster a culture of continuous improvement in our work
- To deal expeditiously with each patient presenting as an emergency
- To incorporate education and research into everything we do
- To use our resources efficiently and in harmony with the environment
- To make our hospital a place in which we take pride and where people like coming to work

Foreword

UL Hospitals is relatively new organisation that has grown from strength to strength in the past two years. The Minster for Health Dr. James Reilly T.D. established the Mid Western Regional Hospitals Group in January 2012 bringing together the six acute hospitals in the Mid West under a single leadership with the appointment of a CEO.

Since then much has happened. An Interim Board under the leadership of Professor Niall O' Higgins has been appointed, a new executive team recruited and four clinical directorates have been established bringing medical, nursing and managerial leadership together to drive service quality and improvement redefined as UL Hospitals since mid 2013.

The scale and pace of the change programme cannot be underestimated and it is a true testament to all our staff for their patience and commitment to the new organisational delivery models and changes of roles for hospitals sites and individuals. There is a single reason for this and that is the absolute commitment by all to the delivery of quality services to and for our population who are predominately from the counties of Clare, North Tipperary and Limerick but not exclusively.

During 2013, we formalised our relationship with the University of Limerick as our academic partner. During 2014, we intend to progress with the appointment of further joint academic posts in the areas of nursing, radiology and pathology.

2014 is going to be an extremely challenging year for UL hospital as it will be for the entire Health Delivery system.
Our challenge may be different to other areas as we are an organisation in a growth and development phase whilst we continue to struggle with inadequate capacity and facilities to meet all the needs of our patients. This manifests itself predominately at the University Hospital Limerick where patients attending our emergency department, regrettably, can experience unacceptable delays in accessing our services. This is something that we are acutely aware of and remain concerned that the solutions to fully address this are not realisable in the short term. We are developing a new Emergency Department and additional bed capacity on the site of UHL however, by the nature of capital development this will not all happen in 2014. We have developed and continue to refine our acute medical assessment services in an effort to address the issues that manifest themselves in the emergency department. This coupled with timely sub speciality access to outpatient services and the maximum usage of our beds at Ennis, Nenagh and St John's Hospitals will assist with our delays in ED.

Our 2014 Operational plan sets out the actions we intend to take in 2014 to deliver our services in line with the commitments of the Health Service National Service Plan 2014 and UL Hospitals Strategic Priorities 2014 – 2016, based on the funding we have received and all our planning assumptions being realised. There are risks to delivery of our plan which are clearly articulated in the plan. We will monitor closely all the measures and parameters of performance and we may need to adjust our plan if unacceptable variance or trends start to emerge.

2013 was a challenging year for UL Hospitals and we achieved a lot. This was only possible with the hard work and commitment of our staff. We are ambitious and aspire to be in the top three university hospital in Ireland by 2018. We have much to do to achieve this but we are confident that this is a realisable goal for us.

Ann Doherty
Chief Executive Officer
February 2014

Introduction

Context

The Health Service National Service Plan 2014 (NSP2014) was approved by the Minister for Health, Dr James Reilly TD on December 16th 2013. The NSP2014 sets out the type and volume of services that the Heath Service will provide directly and through a range of funded agencies, during 2014. These health and social care services must be delivered within the funding provided by Government and within the stipulated employment levels and is informed by the Department of Health's (DoH) *Statement of Strategy 2011 – 2014* and *Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015*, both of which set out the Government's priorities for the health services. In addition and of significance is that NSP2014 is the first plan published by the Health Services following the publication of the Francis Report (February 2013) and the Keogh Report (July 2013) both of which identified weaknesses in the safety of care delivered to patients in hospitals in the UK. Similar findings were also identified in the investigations into the death of Ms Savita Halappanavar at Galway University Hospital (October 2013).These findings must be at the forefront of all planning for services in 2014.

UL Hospitals

UL Hospitals is the primary provider of acute hospital services to the 400,000 people who live in the counties of Clare, North Tipperary and Limerick. Services are delivered at 6 different sites across the three counties.

- University Hospital Limerick (UHL)
- Ennis Hospital (EH)
- Nenagh Hospital (NH)
- Croom Hospital (CH)
- University Maternity Hospital Limerick (UMHL)
- St John's Hospital Limerick (SJH) (Voluntary)

There is one Model 4 hospital[1], UHL, within UL Hospitals group. UHL is one of the 8 designated cancer centres in the country and is also a designated 24/7 Primary Percutaneous Coronary Intervention (PPCI) centre for STEMIs and a thrombolysis centre for the management of acute stroke. UHL is the only hospital site that has a full 24/7 emergency service and critical care service. There are three Model 2 hospitals[2] in the Group EH, NH, and St John's Hospital, collectively referred to as the JEN Hospitals. All three hospitals have being reconfigured to provide service in line with the Small Hospitals Framework published by government in July 2013. The UMH has up to 5,000 births a year and has a Level 3 Neonatal ICU. CH supports Orthopaedic, Specialist Pain Management and Rheumatology services.

UL Hospitals is governed by an interim Board and an Executive Management Team led by a CEO who reports to the Board. The CEO is also accountable to the National Director Acute Services within the HSE. Delegated authority for the operation of the services is through the National Director Acute Services to the CEO of UL Hospitals.

Our services are delivered across the six sites under the leadership of four clinical directorate teams. Medicine, Peri operative, Diagnostic, Maternal and Child Health. Each Directorate is led by a team of staff bringing Clinical and Managerial expertise together to provide quality driven safe services, focused on the experience and outcomes for the patient/Client, that are aware of cost.

[1] Model 4 hospital provides 24/7 acute surgery, acute medicine and critical care while also providing tertiary care in certain locations

[2] Model 2 hospitals provide selected acute medicine, local injuries, point of care testing, day surgery, radiology, rehabilitation and palliative care

The population we serve

Population	Persons 2006	Persons 2011	Actual change 2006-2011	Percentage change 2006-2011
Clare	111,950	117,196	6,246	5.6%
Limerick City	59,790	57,106	-2,684	-4.5%
Limerick County	124,265	134,703	10,438	8.4%
Tipperary North	66,023	70,322	4,299	6.5%
Mid-West	362,028	379,327	18,299	5.1%
Ireland	4,239,848	4,588,252	384,404	8.2%

The population of the Mid-West has increased by 4.8% from 2006 to 2011. This is less than the national increase of 8.2%. The biggest increase has been in County Limerick (8.4%) with Limerick City showing a decrease of 4.5%. Limerick City as currently defined excludes much of the suburbs.

The number of births in the Mid-West in 2012 was 4,930 (compared with 5,169 in 2011). The Crude Birth Rate for the Mid-West in 2012 was 15.8 per 1,000 of the population which is just slightly lower than the national rate at 16.3 per 1,000.

The Dependency Ratio is used to measure the ratio of dependent persons (adults aged > 65 years and children aged < 15 years) to non-dependent persons in the community. It provides a snapshot view of the age structure of a population at any particular point in time. The Dependency Ratio for the Mid-West is 0.50. This compares with national picture of 0.49 (Census 2011, CSO).

Reforming Our Services

The primary focus in 2013 was on strengthening governance. This was achieved through the full implementation of Clinical Directorates and the new model of corporate and clinical governance. Key areas of patient safety concerns were focused on and a change in how business was done driving efficiency through the creation of a single hospital system, breaking down traditional barriers and the utilisation of the total capacity of the organisation to progress the delivery of targets for scheduled and unscheduled care, implementation of commitments as set out by the National Cancer Control Programme (NCCP) and the National Clinical Care Programmes.

During 2013 progress across a range of operational metrics has been achieved:-

- Improved patient flow between UHL and the JEN hospitals maximising utilisation of all our capacity.
- Average length of stay (ALOS) across the group for both Medicine and Surgical was reduced.
- National targets of no adult should wait more than 9 months and no child should wait more than 20 weeks for scheduled treatment by end of 2013 were achieved.
- National target of no patient waiting >52 weeks for a routine outpatient appointment by end December 2013 – Achieved.
- The group achieved our targets for colonoscopy services.
- We operated within our employment ceiling.
- Despite a number of unfunded cost pressures and a significant increase in activity our closing balance is at 4.1% variance on budget.

In addition we:

- Achieved full Implementation of the Small Hospitals Framework across all three Model 2 Hospitals.
- Implemented a new model of care for acute medicine with the development of Acute Medical assessment Unit and Medical Assessment Units in each of the JEN hospitals.
- Commissioned our new Intensive Care Unit at UHL
- Progressed the development of our infrastructure through an aggressive capital programme.
- Further development of our Board – Launched UL Hospitals interim board and developed board sub committees
- Developed our Strategic Plan 2014-2016.

Our Strategic Plan sets out our four Strategic Priorities which sets the context for our work for the next three years. They are:-

A. To develop **a functioning single hospital across multiple sites** and implement a development plan for new and existing physical facilities to ensure a better patient experience across UL Hospitals.
B. To achieve a **well-governed, quality, safe, efficient service;** support a common understanding of healthcare quality amongst stakeholders; and promote the health and wellbeing of our staff.
C. To **develop our ICT systems** to significantly enhance the efficient delivery of high quality healthcare.
D. In collaboration with our academic partner, The University of Limerick, to **promote clinical education and research** within all disciplines and across UL hospitals such that we become a major international centre for education and research.

Key Priorities 2014

- **Patient safety and quality** across our hospitals is at the centre of all decisions and actions
- Progress the implementation of **standards** for safer and better healthcare
- **Improve access** to services by reducing waiting times for emergency or unscheduled care and elective or scheduled care. This includes continuing to improve access to out-patient and diagnostic services.

  Specific targets include:
  - No adult will wait more than 8 months for an elective procedure (either inpatient or day case)
  - No child will wait more than 20 weeks for an elective procedure (either inpatient or day case)
  - No person will wait longer than 52 weeks for an OPD appointment
  - No person will wait more than 4 weeks for an urgent colonoscopy and no person will wait more than 13 weeks following a referral for routine colonoscopy or OGD
  - 95% of all attendees at Emergency Departments will be discharged or admitted within 6 hours of registration
- Continue to review and strengthen our **governance** especially in relation to QPS
- Continue to develop **optimal care pathway** for differing clinical needs by implementation of the National Clinical Programmes and standards set by the National Cancer Control Programme.
- Develop process systems working towards implementation of the **'money follows the patient'** system of funding provided on a per patient basis.
- **Pursue efficiencies** to ensure we maximise available resources
- Progress the **implementation of our ICT** Strategy with the deployment of a new Patient Information System
- Progress our agenda with the **University of Limerick** with the ongoing development of joint Professorial appointments particularly in Pathology, Radiology and Nursing services
- Progress the recruitment of staff to improve our services

Planning Assumptions 2014

- Patient safety concerns are always priorities and addressed
- Income targets are realisable
- Reduced levels of activity service will meet demand and allow for delivery of national targets
- Savings associated with Haddington Road implementation are deliverable
- Full control of the levers to adjust cost base are available to UL Hospitals, i.e. procurement, recruitment and retention strategies

Summary of Service Quantum

- During 2013, UL Hospitals treated:
    - 48,897 in-patient discharges
    - 42,053 day cases
    - 92,563 Emergency presentations
    - 29,713 Emergency admissions
    - 90,186 Emergency attendances
    - 4,652 births
- Planned levels of scheduled care treatments have been reduced , specifically elective inpatient discharges (3% reduction) and day care attendances (3% reduction)

Health Estate

ULH has an ambitious capital programme. Major development work is currently underway at UHL, NH and EH.

In 2014 we will be:-

- Commissioning new theatres at Nenagh Hospital
- Opening additional beds at UHL
- Opening interim Paediatric ED
- Progressing the current developments underway
    - New ED – 2016
    - Dialysis – 2016
    - New Parkinson, Stroke, Breast and Dermatology building – 2015
    - Education and research facility in partnership with UL 2016
- Secure capital for the development of a maternity hospital on site at UHL
- Implement Single Patient Administration System across six sites (iPIMS)

Money Follows the Patient

From the 1st January 2014, phase one of the Money Follows the Patient (MFTP) approach to hospital funding will be implemented in the 38 hospitals in the country participating in the Case Mix system. This program will be implemented over a number of years. A baseline exercise has been undertaken for a number of selected hospitals to compare actual 2013 activity against target activity and assess variance. University Hospital Limerick is the designated hospital within UL Hospitals to participate at this level. There are a number of limitations for UL Hospitals participating fully in this initiative, mainly, our ICT systems are not of a type and standard to allow full participation in Money Follows the Patient exercises in 2014. Despite this UL Hospitals remains very engaged in discussions regarding the development of Money Follows the Patient and will be in a better position to participate more actively with the introduction and development of our ICT capabilities.

Quality and Patient Safety

Quality & Safety is about delivering effective care to patients, improving quality and protecting people from harm and is all our responsibility and a priority for the UL Hospitals. It is the responsibility of each and every one of us to maintain the quality and safety of services and to promote a culture of continuous quality improvement. This will be achieved through strong leadership, evidence based service delivery within the context of good value for money.

The UL Hospitals Quality and Patient Safety Department will support the four Clinical Directorates in the delivery of quality and patient safety goals. For 2014 we will build on the work commenced in 2013 to focus on the implementation of the national standards for safer and better healthcare through a programme of ongoing self assessment and the development and implementation of associated quality improvement plans.

Priorities for 2014

- Support implementation of the standards for Safer and Better Healthcare
- Strengthen the system of integrated corporate and clinical governance
- Build capacity and provide support to all staff to improve quality and patient safety
- Promote an integrated risk management system including feedback from patients and service users
- Promote an organizational culture of learning to achieve better outcomes and experiences for patients/service users and staff
- Continue initiatives enabling optimum standards of infection prevention and control and hygiene

2014 Actions

Priority Area	Action 2014	End Q	SP
Support Implementation of the standards for safer and better healthcare	▪ Finalise self assessments using the national QA&I Tool and complete QA in relation to same	Q1	B
	▪ Develop and implement quality improvement plans at corporate and directorate level	Q2-Q4	B
Strengthen the system of integrated corporate and clinical governance	▪ Ensure that there are clear governance arrangements in place for all services that accurately reflect accountability, responsibility and authority	Q1 –Q4	B
	▪ Undertake an assurance audit of the TORs of all existing UL Hospitals Committees and implement recommendations from these audits	Q2	B
	▪ Standardise role and responsibilities of QPS Managers within Directorates	Q3	B
	▪ Implement a programme of documented quality and safety "walk rounds"	Q1	A&B
	▪ Evaluate existing governance structures and arrangements	Q3	B
	▪ Establish a relationship with a "buddy Hospital"	Q2	B
	▪ Appoint a Chief academic Offer to the Executive Management Team in partnership with UL	Q2	A
Build capacity and provide support to all staff to improve quality and patient safety	▪ Embed quality and safety as a standing agenda item	Q1	B
	▪ Collect, report and monitor national quality and safety indicators	Q1-Q4	B&C
	▪ Develop and provide a programme of training on quality and patient safety	Q1 –Q4	A&B
	▪ Continue the implementation of the National Early Warning score	Q1-Q4	B
	▪ Strengthen and embed a robust Clinical Audit Programme	Q1- Q4	B
Promote an integrated risk management system	▪ Promote an integrated risk management system	Q1-Q4	A&B
	▪ Appoint Corporate risk manager	Q1	B
	▪ Standardize risk management processes	Q1	B
	▪ Standardize risk registers		
	▪ Establish serious incidence management team	Q2	B
	▪ Embed a robust risk management process through the development of KPIs	Q1	B
		Q1-Q4	B
Promote an organizational culture of learning to achieve better outcomes	▪ Develop a process to ensure that all quality and safety reports are reviewed by the relevant governing committees	Q1-Q4	B&C
	▪ Appoint Patient Advocacy and Liaison Manger	Q1	B&C

Priority Area	Action 2014	End Q	SP
and experiences for patients/service users and staff	▪ Evaluate complaints policy	Q1	B
	▪ Roll out programme of evaluation of patient/service user experience	Q2-Q4	B
	▪ Undertake training for staff on national healthcare charter	Q2-Q4	B
	▪ Develop and implement a process to ensure that patients/services users are involved in the design and evaluation of services	Q2- Q4	A&B
	▪ Develop a process to ensure that recommendations of incidence/complaints/feedback are implemented and learning is shared	Q2-Q4	B
	▪ Monitor, review and trend reported clinical incidents/complaints/claims from each directorate for each quarter and provide feedback to through Quality and Patient Safety Committee	Q1 –Q4	B&C
Continue initiatives enabling optimum standards of infection prevention and control and hygiene	▪ Improving compliance with Hand Hygiene standards through education and audit in line with KPIs for each directorate	Q1-Q4	B
	▪ Implement Care Bundles	Q1-Q4	A&B
	▪ Continuously monitor and assess against hygiene standards in support of continuous quality improvement	Q1-Q4	B
	▪ Develop hygiene services strategic plan	Q3	B

Balanced Scorecard

Performance Indicator	Expected Activity / Target 2014
Macro-environment **Activity** Expected no. of inpatient discharges*	46,521
Expected no. of day case discharges	41,002
Emergency Care - New Emergency Department attendances - Return Emergency Department attendances - Other presentations	 54,274 4531 38,114
Expected no. of emergency admissions**	29,506
Elective Inpatient Admissions	11,405
Outpatient Attendances	190,266
New: Return Ratio	1:2
Expected no. of births	4,732
Access **Inpatient and Day Case Waiting Times** - No. of adults waiting > 8 months for an elective procedure (inpatient) - No. of adults waiting > 8 months for an elective procedure (day case) - No. of children waiting > 20 weeks for an elective procedure (inpatient) - No. of children waiting > 20 weeks for an elective procedure (day case)	0
Colonoscopy / Gastrointestinal Service quality indicator - No. of people waiting > 4 weeks for an urgent colonoscopy - No of people waiting > 13 weeks following a referral for routine colonoscopy or OGD	0
Emergency Care - % of all attendees at ED who are discharged or admitted within 6 hours of registration - % of all attendees at ED who are discharged or admitted within 9 hours of registration - Reduction of trolley waits	 95% 100% 10%
HIQA Tallaght Report - No. of patients who re-attend the ED with the same clinical condition within 7 days - No. of patients being cared for in inappropriate care - % of patients who leave the ED without completing their treatment	 < 5% < 5% < 5%
Outpatients (OPD) No. of people waiting longer than 52 weeks for OPD appointment	0

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

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

The Funding Position

The financial outturn for 2013 was €255.6m for UL Hospitals. Our projected outturn for 2014 equates to €263.6m. The difference between our 2013 outturn and our projected costs for 2014 is €8.0m.

The main items which are contributing to our additional costs in 2014 are primarily attributable to full year costs for continuation of 2013 service developments and provisions for the implementation of a replacement Patient Administration System.

The budget allocation assigned to UL Hospitals for 2014 is €235.6m, which reflects a decrease of €9.877m or 4% on our 2013 outturn budget allocation. The 2014 current budget allocation of €235.6m against our 2014 projected outturn of €263.6m results in a financial challenge of €28m which is an 11.9% deficit on the allocation for 2014.

Budget Framework

ESTIMATE 2014	**€m**
UL Hospitals Financial Outturn 2013	**255,600**
UNAVOIDABLE PRESSURES	
Full year additional costs for continuation of service developments and implementation of iPMS	8,000
Total Unavoidable Pressures on Gross	**8,000**
SAVINGS MEASURES	
National Initiatives (Table 1)	(15,398)
HSE Drug Funding (Table 1)	(3,304)
Hospital Initiatives (Table 1)	(2,298)
Total Savings Measures	**(28,000)**
Budget Allocation 2014	**235,600**

REGIONAL BREAKDOWN OF BUDGET FRAMEWORK	**Mid West €m**
Estimate 2014	**255,600**
Unavoidable Pressures	**8,000**
Other	**0**
Savings Measures	**(28,000)**
Net Current Estimate 2014	**235,600**

Income

In 2014, National HSE has a target for increased revenues from private inpatients in public hospitals through revised billing arrangements for private patients, which has been facilitated through the Health Amendment Act 2013.

An increased income budgetary target of €4.9m has been set for UL Hospitals. The ability to realise any of this additional income is significantly dependant on private insurance levels remaining at current levels.

Pay and Pay Related Expenditure

In July, 2013 the Haddington Road Agreement came into effect for UL Hospitals staff. A total budgetary saving of €8.2m has been applied to the UL Hospitals in respect of this public service agreement for 2014. Delivering against these budgetary target is a central component of UL Hospitals overall budget plan for 2014.

In addition to this public sector agreement, payroll budgetary savings of €585,000 and €417,000 have also been applied in respect of Employment Control Framework (ECF) and Incentivised Career Break (ICB). The hospitals ability to deliver on these budgetary targets is highly dependent on National HSE Schemes being implemented to facilitate these anticipated reductions whilst also ensuring that staffing levels remain at adequate levels to provide safe and professional care and services with UL Hospitals. These budgetary targets will be a significant challenge for UL Hospitals.

Non Pay Expenditure

Non Pay Expenditure for UL Hospitals is projected at 32% of total gross expenditure for 2014. The Hospitals has a substantial reliance on National Procurement to ensure that best prices are available for nationally procured items. Within UL Hospitals a target has been established in respect of non pay expenditure. Controlled stock levels, management of medical inflation and negotiation with supplier (not under national contracts) are anticipated to realise financial savings throughout 2014.

Financial Allocation

Income and Expenditure 2014 Allocation Breakdown	Pay €m	Non-Pay €m	Income €m	Total €m
Mid - West				
UL Hospitals	**202,198**	**94,531**	**(61,686)**	**234,861**

Financial Performance

Financial Performance for UL Hospitals is monitored by the interim Board of Directors and the Executive Management Team through monthly management accounts, reporting actual financial performance against budget allocations. Financial performance is also monitored at directorate level and sub-speciality level. Pay and Non Pay expenditure is also monitored through various sub committees namely, Vacancy Approval Committee, Medical and Surgical Committee and Drugs and Therapeutic Committee. Routine stock levels are also monitored closely. Income performance is also examined closely and in particular income collection rates from the various insurance providers.

Cost Containment 2014

UL Hospitals in 2014 is projecting actual net expenditure to be €263.600m versus a current year budget allocation of €235.600m resulting in financial shortfall of €28m. This projected shortfall will be a significant challenge for UL Hospitals in the year ahead.

Financial Challenge

UL Hospitals	€'000
2013 Run Rate	255,600
2014 Requirement	263,600
2014 Allocation	235,600
Challenge	**28,000**
%	**11.9%**

Cost Reduction Measures

A UL Hospitals Cost Containment Plan has been developed to determine how the projected shortfall of €28m can be potentially bridged. This cost containment plan is not without significant risk and a number of the items included in the plan require National enablers to facilitate delivery.

UL Hospitals	€'000	€'000
Projected Budget Shortfall 2014		**(28,000)**
National Initiatives		
Patient Income*	4,991	
EU Patient Income	347	
2013 National Procurement Savings **	1,159	
Critical Care Block	3,000	
Bed capacity full year	500	
Haddington Road Agreement	7,257	
Consultants New Entrants	356	
Consultants Rest Days	258	
Employment Control Framework	586	
Incentivised Career Break	417	
Other	27	18,898
HSE Drug Funding		
Infectious Diseases ***	1,092	
Community Oncology Drugs ***	212	
Community Enzyme Replacement***	2,000	3,304
UL Hospital Initiatives		
Cost Management of Clinical Service Contracts	1,000	
2012 Price Reductions	700	

UL Hospitals	€'000	€'000
Service Contract Savings	200	
Controlled Infusion Levels	250	
Controlled Orthopaedic Levels	500	
Other Measures including staff efficiencies****	1,148	
Provision Releases*****	2,500	5,798
Sub-total		**0**

Table 1 – CCP 2014

* *National HSE estimate of potential income to be realised.*

** *Procurement savings are significantly reliant on National Procurement delivering.*

*** *Relates to spend that is community related and should be transferred to the Primary Care Division*

**** *To be finalised in conjunction with HSE corporate* (Table 1)

***** *National assistance required to realise these provision releases*

Implementation Challenges/Risks

- Financial assumptions do not deliver and alternative savings will have to be found
- The cost of running the service in 2014 has not been provided for and the cost containment requirements may be unachievable and have a direct impact on service delivery and ability to meet national targets
- Consultant and NCHD recruitment will continue to be unsuccessful
- Nursing recruitment will be unsuccessful
- Unknown consequences of incentivised schemes
- Absence of control of the levers to support success continues i.e. Procurement and Recruitment
- Continued demographic pressures and increase in the demand for service over and above the planned levels
- Non pay inflation continues to rise

The Workforce Position

Our staff are our most valuable asset. Therefore it is important that this important resource is managed effectively to ensure that the maximum benefits for patients is attained. It is also important for UL Hospitals to ensure that our staff are well motivated and that their skills both professional and personal are developed to ensure the best clinical outcomes for patients and better care environment for patients and work environment for staff.

Employment Control

The Employment Control Framework requires the health sector to maintain the general moratorium on recruitment and promotion in place since 2009. All recruitment decisions to fill vacancies are the subject to rigorous assessment, control and compliance requirements which have now been devolved to the Hospital Group to allow for employment decisions being made as close as possible to the point of service.

The ECF required the workforce in the UL Hospitals to reduce in 2013 with an approved WTE Ceiling in December 2013 of 2943. This number will be adjusted to take account of the additional 30 WTE set out in the 2013 National Service Plan. The requirement to reduce our WTE's will continue in 2014 with a requirement for a further reduction to meet the targets on public sector numbers. We are currently awaiting clarification on the exact reduction for 2014.

Over the past year the reduction in our WTE has seen us reduce from a WTE outturn figures of 3021 to an outturn figure of 2974 in December 2013

Our normal retirements for 2013 were significantly reduced mainly due to the accelerated retirements in early 2012 and previous exit schemes over the past years. For 2014 a reduction of out WTE will need a strategy to focus on creating further efficiencies that will in turn provide us with an opportunity to offer staff the Voluntary Redundancy Facility. The primary focus has to remain on redeployment, restructuring and reorganisation of the current workforce to deliver services within the budgetary and workforce constraints.

Staff Breakdown by Category

Hospital Group	Area	Medical / Dental	Nursing	Health & Social Care Profess-ionals	Management / Admin.	General Support Staff	Other Patient & Client Care	Total
	UHL	268	707	249	290	151	187	**1852**
	Ennis Hospital	14	99	21	34	14	35	**217**
	Nenagh	16	86	12	30	9	34	**187**
	UMHL	27	196	2	24	23	29	**301**
	Croom Hospital	18	69	2	14	11	37	**152**
	St. John's Hospital	17	111	20	59	34	25	**265**
	Total	**360**	**1268**	**306**	**451**	**242**	**347**	**2974**

Employment Ceilings

UL Hospitals	Ceiling Dec 2013	Dec 2013 outturn	Additional prioritised posts 2013	Ceiling Dec 2014
Total:	2943*	2974	30	2934*

* not including 30 additional posts provided for in NSP 2013

Public Service Reform

The single hospital and its management by directorates require a new level of flexibility that has not been required or experienced in the hospitals heretofore. During 2013, the Group used the PSA process to achieve a number of its objectives:

- The development of a single nursing structure across the hospital group, the redeployment of staff from Ennis and Nenagh hospitals.
- The introduction of the recommendations of the Smaller Hospital Framework in both Ennis Hospital and St. John's Hospital.
- As part of our single hospital laboratory aim the laboratory staff in Nenagh were redeployed to University Hospital Limerick.
- Further reorganisation of the support functions is also ongoing with the unions under the PSA.
- The commencement of the reorganisation of the clerical/admin resources, including a central referrals office.

The *Haddington Road Agreement* came into effect in July 2013, this has brought additional hours for a number of staff grades within the hospital, including Medical, Nursing, Clerical/Admin and Health & Social Care Professional into the system. Both the *Public Service Agreement and the Haddington Road Agreement* continues to have an overarching impact on Human Resources and Workforce Management across Health Services. Along with reducing staffing resources in UL Hospitals, the challenge will be to maintain access, quality and safety of services, to meet the increase in demand for services.

Maintaining staffing levels at the approved WTE ceiling is also subject to financial affordability. This will require robust employment control, with accountability from all services managers. Further reconfiguration and reorganisation of existing work and redeployment of current staff as provided for under the PSA through a consultative process will continue to achieve the employment control framework and deliver on government policy on public service numbers within the current budgetary allocation.

Recruitment

Recruitment will be confined to new service developments and the filling of vacancies following critical analysis. The scale of new service developments is important to improve patient quality and is significantly up on recent years and has to be delivered within employment target reductions. Recruitment cannot compromise adherence to budgets and to financial sustainability, as well as the achievement of compliance with the end-of-year employment ceiling. Robust approval processes for all recruitment is a prerequisite and is now in place. All recruitment will be delivered through the National Recruitment Services or under licence from them.

Absence Management

The national target for absence management remains at 3.5%. Over the past 12 months managers and staff have worked to improve attendance at work across all staff grades. Every effort has been made to continue the focus on all measures to enhance the health sectors capacity to address and manage more effectively absenteeism levels, support people managers in better managing the issue, whilst also supporting staff to regain fitness to work and resume work in a positive and supporting environment. Using the independent audits of our processes which had taken place our focus of attention in 2013 was on those areas with the highest levels in 2012. This has resulted in training with managers on how to conduct return to work meetings and where necessary when to invoke the disciplinary procedure. Our efforts in 2013 proved successful in some areas however other areas were challenged with serious illnesses which hampered their progress. In 2014 we will continue to manage absenteeism aggressively with the aim of achieving the national target of 3.5%. This will be achieved through a change in the delivery of training of managers, ongoing support, closer monitoring and regular audits to ensure compliance with the Managing Attendance Policy. In 2014 we also plan to provide training for managers on how to deal with staff presenting with stress which will be run in conjunction with Occupational Health, Employee Support Services and the Psychology services.

Agency and Overtime Policy

Greater controls on agency and overtime were introduced in 2013 which have focused on reducing the level of both overtime and agency being utilised across all areas within the hospital group. A policy for the hospital group was developed to create greater awareness on this issue and clearly outline the controls to limit the use of agency & overtime. This will result in agency and overtime only being used where no alternative exists for short term need in situation of critical service/safety need. However, in 2013 due to significant gaps in the recruitment of NCHD's and in order to ensure that safe levels of care are maintained UL Hospitals have had to rely on agency and or overtime in certain areas. This will continue pose a challenge in 2014 with many NCHD's positions remaining unfilled thus forcing the service to resort to agency cover.

EWTD

UL Hospitals continues to be committed to the implementation of the European Working Time Directive for Non Consultant Hospital Doctors (NCHDs). An EWTD Steering Group is in place and chaired at Executive Management Team Level and the work of this group will continue to progress and develop the required changes to bring about full EWTD compliance by the end of 2014. Considerable progress was achieved in 2013 with the elimination of 24 hour working across all specialities.
As part of the UL Hospitals commitment to achieving full compliance, the following key priorities for 2014 will include:

- Review of workforce plan across all specialities to support full implementation of EWTD by the end of 2014.
- Establishment and development of the Lead NCHD role to provide formal linkages with NCHDs and Hospital Management.
- Implementation of verification processes on time and attendance patterns as a means of validating compliance within Directorates
- Facilitation and integration of an electronic time and attendance recording system as a means of supporting this validation process

Risks to EWTD implementation

One of the major barriers to successful implementation of EWTD compliance for UL Hospitals is the multi site nature of the services that we deliver. Our services are delivered across 6 sites. Attainment of full compliance will require the recruitment of additional NCHD'S which is both dependant on securing new resources and WTE's to support this.

Governance and Accountability

UL Hospitals is governed by an interim Board and an Executive Management Team led by a CEO who reports to the Board. The CEO is accountable to the National Director Acute Services within the HSE. Delegated authority for the operation of the services is through the National Director Acute Services to the CEO of UL Hospitals.

Acute hospital services are delivered across six sites under the leadership of four clinical directorate teams. Medicine, Peri operative, Diagnostic, Maternal and Child Health. Each Directorate is led by a team of people bringing Clinical and Managerial expertise together to provide quality driven safe services, focused on the experience and outcomes for the patient/Client, that are aware of cost.

Our strategic plan 2014 -2016 informs our corporate annual operational plan. Each Directorate has a detailed business plan that guides the directorate activity for the year. Each directorate has its own trackers and performance indicators that form the basis of management review throughout the directorate and between the directorates.

St John's Hospital, whilst a member of UL Hospitals, continues to have a separate governance arrangement with its own Board of Management, but is financially accountable by way of Service Level Arrangement to the CEO of UL Hospitals.

Control Systems

A number of control systems have been developed during 2013 and they will continue to form part of our governance and assurance arrangements for 2014.

These include:-

- Vacancy Approval Committee
- Drugs and Therapeutics Committee
- Medical and Surgical Supplies Committee
- Medical Equipment and Devices Committee
- Accommodation Committee
- Clinical Governance Committees
- Corporate Risk register
- ICT Governance Committee

Review Process

Performance evaluation and management is a cornerstone in the improvement and more efficient delivery of health services. We are committed to the evaluation and management of performance at all levels. Progress has been made to incorporate links between funding, staffing, service priorities, patient safety and an improved set of activity measures, performance indicators and deliverables in key service areas have been included. This plan sets out information at national, regional and programme level on performance expectations. Performance Indicators (PIs) and agreed targets for activity during 2013 are set out. A set of key performance indicators is represented by the performance scorecard.

A key priority for 2013 is to ensure that financial, workforce and service performance is actively managed and reported in a timely manner. Performance will be measured against agreed plans and managed in the context of cost reduction, absenteeism, achievement of service targets and productivity.
Compstat will continue to support performance management as it continues to be embedded in the operational system. Directorates will be held to account and under-performance addressed. Stringent processes are in place to monitor compliance with plans.

Actions 2014

UL Hospitals Strategic Priorities 2014-2016:

A. To develop a functioning single hospital across multiple sites and implement a development plan for new and existing physical facilities to ensure a better patient experience across UL Hospitals.
B. To achieve a well-governed, quality, safe, efficient service; support a common understanding of healthcare quality amongst stakeholders; and promote the health and wellbeing of our staff.
C. To develop our ICT systems to significantly enhance the efficient delivery of high quality healthcare.
D. In collaboration with our academic partner, The University of Limerick, to promote clinical education and research within a disciplines and across UL hospitals such that we become a major international centre for education and research.

Priority Area	Action 2014	End Q	ULH Strategic Priority
Medicine Directorate			
Cardiac Services	▪ Develop a plan to support the opening of the 2nd CATH Lab	Q3	B
	▪ Complete regionalisation of Heart Failure service	Q2	A&B
	▪ Complete regionalisation of Cardiac Rehabilitation	Q3	A&B
	▪ Continue to provide 24/7 PPCI service and early repatriation	Q1	B
	▪ Establishment of rapid access chest pain clinic	Q2	B
	▪ Develop plan to support data management	Q1	B&C
		Ongoing	C
Acute Medical Programme	▪ Extend AMU function to operate 7/7	Q1	A&B
	▪ Progress the appointment of additional AMP physicians in partnership with national clinical programme	ongoing	A&B
	▪ Implement short stay unit to complement the AMU.	Q2	A&B
	▪ Develop and expand the MAUs at Jen Hospitals	Ongoing	A&B
	▪ Monitor and achieve AMP targets across the Group	Q1-Q4	C
Respiratory	▪ Achieve ALOS reduction for respiratory services	Q2	B
	▪ Reduce ED visits due to Asthma	Q2	B
	▪ Establish Rapid Access Chest Clinic	Q3	B
	▪ Finalise plans for the opening of the new adult CF Unit in 2015	Q3	A&B
	▪ Plan for the development of psychology services for adults in partnership with TLC4CF	Q1	B
	▪ Progress CNS to ANP	Ongoing	B
Dermatology	▪ Finalise plan for regional Dermatology service	Q2	A&B
	▪ Develop regional dermatology nursing service	Q3	A&B
	▪ Progress CNS to ANP	ongoing	B
	▪ Finalise plan for the opening of the new dermatology unit at UHL in 2015	Q3	A&B
Emergency Medicine	▪ Continue to streamline patient flow process in the Emergency Department(ED)	Q1-Q4	A&B
	▪ Establish an ambulance handover area	ongoing	A&B
	▪ Monitor and improve PET times	Q2	B
	▪ Further development of the ICT infrastructure within the ED	Q1	B&C
	▪ Finalise the new paediatric ED area	Q3	B
	▪ Progress development of Paediatric Assessment Unit	Q3	B
	▪ Finalise plans for the opening of new ED (2016)	Q3	A&B
Renal	▪ Continue to expand the number of patients accessing home dialysis therapies Targets 25PD and 4Haemodaylisis	Q4	A&B
	▪ Complete the recruitment process for an additional Renal Consultant	Q3	B
	▪ Finalise in conjunction with Procurement the renewal of the national dialysis service contract	Q2	B
	▪ Review patient transport services	Q1	A&B
	▪ Progress the establishment of specific kidney transplant clinic	Q2	B
	▪ Progress the development of a plasma exchange programme for the Mid West.	Q2	B
	▪ Finalise plans for transfer to new Dialysis unit at UHL (2016)	Q1	A&B
	▪ Further develop CNS roles in renal medicine	Q3	B
Endocrinology	▪ Develop a plan for endocrinology services	Q2	A&B

Priority Area	Action 2014	End Q	ULH Strategic Priority
	▪ Progress the development of the service with additional Medical Manpower ▪ Review and monitor KPI's for diabetic services ▪ Develop CNS role	Q3 ongoing Q4	B B&C B
Rheumatology	▪ Regionalise rheumatology services and resources ▪ Proactively manage infusions services ▪ Monitor and review rheumatology referral to MSK programme	Q2 Q1-Q4 Q1	A&B B B
Neurology	▪ Develop a plan for Neurology Services ▪ Review and monitor KPI's for epilepsy services ▪ Establish a clear rehabilitation programme for patients presenting under 65 yrs ▪ Progress rapid TIA assessment ▪ Progress the development of CNS service for MS Services ▪ Finalise plan for the opening of new dedicated stroke unit in 2015. ▪ Finalise plan for the opening of new dedicated Parkinson's service in 2015	Q2 Q4 Q2 Q3 Q3 Q3 Q3	A&B B&C A&B A&B B B B
Elderly Medicine	▪ Establish Clinical operations Group for Older People Services ▪ Further develop frail elderly pathway ▪ Develop and monitor KPIs for Older People Services ▪ Develop elderly care services at St John's Hospital, Limerick	Q1 Q3 Q1 Q3	A&B A& B B&C A&B
Gastroenterology	▪ Develop regional gastroenterology service and appoint clinical lead ▪ Recruit permanent Consultant Gastroenterologist	Q1 Q3	A&B B
Infectious Diseases	▪ Strengthen OPAT Service	ongoing	A&B

The Medicine Directorate Team responsible for leading the implementation of the 2014 Operation Plan are:

- Dr. Con Cronin, Clinical Director
- Ms. Paula Cussen Murphy, Directorate Manager
- Ms. Mary O Brien, Directorate Nurse Manager
- Mr. Jim Gallagher, Business Manager
- Ms. Una McCarthy, Quality and Patient Safety Manager
- Ms. Joanne McNamara, Management Accountant
- Ms. Cepta Hanley, HR Representative

Peri-operative Directorate

Surgery	▪ Implement the realisable benefits as set out in the national surgical and anaesthetic programme with the increased use of:- o pre operative assessment o day of surgery admission o day case surgery o surgical assessment service	Ongoing	A&B
	▪ Develop and monitor clearance plans to ensure delivery of national targets for PTLs, targeting additional capacity in areas where there is a gap in service provision through the national resources as detailed in the Health Services NSP 2014 (p29)	Q2	B
	▪ Review elective theatre activity across all sites and maximize use of surgical facilities in JEN hospitals	Q1-Q4	A&B
	▪ Expand the Surgical Day Ward capacity at UHL	Q1/Q2	B
	▪ Expand Emergency Theatre service to increase access on Saturdays	Q1	B
	▪ Commission and open new theatre complex in Nenagh	Q3	A&B
	▪ Develop ANP posts to support POA, TV, Orthopaedic services	Ongoing	A&B
	▪ Develop CNS posts to support Tracheotomy care and Urology Services	Ongoing	B
	▪ Audit safe site surgery for all theatres	Q1-Q4	B&C
	▪ Re-establish and develop TPOT	Q1 – Q4	B
	▪ Commencement of surgery in I suite	Q1-Q4	B
		Q1	B

	▪ Work closely with NCSS to further develop Colorectal Screening Programme at:- o Ennis Hospital o Apply for JAG Accreditation for Nenagh o Commence screening at Nenagh Hospital	Q2-Q4	A&B
	▪ Recruit consultant surgeons where vacancies have arisen in Colorectal, Vascular and Orthopaedic services	Q1-Q4	B
	▪ Progress the development of Senior Lecturers(Consultants) in surgery in partnership with UL	Q1-Q4	B&D
	▪ Progress implementation of Diabetic Retinopathy Service in partnership with NCSS	Q1-Q4	B
Anaesthetics/ Pain /Critical Care Services	▪ Continue extension of Critical Care services as a follow through on the commission of the new unit commenced in 2013 (MWRHGSP2013 – 10 ICU/8 HDU beds)	Q1/Q4	B
	▪ Complete Integrate the governance of ICU and HDU	Q2	B
	▪ Commence participation in National ICU Audit Programme and with the appointment of Audit Nurse	Q1	B&C
	▪ Complete development of single Department of Anaesthetics.	Q1	A&B
	▪ Progress the implementation of local referral service	Q2	A&B
	▪ Review pain management services	Q3	B

The Peri-operative Directorate Team responsible for leading the implementation of the 2014 Operation Plan are:

- Dr. John Kennedy, Clinical Director
- Mr. John Doyle, Directorate Manager
- Ms. Kay Chawke, Directorate Nurse Manager
- Ms. Deirdre King de Montana, Business Manager
- Ms. Marie Louise Sheehy, Quality and Patient Safety Manager
- Ms. Helen McCormack, Surgical Access Coordinator
- Ms. Josephine Earls, Waiting List Management
- Mr. David Frawley, Management Accountant
- Ms. Ann Kerwin-Meany, HR Representative

Maternal & Child Health Directorate			
Obstetrics/ Gynaecology	▪ Target necessary patient centred improvements in Maternity Care in line with HSNSP2014 (pg 29) by putting in place safety measures to mitigate risks associated with stand alone hospital by:- o Recruitment of additional Consultant Obstetricians/Gynaecologists o Permanently filling Midwifery Vacancies o Recruitment of Clinical Skills Facilitator	Q2-Q4	B
	▪ Rollout Advanced Midwife and Advanced Nurse Practitioners	Ongoing	B
	▪ Progress plan for moving the service to the UHL campus	Q1	A&B
	▪ Progress implementation of National Maternal and Newborn Clinical Management System (MN-CMS).	Q3	B
	▪ Develop Midwifery-provided ultrasonography services at UMHL	Q3/Q4	B
Neonatology	▪ Create separate on-call rota for neonatal services	Q2	B
	▪ Increase Consultant Staffing to facilitate total rota separation by recruiting additional Neonatologists	Q2	B
	▪ Complete site preparation and development of ANPs in Neonatology	Q4	A&B
	▪ Agree plan for the provision of Peri Natal Pathology services	Q2	B
Paediatrics	▪ Progress the development of community paediatrics in partnership with PCCC by recruiting an additional Paediatrician on a 50:50 basis	Q3	B
	▪ Develop Paediatric Assessment Services in ED	Q2	B
	▪ Roll out the CSII programme	Q1	B
	▪ Enhance Paediatric Day unit facilities to increase the throughput and facilitate rapid access	Q1-Q4	A&B

	▪ Complete site preparation for the development of ANP in Paediatrics ▪ Support a feasibility study on the establishment of a national database for the identification of children with life-limiting conditions	Q3 Q2	B C

The Maternal and Child Health Directorate Team responsible for leading the implementation of the 2014 Operation Plan are:

- Dr. Roy Philip, Clinical Director
- Mr. Frank Keane, Directorate Manager
- Ms. Margaret Quigley, Directorate Nurse Manager
- Mr. Eamon Leahy, Business Manager
- Ms. Teresa O Donoghue, Quality and Patient Safety Manager
- Ms. Eileen Brosnan, Management Accountant
- Ms. Lorraine Rafter, HR Representative

Diagnostics Directorate

Radiology Services	▪ Implement single department of radiology ▪ Develop and commence implementation of manpower plan for department ▪ Develop Clinical Operations Groups for radiology service ▪ Implement NIMIS St John's Limerick ▪ Assess utilisation of all modalities and rebalance workload accordingly across sites ▪ Develop and implement clearance plan for waiting list in U/S and MRI ▪ Review service delivery and develop governance framework for the management of 3rd party SLAs ▪ Measure against departmental KPI's ▪ Increase ultrasound capacity group wide via training programme to up skill radiography staff ▪ Increase MRI capacity via training programme for one radiographer ▪ Continue to develop QA programme for radiology.	Ongoing Q2 Q1 Q3 Q2 Q2 Q2 Q1 Q4 Q1-Q4 Q1-Q4 Q1-Q4	A B&D B A&B A&C B A&B B A&B A&B B
Pathology/ Laboratory Services	▪ Progress the next phase of centralisation of the laboratory's blood sciences project and the associated development of POC or stat services at JEN hospitals ▪ Extend paperless reporting solution ▪ Progress appointment of Consultant Biochemist ▪ Strengthen histopathology services through recruitment and through the development of a strategic alliances ▪ Develop Clinical Operations Groups for Laboratory service ▪ Continue to develop Pathology QA Programme	Q3 Q1-Q4 Q1 Ongoing Ongoing Q1 Q1-Q4	A A A B B A&B B

The Diagnostic Directorate Team responsible for leading the implementation of the 2014 Operation Plan are:

- Dr. Bryan Kenny, Clinical Director
- Ms. Mary Donnellan O Brien, Directorate Manager
- Ms. Gena Nicholas, Radiology Services Manager
- Mr. Kevin O'Connell, Laboratory Services Manager
- Ms. Marti Lotter, Quality Manager Radiology
- Ms. Kathleen Keane, Quality Manager Laboratory Services
- Mr. Tadhg Murnane, Management Accountant
- Ms. Ann Marie Kennedy, HR Representative

Clinical Support Services			
Professions Allied to Medicine	• Strengthen Speech and Language Therapy Services (SALT) ▪ Strengthen Occupational Therapy services (OT) ▪ Commence the development of psychology service for Adult Cystic Fibrosis patients in partnership with TLC4CF ▪ Commence the implementation of single departments of Physiotherapy and Pharmacy for UL Hospitals ▪ Facilitate the clinical placement of Physiotherapy students for UL ▪ Work with the Health Sciences schools to develop clinical placements in SALT and OT	Q3 Q3 Q1 Q2-Q4 Q2 Q1-Q4	B B B A D D
Facilities Management	▪ Review catering services ▪ Redesign and implement a new model for secretariat services	Q2 Q1-Q3	B B
Quality Improvement Programme	▪ Progress the Outpatient Quality Improvement Programme particularly in relation to waiting list management and operational control	Q1-Q4	B
IPMs	▪ Recruit project support team to support implementation	Q2	B&C
National Cancer Control Programme			
Colorectal Cancer	▪ Continue roll out of Colorectal ▪ Recruit 4th Consultant Colorectal Surgeon ▪ Monitor KPIs	Q2 Q3 ongoing	A&B B B&C
Lung Cancer	▪ Sustain and develop Bronchoscopy Service ▪ Ensure the availability of EBUS and ROSE (Rapid on site evaluation) ▪ Monitor KPIs and activity in NCCP Rapid Access Lung clinic	Q1-Q4 Q1-Q4 Q4	B B B&C
Urology Cancer	▪ Monitor KPIs and activity in NCCP Rapid Access Prostate clinic	Q1-Q4	B&C
Supporting Services	▪ Develop the role of HCAs in oncology ward and day unit/ Clinic Develop the role of Advanced Nurse Practitioner in Oncology ▪ Continue to improve the organisation and management of MDTs	Q2 Q3 ongoing	B B&C
Medical Oncology	▪ Develop plan to support the recruitment of a 3rd Medical Oncologist ▪ Continue to strengthen and develop clinical trials portfolio	Q2 Ongoing	B B&D
Breast Cancer	▪ Establish family history clinics ▪ Monitor KPIs and activity in Breast Service and adjust service provision to support demand ▪ Finalise plan for move to new symptomatic breast unit in 2015	Q1-Q4 Q1-Q4 Q2	B B&C A&B
Palliative Care	▪ Participate in Minimum Data Set for Palliative Care in Acute Hospitals ▪ Continue to promote and develop links for Palliative Care needs for non malignant disease ▪ Develop IT links between Milford Care Centre and UHL	Q2 Q4 Q4	B&C B A&B
Daffodil Centre	▪ Develop and open a Daffodil Centre at UHL in conjunction with the Irish Cancer Society	Q2	A
End of Life Care	▪ Participate in the pilot of national End-of-Life Care Audit & Review system ▪ Continuing to progress the 'Design & Dignity' agenda, addressing physical environments in our hospitals: o Complete extension to Mortuary at UHL o Inclusion of EOL Care suite in new ED ▪ Implementation, monitoring and review of Part 4 of the *National Consent Policy which* looks at 'Do Not Attempt Resuscitation' decision-making procedures.	Q1 Q1-Q4 Q2	B&C A&B B

Performance Measures 2014

UL Hospitals			
Expected Service Activity	**NSP 2013 Activity**	**Projected Outturn 2013**	**Expected Activity 2014**
Activity (Monthly) Expected no. of inpatient discharges	48,897	48,897	46,521
Expected no. of day case discharges	42,053	42,053	41,002
Emergency Care - New ED attendances - Return ED attendances - Other presentations	 80,185 10,001 2,377	 80,185 10,001 2,377	 54,274 4,531 38,114
Expected no. of emergency admissions	29,713	29,713	29,506
Elective inpatient admissions	18,817	18,817	11,405
Outpatient attendances	New PI 2014	13,016*	190,266
New: Return Ratio	**	**	1:2
Expected no. of births	4,652	4,652	4,732
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Inpatient and Day Case Waiting Times (Monthly) No. of adults waiting > 8 months for an elective procedure (inpatient)	0	0	0
No. of adults waiting > 8 months for an elective procedure (day case)	0	0	0
No. of children waiting > 20 weeks for an elective procedure (inpatient)	0	0	0
No. of children waiting > 20 weeks for an elective procedure (day case)	0	0	0
Colonoscopy / Gastrointestinal Service (Monthly) No. of people waiting > 4 weeks for an urgent colonoscopy	0	0	0
No. of people waiting > 13 weeks following a referral for routine colonoscopy or OGD	0	0	0
Emergency Care (Monthly) % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	58.4%*	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	100%	75%*	100%
Reduction of trolley waits	New PI 2014	New PI 2014	10%
HIQA Tallaght Report (Quarterly) No. of patients who re-attend the ED with the same clinical condition within 7 days	New PI 2014	New PI 2014	< 5%
No. of patients being cared for in inappropriate care	New PI 2014	New PI 2014	< 5%
% of patients who leave the ED without completing their treatment	<5%	**	< 5%
Outpatients (OPD) (Monthly) No. of people waiting longer than 52 weeks for OPD appointment	0	0	0
Acute Medical Patient Processing (Monthly) % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	95%	Not reported 2013	95%
ALOS (Monthly) Medical patient average length of stay	5.8	4.8*	5.8
Surgical patient average length of stay	5.3	2.7*	5.3
ALOS for all inpatients	5.6	**	5.6
ALOS for all inpatient discharges excluding LOS over 30 days	4.5	**	4.5
Acute Division, contd.			
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Stroke Care (Bi-annually) % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	9%	***	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	50%	***	50%
Acute Coronary Syndrome (Quarterly) % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%	***	70%

Surgery (Monthly) % of elective surgical inpatients who had principal procedure conducted on day of admission	85%	**	85%
Time to Surgery (Monthly) % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%	82%*	95%
Hospital Mortality (Annually) Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	New PI 2014	New PI 2014	National average or lower
Re-Admission (Monthly) % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%	8.2%*	9.6%
% of surgical re-admissions to the same hospital within 30 days of discharge	< 3%	0.8%*	< 3%
Medication Management (Quarterly) % of medication errors causing harm / no harm / death reported to CIS – as a % of bed days or population	New PI 2014	New PI 2014	Hospital variance with national baseline
Delayed Discharges (Monthly) Reduction in bed days lost through delayed discharges	10% reduction	****	10% reduction
Reduction in no. of people subject to delayed discharges	10% reduction	****	10% reduction
Healthcare Associated Infections Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	< 0.060	*****	< 0.057
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used (Quarterly)	< 2.5	*****	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital (Bi-annually)	83.7	******	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used) (Bi-annually)	25	*******	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool (Bi-annually)	90%	********	90%
Patient Experience (Annually) % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	New PI 2014	New PI 2014	100%
Compliance with EWTD (Monthly) - < 24 hour shift - < 48 hour working week	New PI 2014	New PI 2014	100% 100%
National Early Warning Score (NEWS) (Quarterly) % of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	New PI 2014	New PI 2014	95%
% of all clinical staff who have been trained in the COMPASS programme	New PI 2014	New PI 2014	> 95%
National Standards (Quarterly) % of hospitals who have commenced first assessment against the NSSBH	New PI 2014	New PI 2014	95%
% of hospitals who have completed first assessment against the NSSBH	New PI 2014	New PI 2014	95%
MFTP % of HIPE coding episodes completed within 30 days of discharge	New PI 2014	New PI 2014	> 95%
Acute Division (National Cancer Control Programme)			
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Symptomatic Breast Cancer Services (Quarterly) No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals	National Figures 13,200 95%	*********	13,200 95%
Lung Cancers (Quarterly) No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre	2,565 95%	335 **********	2,565 95%
Prostate Cancers (Quarterly) No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	2,673 90%	64 **********	2,673 90%
Radiotherapy (Quarterly) No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	90%	*********	4,546 90%

Corporate Services			
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Finance (Monthly) Variance against Budget: Income and Expenditure	≤ 0%	To be reported in Annual Financial Statements 2013	≤ 0%
Variance against Budget: Income collection / Pay / Non Pay / Revenue and Capital Vote	≤ 0%		≤ 0%
HR (Monthly) Absenteeism rates	3.5%	**********	3.5%
Variance from approved WTE ceiling	≤ 0%	**********	≤ 0%

Membership of Board and Executive Management Team

Board

- Professor Niall O'Higgins, Chairman
- Professor Don Barry, President of University of Limerick
- Dr. Sheelah Ryan, Former Chair of the National Cancer Screening Service Board
- Mr. Maurice Carr, Chartered Accountant
- Mr. Tiernan O'Neill, Principal (Corpus Christi School & Moyross Adult Education)
- Mr. Seumas Gubbins, Chartered Accountant
- Dr. Mary Gray, GP, Corbally Clinic
- Mr. Dara Purcell, Secretary of the Board

Executive

- Ms. Ann Doherty, Chief Executive Officer, UL Hospitals
- Professor Pierce Grace, Chief Clinical Director, UL Hospitals
- Dr. John Kennedy, Clinical Director, Peri-Operative Directorate, UL Hospitals
- Dr. Bryan Kenny, Clinical Director, Diagnostic Directorate, UL Hospitals
- Dr. Roy Philip, Clinical Director, Maternal and Child Health Directorate, UL Hospitals
- Dr. Cornelius Cronin, Clinical Director, Medicine Directorate, UL Hospitals
- Mr. Liam Casey, Chief Operations Officer, UL Hospitals
- Ms. Noreen Spillane, Chief Director of Nursing, Mid-Wifery and Clinical Operations, UL Hospitals
- Ms. Josephine Hynes, Director of HR, UL Hospitals
- Mr. Hugh Brady, Chief Financial Officer, UL Hospitals
- Ms. Breda Duggan, Secretary to the Executive Management Team