



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# National Service Plan

2006

8<sup>th</sup> December 2005



## TABLE OF CONTENTS

<b>1.0</b>	<b>CEO FOREWORD.....</b>	<b>1</b>
<b>2.0</b>	<b>INTRODUCTION .....</b>	<b>3</b>
<b>3.0</b>	<b>POPULATION HEALTH STATUS .....</b>	<b>7</b>
<b>4.0</b>	<b>PRIMARY, COMMUNITY AND CONTINUING CARE SERVICES.....</b>	<b>16</b>
4.1	PRIMARY CARE SERVICES .....	20
4.2	CHILDREN AND FAMILIES .....	25
4.3	SERVICES FOR OLDER PEOPLE .....	31
4.4	MENTAL HEALTH SERVICES .....	36
4.5	PALLIATIVE CARE .....	41
4.6	CHRONIC ILLNESS .....	46
4.7	SOCIAL INCLUSION .....	49
4.8	PERSONS WITH DISABILITIES .....	57
<b>5.0</b>	<b>NATIONAL HOSPITALS' OFFICE.....</b>	<b>65</b>
5.1	AMBULANCE SERVICES .....	77
<b>6.0</b>	<b>CORPORATE FUNCTIONS AND SUPPORTS.....</b>	<b>81</b>
6.1	POPULATION HEALTH.....	82
6.2	NATIONAL SHARED SERVICES .....	92
6.3	HUMAN RESOURCES .....	95
6.4	INFORMATION AND COMMUNICATIONS TECHNOLOGY .....	100
6.5	FINANCE .....	103
6.6	ESTATES MANAGEMENT.....	106
6.7	CORPORATE SUPPORT SERVICES .....	108
	APPENDIX 1: HEALTH AND SOCIAL POLICY STRATEGY DOCUMENTS AND OTHER SOURCES.....	111



## 1.0 CEO FOREWORD

### CEO Foreword

The Health Service Executive (HSE) came into existence on 1<sup>st</sup> January, 2005 following the enactment of the Health Act, 2004 and is the first ever Body charged with managing the operation of the health service as a unified system, bringing together the roles of many agencies that previously operated as separate entities. This process has involved merging 11 organisations and the specialist agencies to be streamlined into one organisation, creating the single biggest employer in the State.

While we know that the benefits of a unified health system are many, including a reduction in the level of fragmentation that has existed in the management and delivery of health care, promoting the harmonisation and equity of all services nationally while providing best care for patients, the challenges which face us in implementing this massive and complex change programme are many.

Patient experiences must be improved. It is vital that our services are delivered in a streamlined and seamless manner and that the way in which people access our services is simplified. In order to achieve this, we must ensure that we work together across the continuum of care. This will require us to work in co-ordinated, multi-disciplinary teams which are responsive to the multifaceted care needs of the people we serve.

Strategic planning and reform implementation are key enablers in ensuring that the HSE's planning and reform / change programme is carried out in a way which takes account of the organisation's size and complexity. I have put in place a Strategic Planning and Reform Implementation Unit (SPRI) which will work closely with service managers at all levels of the system, ensuring that key milestones are achieved.

Strengthened governance arrangements will now be put in place. This will enable further development of a standard approach to the planning and delivery of services and implementation of a streamlined management structure, thereby delivering real benefit.

We have recently published our Corporate Plan which sets out the future direction for the health and personal services for the period 2005 – 2008. This Plan has been prepared against a background of the most significant reform of the health system since the establishment of the Health Boards in 1970, with the principal aim of maximising the level and quality of our services, while delivering a more responsive, adaptable health system that meets the needs of our population effectively and at an affordable cost.

The National Service Plan (NSP) sets out how we will deliver on our Corporate Plan on an annual basis. This is supported by a comprehensive business planning process (inclusive of a performance monitoring framework) that will facilitate its delivery by the Executive, detailing exactly how our plan will be delivered each year. This business model will clearly need to be reviewed and updated as we continue to develop as an organisation.

I believe that we have tremendous potential to provide a world-class service. There are many talented staff involved in service delivery who are passionate and committed to the achievement of this. Additionally, there are many individuals, communities, voluntary, private and other bodies involved in the provision of our health and personal social services. It is only by working in partnership that we can ensure that we will see tangible improvements in the nature and quality of health, and not just health services.

I would like to take this opportunity to acknowledge and thank all our staff for their unstinting dedication and hard work throughout 2005. Although we have experienced major transformation in our structures and organisation during this past year, there has been no disruption or reduction in patients' experience of our services, because staff across the spectrum, from hospital care to care in the community, have continued to focus on the delivery of the best possible care for all. While we will undoubtedly face many challenges as we go forward, I am heartened by the manifest commitment of staff throughout the delivery system, and I am confident that we are ready to meet those challenges and turn them into opportunities in the year ahead.

**Professor Brendan Drumm**  
**Chief Executive Officer**

**8<sup>th</sup> December 2005**

## 2.0 INTRODUCTION

### INTRODUCTION

Under the terms of the Health Act 2004 the Health Service Executive (HSE) is required to prepare a service plan for the financial year in question. The Service Plan is accompanied by a Capital Plan, as required under Section 31 of the Health Act 2004. Once adopted by the Board of the Executive, the Service Plan must be submitted to the Minister for Health and Children for approval, no later than 21 days after the publication by the Government of the Estimates.

This Service Plan outlines the agreed level of health and personal social services to be provided by the Executive for 2006 within the voted allocation of the Oireachtas and the approved employment levels, as established in government policy.

Additional funding of €239.780 million for service developments has also been received. These developments will be undertaken during 2006 on the basis that the HSE receives the appropriate adjustments to its employment levels and the global responsibilities of the Vote holder, as well as the finance governance responsibilities of the Board.

### NATIONAL POLICY CONTEXT AND STRATEGIC FOCUS

Health and personal social services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System For You* (2001).

Additional relevant legislation and national policy documents which govern service provision are listed in Appendix 1.

In October 2005, the Minister for Health and Children formally accepted the HSE Corporate Plan in respect of the period 2005-2008. This Corporate Plan fulfils a number of roles. It outlines the HSE agenda for the period, identifies our response to the National Health Strategy (Quality and Fairness), reflects the policy decisions of our Board and takes cognisance of other national policies and priorities. It maps out the future direction for the health and personal services which will be delivered through the annual National Service Plan and associated business planning process.

Our Corporate Plan has identified the HSE's vision, mission and corporate objectives, mindful of the four goals set out in Quality and Fairness.

#### ▪ VISION

Our Vision is "To consistently provide equitable services of the highest quality to the population we serve."

#### ▪ MISSION

Our Mission for the future is to provide high-quality, integrated health and personal social services built around the needs of the individual and supported by effective team-working.

We will:

- Promote health and empower people to maintain their own health
- Provide easily accessible services
- Take decisions based on evidence
- Deliver the best possible care within available resources

▪ **CORPORATE OBJECTIVES**

In order to deliver on what is expected of us we have developed a set of Corporate Objectives:

**1. We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

This means that our services will be person centred, offering choice wherever possible. We will support individuals and their families to be actively involved in decisions about their health and care. We will develop a consistent approach to access to service throughout the country, based on identified need. We will pursue, develop and implement quality standards throughout our services and foster a culture of review and audit at all levels.

**2. We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

This means that we are fully committed to the implementation of national strategies / policies. We recognise the wide spectrum of determinants of health, and will participate in and support inter-sectoral working at national, regional and local level, to best influence the health of the population. Information and evidence about the health of the population will underpin the planning, design and delivery of our services.

**3. We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

As a new organisation, we seek to ensure that the health services have the right people with the right competencies in the right numbers, organised and managed in the right way to deliver our Objectives and Goals. The development of a Human Resource strategy is a key step for us in doing this.

**4. We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit/Voluntary/Community sector and other stakeholders**

This means that we are committed to listening to and learning from the experience of our service users, partner service providers, staff and other stakeholders. We will actively consult around the planning, delivery and evaluation of our services. We will develop an organisation that maximises the benefits of moving to a unitary system and is committed to strengthening accountability at all levels.

These corporate objectives provide the basis on which all our actions are built.

## PLANNING ASSUMPTIONS

In drafting our service plan for 2006 the following planning assumptions apply: -

- The priority focus is improving patient care, better value for taxpayers money and improved health care management.
- The overall policy framework is that set out in the *National Health Strategy Quality and Fairness: A Health System For You* (2001).
- Population Health themes - While health status in Ireland is at an all time high, there are emerging public health problems which will inevitably impede improvement in health status in the future. The Corporate Plan has identified priorities for improvements in population health. These priorities have also been reflected in this NSP.
- Service delivery will be in keeping with the Existing Level of Service (ELS) principle – service developments will be financed in two ways, either through new development funds which have been specifically allocated to the executive in the vote or through the realignment of existing resources.
- Approved employment ceilings apply.
- Delivering better Value for Money (VFM) is a key objective.
- Supplementary Estimates cannot be anticipated, ongoing contingency arrangements continue to apply.

## ACCOUNTABILITY AND GOVERNANCE

The NSP is supported by a comprehensive business planning process which will facilitate its delivery by the Executive during the year. The planned actions and activity for 2006 outlined in the NSP are necessarily presented at a very high level. Each element of the NSP is supported by a range of Business Plans at regional area and unit level that translate these national actions into specific deliverables at all levels of the system.

We are committed to the further development and promotion of a performance management culture as an integral part of our new unified organisation. This means that we account for our performance in a transparent manner. To ensure that implementation of, and accountability for, the NSP and associated business plans is in place, a standardised Performance Monitoring Framework has been developed. This Framework ensures that at all levels of the Executive we are monitoring the achievement of our objectives within allocated resources and approved employment levels and taking the necessary corrective action as appropriate.

The Framework details timeframes for the completion of defined monthly and quarterly performance monitoring reports. It also outlines the format of these reports, which include both a qualitative and quantitative assessment of our performance by reporting against the objectives and actions outlined in the NSP, activity and performance measures (including the National Performance Indicator Suite) together with financial and human resource performance.

A standardised approach to performance monitoring will enable the Board to oversee the implementation of the NSP in accordance with its legal obligations, and account to the Minister for Health and Children for the provision of the services as specified within the Plan.

**GUIDE TO READING THE NATIONAL SERVICE PLAN (NSP)**

The format and presentation of the NSP is set out in accordance with the National Service Plan Template.

Chapter 3 sets the scene in terms of an assessment of the population profile and an identification of the key population health challenges. Primary, Community and Continuing Care and National Hospitals' Office are set out in Chapters 4 and 5, which open with a brief overview and description of the services. Under each of the HSE Corporate Objectives, specific actions are set out which identify how the service will be delivered during 2006, while responding to the population health challenges (as appropriate).

Each action is referenced back to the HSE's Corporate Plan. The Corporate Plan outlines the HSE agenda for the period 2005 – 2008 and is translated on an annual basis through the NSP. This enables us to monitor our progress against our Corporate Plan on a continuous basis.

Service delivery is supported by a range of Corporate Functions and Support services which are detailed in Chapter 6.

## 3.0 POPULATION HEALTH STATUS

This Service Plan facilitates the implementation of measures to enhance population health. While the health of the population of Ireland has improved substantially over the past 30 years, we still have higher premature mortality than many of our European neighbours. Cardiovascular disease and cancer account for nearly two-thirds of all deaths. Many conditions are lifestyle and social class related, e.g. heart disease, cancer, obesity, injury and infectious diseases. Inequalities in health and social class gradients are major factors in determining health status. This NSP recognises the increasing ethnicity of the Irish population and acknowledges that our services must adapt to the changing needs of our diverse population in a responsive and appropriate way.

### POPULATION HEALTH

A population health approach recognises that health is a resource, that factors outside the health care system significantly affect health, and that delivery of healthcare is only part of what contributes to health.

Investment aimed at improved population health is increasingly seen in developed countries as an economically valuable activity contributing to economic competitiveness and is an important factor of economic success.

This National Service Plan is underpinned by a population health approach, which seeks to promote and protect the health of the whole population, or of subgroups of the population, with particular emphasis on reducing health inequalities. It takes account of the determinants of health and recognises that health is the responsibility of all sectors, communities and individuals. This definition supports the four goals of the National Health Strategy, *Quality and Fairness: A Health System for You (2001)*, and in particular Goal Number 1 of the Strategy – Better health for everyone.

A population health approach underpins the Executive's corporate planning, ensuring a single interpretation of national policy and that health and social interventions are based on best available evidence.

The functions of the Population Health Directorate will enable the Executive to distribute its funding in a manner which reflects best possible return in health terms and, therefore, value for money. This approach will be evident in annual service planning.

A population health approach includes the following:

- Using the best health intelligence for planning, evaluation and performance management.
- Planning for health and not just health services.
- Promoting equity as a strong value in the health system.
- Applying research evidence to improve health outcomes.
- Adopting a formal approach to needs assessment to identify gaps in services.
- Re-orienting service delivery from hospital to primary care and health promotion.
- Providing services which are integrated within the health sector and with those of other sectors.
- Working with other sectors to improve health.
- Demonstrating a better return for society from investment in health.

The adoption and implementation of a population health approach to service planning and delivery is the responsibility of all those who manage and deliver services that impact on the health of the population. The Population Health Directorate will lead and support the implementation of a population health approach and assess the health impact of services.

## **HEALTH STATUS IN IRELAND**

### **DEMOGRAPHY**

The 2002 census recorded a population of 3,917,203 persons in the state, the highest since the census of 1871. It reflects an increase in population of 8% or 291,116 persons since the 1996 census.

In April 2005 the Central Statistics Office estimated that the population exceeded four million persons (4.13 million). This is due to an increase in the number of births and immigration, both of returning Irish nationals and foreign nationals (EU and non-EU), with a welcome increase in life expectancy and a reduction in death rates.

### **BIRTHS**

There were 61,684 births registered in 2004 - 31,817 males and 29,867 females - an increase of 167 on 2003.

The 2004 total is 27% higher than in 1995, when 48,530 births were registered. The 2004 number represents an annual birth rate of 15.3 per 1,000 of the population, 0.2% less than 2003.

In 2004 the Total Period Fertility Rate for Ireland was 1.95, which is below the value of 2.1 which is considered to be the level at which the population would replace itself in the long run, ignoring migration.

A total of 24,125 births (39.8%) were to first time mothers in 2004. Second time mothers had 19,735 births (32.6%) and 27.6% of mothers already had two or more live children.

There were 19,938 (32.3%) births registered as occurring outside of marriage in 2004, an increase of 0.9% on the 2003 figure.

A total of 2,560 teenagers had babies in 2004, of whom 53 were aged less than 16 years.

### **AGE-PROFILE**

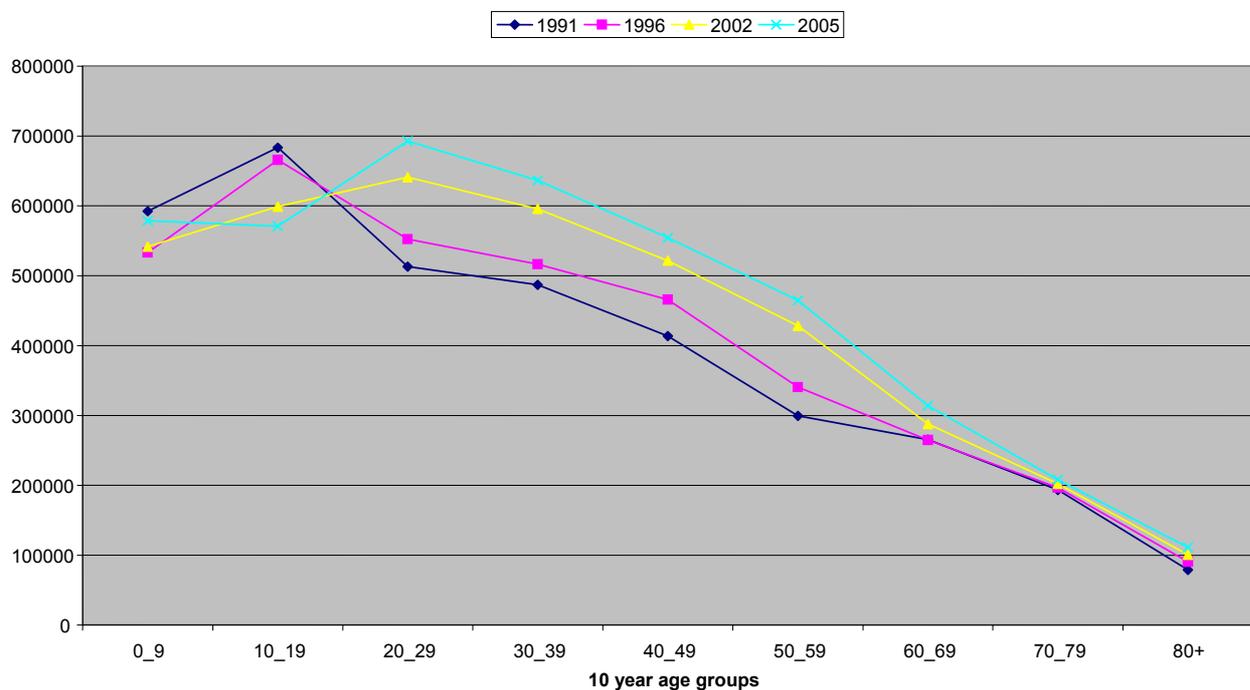
Table 3.0.1 and Figure 3.0.1 show the age distribution for the population of Ireland for 1991 through to 2005. It is apparent that there has been an increase in population numbers in nearly every age group over 20 years since 1991, with the greatest increases in the 50-59 year age group followed by those 80+ years.

TABLE 3.0.1: POPULATION BY AGE 1991-2005

Age Group	Years				% change 1991 - 2005
	1991	1996	2002	2005	
0-9	592,246	533,337	541,720	578,575	-2.3%
10-19	683,354	665,623	598,896	570,719	-16.5%
20-29	512,893	552,399	641,027	692,755	35.1%
30-39	486,960	516,605	595,582	636,599	30.7%
40-49	413,445	465,841	521,588	554,446	34.1%
50-59	299,355	340,454	428,137	464,537	55.2%
60-69	265,318	264,755	287,726	313,792	18.3%
70-79	193,407	196,639	201,944	208,006	7.5%
80+	78,741	90,434	100,583	111,293	41.3%
<b>Total</b>	<b>3,525,719</b>	<b>3,626,087</b>	<b>3,917,203</b>	<b>4,130,722</b>	<b>17.2%</b>

Source: CSO 2005

FIGURE 3.0.1: POPULATION BY AGE 1991-2005



## LIFE EXPECTANCY

Life expectancy at birth in 2002 was 75.1 years for males and 80.3 years for females. Between 1996 and 2002 life expectancy increased by 2.1 years for males and 1.8 years for females. This rate of improvement was the highest recorded in several decades (CSO).

In 2002, a 65 year-old male could expect to live for 15.4 years, an improvement of 2 years or 14.9% over the previous decade. This is above the corresponding EU 15 (EU member states prior to enlargement in 2004) average improvement in the same period of 1.7 years (11.6%).

A 65 year-old female could expect to live 18.7 years, an increase of 1.6 years or 9.4% over the last decade. This is also above the corresponding EU 15 (EU member states prior to enlargement in 2004) average improvement in the same period of 1.5 years (8.2%).

## MORTALITY RATES

The total number of deaths registered in the state in 2004 was 28,151. This figure is 10.6% lower than in 1995 when 31,494 deaths were registered.

**TABLE 3.0.2: NUMBER OF DEATHS IN IRELAND 2004**

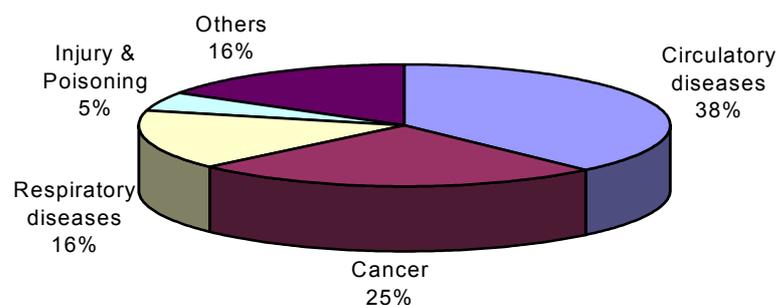
Number of Deaths	2004
Males	14,484
Females	13,667
<b>Total</b>	<b>28,151</b>

Source: CSO 2005

## PRINCIPAL CAUSES OF DEATH IN IRELAND

Disease of the circulatory system is the leading cause of death in Ireland followed by cancer, respiratory diseases and injuries and poisonings (Figure 3.0.2).

**FIGURE 3.0.2: PRINCIPAL CAUSES OF DEATH IN IRELAND**



Source: CSO 2005

While death rates from all causes have been in steady decline (from 8.8 per 1,000 population in 1995 to 7.0 in 2004), most of this decline can be attributed to the improved situation with respect to deaths from circulatory diseases.

Cancer of the lung was the most common type of cancer causing death (21%), followed by colorectal cancer (12%) and breast cancer (8%). Lung cancer was the most common cause of death from cancer in men while breast cancer was the most common cause in women.

Infectious diseases (pneumonia and influenza) and chronic obstructive airways disease are the leading causes of death from respiratory disease in Ireland.

Suicide is the most common cause of death registered under 'injuries and poisonings', followed by motor vehicle accidents and falls. The majority of motor vehicle accident deaths occur in males. For young males aged 15-24 years the most common cause of death is from injuries and poisonings.

## SUICIDE AND DELIBERATE SELF HARM

The number of suicides registered in Ireland in 2004 was 457, and the number of deliberate self harm presentations to Accident & Emergency Departments was 11,204. Whilst Ireland ranks 17<sup>th</sup> out of 24 amongst the EU for overall suicide rate, the rate of

youth suicide (15-24 years) is the 5<sup>th</sup> highest in Europe and 40% of suicides in Ireland are young men under the age of 44 years.

The ratio of male suicides to female suicides is 4.5 to 1. Whilst suicide is largely a male phenomenon, the incidence of deliberate self harm is slightly higher for women than men. 46.9% of presentations are amongst people under 30 years of age.

### **INFANT MORTALITY RATE**

Infant mortality rate is an important indicator of population health. Over the past decade the rate has fallen by 37% from 8.15 per 1,000 live births in 1990 to 4.9 per 1,000 live births in 2004.

### **ILLNESSES REQUIRING HOSPITALISATION**

The Hospital Inpatient Enquiry (HIPE) system is a reliable source of information on illnesses requiring hospitalisation. This records the number of discharges and procedures performed in publicly funded hospitals. Only two private hospitals are included in the system.

Data from HIPE shows that in 2003 there were 930,502 discharges (direct age standardised rate 23,640 per 100,000) from hospitals in Ireland.

Diseases of the digestive system accounted for over 1 in 9 hospital discharges; neoplasms for 1 in 11 discharges and diseases of the circulatory system for 1 in 12 discharges.

### **CARDIOVASCULAR DISEASE**

Diseases of the vascular system, be it coronary (heart), cerebral (stroke) or peripheral vascular (limbs) accounts for four out of every ten deaths in Ireland. Furthermore, for premature mortality from heart disease (under 65 years), Ireland remains at the top of the league table among the EU 15.

Ireland, like most developed countries, has experienced a declining death rate from coronary heart disease (CHD) with 5,648 deaths in 2003 (141.9 per 100,000) compared with 8,326 in 1980 (244.8 per 100,000). Males accounted for 55.9% of deaths in 2003. The trend in mortality decline has been unequal; mortality rates in unskilled male workers are now almost three times higher than professional counterparts.

The declining trend in mortality in Ireland shows that half of the decline is due to a decrease in risk factors, especially smoking, and the second half is accounted for by improved treatments.

With decreased mortality, the pattern has shifted to increasing survival, with increasing numbers who have a high risk of recurrence of symptoms, and an increase in those with heart failure. This presents an increasing burden on Primary and Secondary care services. This, along with an increase in obesity, an aging population and raised prevalence of diabetes, presents major challenges in the fight to bring Irish death rates and burden of cardiovascular illness into line with our European neighbours.

## DIABETES

The incidence of diabetes is increasing in all age groups, particularly among the under 5 year olds for type 1 diabetes, while type 2 diabetes is increasing in all age groups, including children and young adults. The Irish incidence of type 1 diabetes is 16.8 per 100,000, which is above the E.U. average. Over 85% of all diabetics have type 2 diabetes. The prevalence of diabetes in Ireland has been documented as 2 to 7% in the whole population, this rises to 10 to 14% in the over 40 year olds.

Diabetes is associated with significant increased mortality and morbidity, particularly from increased rates of cardiovascular, cerebrovascular and peripheral vascular disease. Diabetes patients also have an increased burden of renal disease and visual impairment, and may present with acute medical emergencies due to poor control.

In 2002 there were 2,091 deaths due to diabetes. In 2003 there were 6,014 hospital admissions with a primary diagnosis of diabetes, and 29,285 hospital admissions of people who suffered from diabetes. Of these, 79% were for type 2 diabetes and 21% were for type 1 diabetes. More than half of all hospital admissions for diabetes are for diabetic complications; ketoacidosis is the most common complication in type 1 diabetes and ophthalmic complications are the most common in type 2 diabetes.

## CANCER

The most recent report from the National Cancer Registry, *Cancer in Ireland 1994-2001* states that on average 20,523 cancer cases were registered each year. A majority of cancers (88%) were classified as invasive, the remainder being mainly in-situ cancers of skin, breast and cervix. The most common invasive cancer was non-melanoma skin cancer (29%). If non-melanoma skin cancer is excluded, the commonest cancer in women was breast cancer (28% of all malignant cancers) and the commonest cancer in men was prostate cancer (21%).

During the same period there was an average of 7,584 cancer deaths each year, about 25% of all deaths. Lung cancer accounted for 20% of cancer deaths (1,499 per year) and was the commonest cause of death from cancer, although breast cancer (644 deaths) caused more deaths than lung cancer (534 deaths) in women.

The number of cancer cases increased by 2.3% annually between 1994 and 2001. This increase seemed to be almost entirely due to changes in the size and age distribution of the population, with very little increase in the underlying risk of developing cancer. However, for some cancers – those of the kidney, prostate, testis and breast – there were significant increases in risk, of the order of 3-5% per annum, while for others – stomach, bladder, larynx, and head and neck there was a significant decrease in risk.

## INEQUALITIES IN HEALTH

While life expectancy has improved over the last 50 years, major inequalities in health continue to exist. Those at the higher end of the socio-economic scale live longer and enjoy better health than those at the lower end, who are also more likely to experience the effects of social exclusion.

While death rates in Ireland have fallen over the past 50 years amongst men and women in all socio-economic groups, the difference in rates between those at the top and bottom of the social scale has widened. From 1989 to 1998 all cause mortality was 3.5 times higher in the lowest occupational class (*Public Health Alliance Ireland, 2004*). Chronic physical illness is 2-5 times higher among the poor in relation to obesity, hypertension, accidents and mental illness.

There is a clear social class gradient for both men and women in the proportion who smoke. In Ireland in 2002, 32% of men aged 35-54 years in the lowest educational group (primary/no education) and 18% in the highest educational group (tertiary education) were smokers. The same trend is seen in women i.e. 35% in the lowest group and 16% in the highest group were smokers. While recent legislative changes have improved the situation in regard to passive smoking, allied to an overall decline in smoking rates from approximately one third of the population during the 1990s to a rate of about 25% in 2004. (Office of Tobacco Control Annual Report 2004), younger people continue to commence smoking, with approximately 20% of those aged 15 to 18 reporting that they are smokers.

People in lower socio-economic groups tend to eat less fruit and vegetables, and less food which is rich in fibre. Perinatal and infant mortality is three times higher in poorer families. Travellers live 10-12 years less on average than the population as a whole.

Therefore, the approach to addressing inequalities needs to be broadly based, address the broad determinants of health, and ensure that all policies and developments are proofed for their impact on health inequalities and social exclusion. Health Impact Assessment (HIA), which examines the health consequences of the policies and plans of all sectors, not just health, should be utilised in developing a broad-based strategy with greater emphasis on the socio-economic determinants of health. This would include a variety of components including consultation, advocacy for health, monitoring of inequalities and a greater awareness by individual services of how they can address inequalities and social inclusion. The planned improvements in services are built on steps towards improving capacity in these areas.

One of the clear determinants of health and social inclusion is income level. The most recent review of the implementation of the *National Action Plan Against Poverty and Social Exclusion 2003-2005* shows that some, though not all, of the commitments in the plan have been delivered. In a number of cases, while implementation is ongoing, progress is difficult to measure due to data deficiencies. Where monitoring of data is possible, the latest data available (for 2003) show considerable gaps between the highest and lowest socio-economic groups for death rates from circulatory diseases, cancers, injuries and poisoning and also for low birth weight (the narrowing of these gaps being two of the key health targets).

Greater recognition is required of the fact that health outcomes result, on a population level, from national policies across a range of Government Departments and at an individual level are greatly influenced by income level and opportunity.

## **EMERGING PUBLIC HEALTH ISSUES**

### **ALCOHOL**

Alcohol misuse is a serious public health problem. The Chief Medical Officer's *Annual Report 2004* shows that since 1960 the consumption of alcohol has increased from 5 litres of pure alcohol per adult (15 years and over) to 14.2 litres. Much of this increase is characterised by younger drinking, binge drinking and the consumption of higher volumes.

Over half of Ireland's young people begin experimentation with alcohol before the age of 12 years, with over one-third of 15-16 year olds binge drinking three or more times in the previous month. In the 18-24 year age category more females than males engage in binge drinking. The adverse effects extend beyond physical health issues (such as cancer, heart disease and liver disorders) to mental, social and financial problems.

Indicators of alcohol related harm include alcohol related mortality, unintentional injuries, road traffic accidents (RTA), mental health problems and sexual health problems. While all causes total mortality decreased in Ireland during the 1990s by about 15%, there has been a rise in alcohol related mortality ranging from 90% (alcohol poisoning), through 70% for cirrhosis to 60% for chronic alcoholism. It is estimated that approximately 25% of A & E attendances are alcohol related. Up to 40% of fatal RTAs and 30% of all RTAs are attributed to alcohol. One quarter of male admissions and one tenth of female admissions to mental health services are alcohol related. Much of the rise in sexually transmitted infections has been linked to alcohol (*Reports of the Strategic Task Force on Alcohol (2002 and 2004)*).

The second interim report of the Strategic Task Force on Alcohol (2004) assessed the measures taken by government and the drinks industry itself to deal with the situation. The report found that many of the actions taken already have been to educate people about the dangers of alcohol abuse and provide the public with information about alcohol. The report states that the supply side (the drinks industry itself) has taken very few steps towards dealing with the problem.

Over the past year the need to provide a more comprehensive response to problematic alcohol use has become more acute, exemplified by further evidence from the A&E departments, as well as continuing suicide, sexual infection, road traffic accidents and home and water safety concerns.

In 2003 it was estimated that the health costs of alcohol related harm were €433 million. Reduction in alcohol per capita consumption to the level recommended by the Strategic Task Force on Alcohol would reduce this healthcare and other additional social care burdens.

## **OBESITY**

Obesity was declared a 'global epidemic' by the World Health Organisation (WHO) in 1998.

Obesity is now recognised as a major public health problem in Ireland, with the establishment of a National Task Force in 2004, the development of a major health promotion campaign by the Department of Health and Children and the development of physical activity and nutrition projects to counter obesity.

The prevalence of overweight and obesity is increasing in Ireland, similar to global trends. The North/South Ireland Food Consumption Survey (NSIFCS) (2000) showed that 40% of Irish adults were overweight and an additional 18% were obese, which represented a 1.7 fold increase in obesity over the previous 10 years. The SLÁN survey in 2002 found that 14% of men and 12% of women were obese, with an additional 34% overweight. This was a 3% increase since 1998. Recent data from the National Children's Survey (IUNA, 2005) shows that overweight and obesity has increased from 11% to 20% in boys and from 14% to 23% in girls.

These increasing rates in obesity in both adults and children are multifactorial and reflect the increased availability of energy-dense foods and reduced physical activity associated with daily life.

The report of the National Task Force on Obesity (2005) provides the policy framework for addressing obesity in Ireland. It outlines the proposed responsibilities of a range of sectors: government, education, health, social and community sector, food production and supply and the physical environment, in tackling obesity through intersectoral collaboration.

Health problems associated with obesity include respiratory problems, chronic arthritis and infertility. More serious consequences include increased risk of cardiovascular disease, increased risk for type 2 diabetes, an association with certain types of cancer, especially hormone-related cancer (breast and prostate), colon cancer and gall-bladder disease. Obesity is also associated with a 50-100% increased risk of premature death from all causes, compared to individuals with a normal weight. The WHO estimates that overweight and obesity leads to three million deaths per annum at present and that this will increase to five million by 2020.

### **CHRONIC ILLNESS**

Declining mortality rates in the general population are affecting the number of people living with chronic disease and disability. The overall rise in the proportion and absolute numbers of older people has led to concern about the societal and health care provision consequences of an ageing population. The prevalence of many chronic diseases is higher in older people, but as outlined above attention to many of the lifestyle factors that influence chronic diseases will have positive effects on population health at all ages and will reduce the impact of such diseases on the provision of acute health care. In addition, the support of people with chronic diseases needs to be delivered to high quality standards within their own communities.

### **INFLUENZA PANDEMIC**

The risk of a global influenza pandemic arising from a mutation of the current avian flu (H5NI) is growing. The world experiences three or four influenza pandemics each century and experts believe the H5NI virus could be the trigger for the next one. In a worst case scenario 25% plus of the population in Ireland could become infected, with a death rate of 5% or higher. No one can foresee what strain will emerge as the next influenza pandemic, or when this might occur, but it is incumbent on the HSE to plan for any eventuality.

Together with the Department of Health and Children we had identified our preparedness for influenza pandemic as a priority for 2005. We have embarked on a major programme of work to achieve this. This implementation process will take a number of months, will provide for meeting one hundred actions identified by the WHO and involves hundreds of staff across all parts of the health service.

### **PLANNING FOR IMPROVED POPULATION HEALTH**

Health status in Ireland is at an all time high. However, the emerging public health problems mentioned above will inevitably impede improvement in health status in the future. For example the twin epidemics of diabetes and obesity have the potential to hinder and perhaps, at sometime in the future even reverse, the current favourable trends in circulatory disease mortality. While tackling the major problems which currently face the health services, the Executive will also invest in preventative strategies which will bring future rather than immediate benefits.

The Corporate Plan has identified priorities for improvements in population health. These priorities are being reflected in the annual Service Plan and supporting Business Plans as funding permits.

The Population Health Directorate will produce a periodic report on the health status of the population, reporting on changes in population health status, other population health indicators and the health impact of the services provided.

## 4.0 PRIMARY, COMMUNITY AND CONTINUING CARE SERVICES

### 4.0.1 CONTEXT

#### ROLE AND PURPOSE

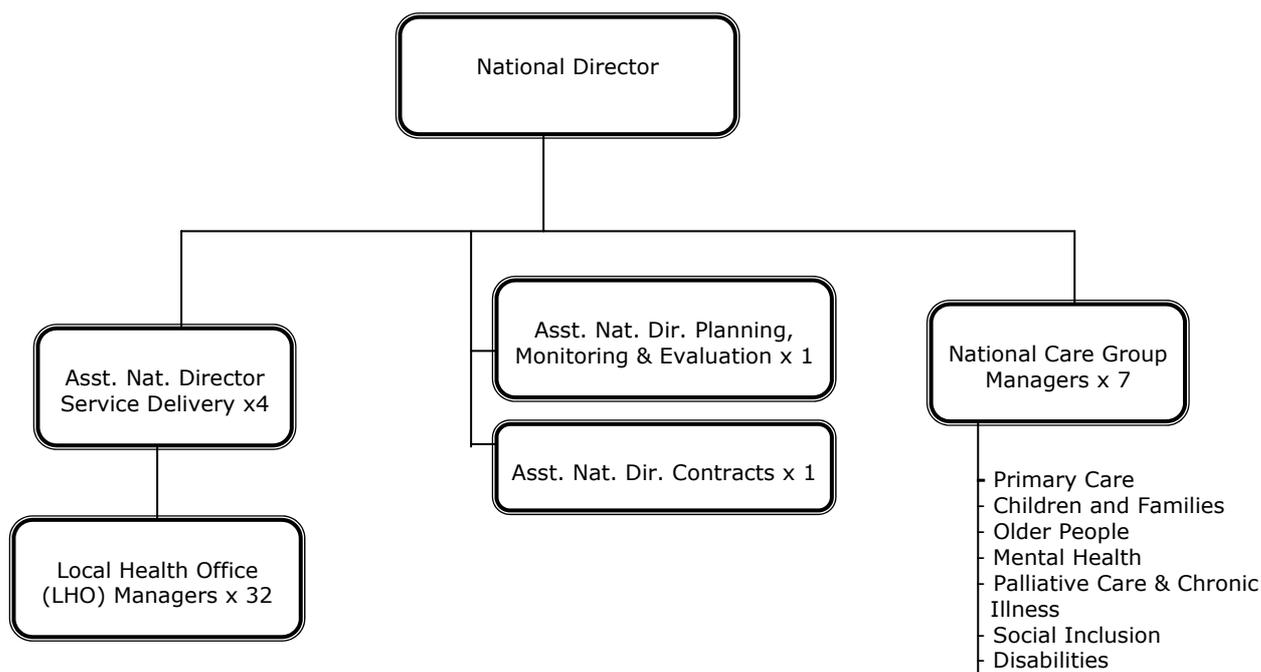
The Primary Community and Continuing Care (PCCC) Directorate is responsible for the provision of all health and personal social services provided in a community setting, including primary care, mental health, disability, community hospital and continuing care services.

PCCC services aim to support, maintain and promote the health and social well-being of individuals and their families. This is achieved through a partnership approach with individuals, families, communities and a range of providers, agencies and organisations to ensure the delivery of person-centred, needs led integrated services.

These services are delivered through 32 Local Health Offices. The work of these offices is enabled, supported and performance managed through the Assistant National Directors. A specific care-group focus at national level is provided through the PCCC structures in respect of Primary Care; Children and Families; Older People; Mental Health; Palliative Care and Chronic Illness; Social Inclusion; and Disabilities. This national focus facilitates the translation of existing and emerging policy and strategy into implementation frameworks, the development of appropriate Performance Indicators, and the use of appropriate monitoring mechanisms to ensure integrated system wide collaboration.

The management structure of the PCCC is set out below:

**FIGURE 4.0.1: PRIMARY, COMMUNITY AND CONTINUING CARE MANAGEMENT STRUCTURE**



#### 4.2.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Service Provision includes the following:

- Primary and Community Care Services.
- Services for Children and Families (including Immunisation, Childcare and Family Support).
- Services for Older People.
- Mental Health Services (including Child and Adolescent Psychiatry and Old Age Psychiatry).
- Palliative Care Services and Services for Persons with Chronic Illness.
- Social Inclusion Services (including Homeless, Ethnic Minorities, Travellers and Addiction Services).
- Services for Persons with Disabilities.

In addition, services are also provided by independent contractors (e.g. General Practitioners, Pharmacists, Optometrists, Dentists), non-statutory, voluntary and community groups on behalf of the Health Service Executive.

Further details of the range of PCCC services provided within each care-group are outlined in the relevant sections.

#### 4.1.3 THE YEAR AHEAD

The HSE's Corporate Plan sets out four objectives, along with supporting goals and high level actions to be taken over the life of the Plan (2005 – 2008). The care-group actions to be undertaken in 2006 are contained in the relevant sections. In achieving our objectives, we are committed, across the PCCC services, to:

##### *Reorganisation of Services*

- Reconfiguring services having regard to the Primary Care Strategy.
- Strengthening and supporting the new organisational structures and ensuring that change continues to be managed effectively within and across services.
- Applying capital funding to support the re-configuration of services and enhancing environments for service users and staff.

##### *Integration*

- Developing effective team-working to support integrated care for patients, clients and service users, thus simplifying access to services.
- Developing better integration and collaborative arrangements between PCCC services and hospital services to ensure continuity of care for patients, clients and service users.

##### *Patient/Client Focus*

- Improving the experiences of patients, clients and service users by providing opportunities for them to express their views and feedback on our services.
- Supporting parents, children and families in the improvement of health and family well-being through the implementation of the National Family Support Strategy.

- Supporting initiatives aimed at reducing the stigmatisation associated with particular conditions.
- Working with Population Health and the National Hospitals' Office in developing a Hepatitis B Control Strategy.

#### *Improving Access*

- Re-balancing the application of resources across PCCC services to ensure consistency in the accessibility and availability of services.
- Building on existing models of good practice, re-orientating resources, where possible, towards the provision of care in, or proximal to, peoples' own homes.
- Ensuring that those requiring our services can do so in a timely manner, through the development of specific proposals to reduce waiting times and waiting lists.
- Improving access to mainstream and targeted services for socially excluded groups and communities and developing culturally appropriate services that acknowledge and respond to the diversity of our patients, clients and service users.
- Fulfilling our statutory requirements through the implementation of the relevant aspects of key legislation such as the Disability Act (2005), the Education for People with Special Needs Act (2004), the Mental Act (2001), the Children's Act (2001) etc.
- Implementing the relevant aspects of the A&E 10 Point Plan.
- Opening a 24-hour Health Service Direct Telephone Line to simplify and improve access to services.

#### *Governance, Risk & Accountability*

- Strengthening governance arrangements across all our services, enabling the further development of a standard approach to the planning and delivery of services.
- Enhancing quality and probity assurance processes across our contracted services.
- Negotiating new contracts with General Practitioners, Dentists and other key staff groups, ensuring that the changing needs of patients are addressed.
- Developing standardised data-sets across PCCC to support the planning, monitoring and evaluation of services and the achievement of value for money.
- Developing and refining appropriate performance indicators for our services, with particular emphasis on outcome measures.
- Strengthening our research capacity to support decision-making based on best evidence, through developing partnerships with Universities, 3rd level institutions and other relevant organisations.
- Pursuing, developing and implementing quality standards throughout our services, driving a culture of safety, review and audit at all levels with particular emphasis on peer review.

- Working across the system to reduce the incidence of health care acquired infection.

#### *Emergency Planning*

- Implementing relevant actions in relation to contingency planning, general emergency planning and influenza pandemic planning at local, regional and national levels, including complying with the revised inter-sectoral framework document.

#### *Partnership & Inter-agency working*

- Continuing to develop partnerships with the voluntary / community and the not-for-profit sector to ensure a co-ordinated approach to the planning and delivery of services.
- Strengthening inter-agency and inter-sectoral working through the development of closer links between Local Health Offices and County Development Boards etc.
- Working in partnership with local non-statutory and voluntary groups to re-prioritise resources available under the RAPID / CLAR programmes.

The following Care Sections detail the specific actions that will be undertaken in 2006 to deliver on our objectives and commitments in PCCC.

## 4.1 PRIMARY CARE SERVICES

### 4.1.1 CONTEXT

#### ROLE AND PURPOSE

Primary Care Services aim to support and promote the health and well-being of the population by providing locally based, accessible services. It is our objective that these services will be of high quality, with local teams working closely together to deliver user-friendly primary care to the local population.

We are working towards services which are based on the assessment of local need and which are closely integrated with those of acute hospitals and other agencies. The involvement of the local community is a key feature of primary care.

#### PROFILE

A key imperative of the Primary Care Strategy is that services in future will respond to local need. The ten Implementation Projects have undertaken local needs assessments and these are informing service development. In further rolling out the Primary Care Strategy, all Local Health Offices will develop skills in needs assessment and use the findings from these to shape future services.

**TABLE 4.1.1: POPULATION PROFILE BY AGE GROUP**

Age Group	Ireland No. of Persons			% Population
	Total	Male	Female	
Children 0-17 years	1,027,880	527,389	500,491	25%
Adult 18 - 64 years	2,642,136	1,329,155	1,312,981	64%
Older people (> 65 years)	460,706	202,408	258,298	11%
<b>Total</b>	<b>4,130,722</b>	<b>2,058,952</b>	<b>2,071,770</b>	<b>100%</b>

Source: CSO 2005

**TABLE 4.1.2: NUMBER OF ELIGIBLE PERSONS AS AT 31.12.2004**

	Number of Eligible Persons		
	General Medical Services	Drugs Payment Scheme	Long-Term Illness Scheme
<b>Total</b>	<b>1,148,914</b>	<b>1,469,251</b>	<b>93,504</b>

Source: Primary Care Reimbursement Service 2004

### 4.1.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The national population, estimated to be 4.13m people, can access primary care services. Those who are unable, without undue hardship, to arrange General Practitioner, medicines and hospital services for themselves and their dependants, have an entitlement to free General Medical Services. This entitlement also extends to those over 70 years of age. These services include free GP (family doctor) services; prescribed drugs and medicines (with some exceptions); inpatient public hospital services; outpatient services; dental, optical and aural services; medical appliances and maternity and infant care services.

Currently, 28.42% of the population hold a medical card. Entitlement to access the services of a General Practitioner without charge has been extended to people who come within certain income limits, under the terms of the GP Visit Card.

In addition, eligibility for the following schemes also applies to certain groups within the population:

- Drugs Payment Scheme
- Long Term Illness Scheme
- Dental Treatment Services Scheme
- European Economic Area (EEA)
- High Tech Drugs Scheme
- Primary Childhood Immunisation Scheme
- Health (Amendment) Act 1996 – Persons with Hepatitis C
- Methadone Treatment Scheme
- Community Ophthalmic Services Scheme

The Primary Care Reimbursement Service (formerly the GMS Payments Board) makes payments to general practitioners, pharmacists, dentists and optometrists who have contracts to provide services to holders of Medical Cards, GP visit cards (GPs only) and to people who qualify under other community drugs schemes.

Primary Care services are delivered from a number of settings including health centres, primary care centres and, in the case of most independent contractors i.e. general practitioners, pharmacists, dentists and optometrists, in privately owned premises.

A wide range of professionals are involved in the delivery of Primary Care services, including: general practitioners, public health nurses, community pharmacists, audiologists, home helps, dieticians, dentists, chiropodists, community welfare officers, occupational therapists, physiotherapists, social workers, speech and language therapists, community workers, environmental health officers, psychologists, ophthalmologists and audiologists. Non-statutory, voluntary and community groups are also involved in providing services. Administrative staff support these professionals and also work in processing a number of schemes for claimants.

Directly provided and contracted services include:

- General Practice – including practice based nursing and other services
- Community Nursing
- Therapy Services – including physiotherapy; speech & language therapy; occupational therapy; dietetics
- Entitlement and Benefit Schemes
- Information services
- Community Pharmacy
- Dental
- Ophthalmology/Optomety
- Audiology
- Community Health Services

**TABLE 4.1.3: NUMBER OF AGREEMENTS WITH GPs, PHARMACISTS, DENTISTS AND OPTOMETRISTS FOR SERVICES AS AT 31<sup>ST</sup> DECEMBER 2004**

	General Practitioners	Pharmacists	Dentists	Optometrists
<b>Number of Agreements for Services</b>	2,210	1,333	1,340	489

*Source: Primary Care Reimbursement Service Annual Report 2004.*

### 4.1.3 THE YEAR AHEAD

A number of actions which began in 2005 will continue to be progressed or will be finalised in 2006. Specific details are reflected in the individual Business Plans that support the National Service Plan.

#### 4.1.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experiences of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Progress the reconfiguration of existing services, having regard to the Primary Care Strategy, to include the development of Primary Care Networks. *(Corporate Plan Action 1.6.1)*
- Negotiate the contract for general practitioners providing services to Medical Card patients. *(Corporate Plan Action 1.6.2)*
- Negotiate the contract for dental services under the DTSS. *(Corporate Plan Action 1.6.2)*
- Expand the range and geographical coverage of GP Out of Hours services and develop common national standards. *(Corporate Plan Action 1.6.1)*
- Develop plans to integrate primary care and acute hospital services, including measures to improve access to diagnostic services for patients of general practitioners. *(Corporate Plan Action 1.6.2)*
- Review and Evaluate the Primary Care Implementation projects to guide and support the re-configuration of services. *(Corporate Plan Action 1.6.1)*
- Further the implementation of action plans agreed under the National Schemes Modernisation Projects. *(Corporate Plan Action 1.6.1)*
- Review Indicative Drug Target Savings Scheme. *(Corporate Plan Action 1.6.1)*
- Review Community Ophthalmic Services Medical Pilot Scheme. *(Corporate Plan Action 1.6.1)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Progress the implementation of the new medical card guidelines and GP Visit card initiative. *(Corporate Plan Action 1.1.1, 1.1.6)*
- Implement relevant actions in relation to influenza pandemic planning at local, regional and national level. *(Corporate Plan Action 2.1.9)*
- Undertake needs assessment in partnership with communities, non-statutory, voluntary and community groups. *(Corporate Plan Action 2.1.2)*
- Enforce relevant tobacco and food hygiene legislation. *(Corporate Plan Action 2.3.2)*

### Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.

- Develop effective multi-disciplinary team working to support integrated care for patients. *(Corporate Plan Action 3.4.1)*
- Design and implement a standardised instrument to measure local progress towards the reconfiguration of services. *(Corporate Plan Action 1.6.2, 3.4.1)*

### Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders.

- Promote the involvement of service users in planning, consultative and decision making forums. *(Corporate Plan Action 4.1.1)*
- Work closely with educational and training institutions at undergraduate and postgraduate levels, to ensure a co-ordinated approach to the training of personnel and to meet staffing requirements. *(Corporate Plan Action 3.1.1)*
- Maximise opportunities to enhance IT support and connectivity within and across services. *(Corporate Plan Action 1.6.1, 4.3.2, 4.3.3)*
- Enhance governance arrangements across contracted services and Primary Care Schemes. *(Corporate Plan Action 1.6.1, 4.4.1, 4.4.3)*
- Implement a National Contract Management Framework. *(Corporate Plan Action 4.3.4, 4.4.1, 4.4.3, 4.4.4)*

#### ACTIVITY

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable.

#### FUNDED SERVICE DEVELOPMENTS

Additional funding of €16m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	• Further enhancement of Primary Care Services through the provision of additional front-line staff for Primary care teams. <i>(Corporate Plan Action 1.6.1)</i>	€10m
	• Further improvement of access to diagnostics for general practitioners. <i>(Corporate Plan Action 1.6.2)</i>	(Included above)
	• Provision of funding for 22 additional general practitioner training places.	€4m
	• Expanding the range and geographical coverage of out-of-hours general practitioner services. <i>(Corporate Plan Action 1.6.1)</i>	€2m
<b>TOTAL</b>		<b>€16M</b>

**4.1.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- Successful completion of contract negotiations.
- Potential impact of influenza outbreak on Existing Levels of Service (ELS).
- Increasing costs of demand led schemes in the context of defined budgets.
- Recruitment and retention of staff in particular disciplines / areas.

**4.1.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

In addition, we will focus on monitoring:

- Local Health Offices' level of progress/preparedness for integrated working

**4.1.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.2 CHILDREN AND FAMILIES

### 4.2.1 CONTEXT

#### ROLE AND PURPOSE

Services for Children and Families aim to promote and protect the health and well-being of children and families. Responsive services based on best practice, delivered in partnership with children and their families, carers, local communities and non-statutory, voluntary and community groups enable them to realise their potential. The emphasis is on provision of universal preventive services, with positive discrimination in favour of the most vulnerable and those experiencing greatest adversity.

#### PROFILE

The 2005 Estimate of Population indicated that there were 1,027,880 young people (i.e. people aged 0-17 years) in the country, representing 25% of the overall population. Table 4.2.1 below presents a profile of this population by age category and compares it to the 2002 Census.

**TABLE 4.2.1: YOUNG PEOPLE POPULATION PROFILE BY AGE GROUP 2002 AND 2005**

	No. of Persons							
	Total Population	Aged 0-17 Years	Aged under 1 year	Aged 1-4 Years	Aged 5-9 Years	Aged 10-14 Years	Aged 15-17 Years	%age Aged 0-17 Years
<b>Ireland 2005</b>	<b>4,130,722</b>	<b>1,027,880</b>	61,066	236,299	281,210	274,715	174,590	<b>25%</b>
<b>Ireland 2002</b>	<b>3,917,203</b>	<b>1,013,031</b>	54,499	223,131	264,090	285,708	185,603	<b>26%</b>
<b>Variance 2002-2005</b>	<b>213,519</b>	<b>14,849</b>	6,567	13,168	17,120	-10,993	-11,01	
<b>Percentage Variance 2002-2005</b>		<b>1.5%</b>	12.0%	5.9%	6.5%	-3.8%	-5.9%	

Source: CSO 2002 and 2005

Overall, the children and adolescent population has increased by 14,849 (1.5%) in the period since 2002. However, this increase has been in the age groups from 0-9. years. A profile of the 2005 children and adolescents population by gender is presented in Table 4.2.2 below.

**TABLE 4.2.2: YOUNG PEOPLE POPULATION PROFILE BY GENDER 2005**

	Total Number of Persons Aged 0-17 Years	Number of Persons Aged under 1 year	Number of Persons Aged 1-4 Years	Number of Persons Aged 5-9 Years	Number of Persons Aged 10-14 Years	Number of Persons Aged 15-17 Years	Percentage Population Aged 0-17 Years
<b>Males</b>	527,389	31,493	120,937	144,596	141,063	89,300	51%
<b>Females</b>	500,491	29,573	115,362	136,614	133,652	85,290	49%
<b>Total</b>	<b>1,027,880</b>	<b>61,066</b>	<b>236,299</b>	<b>281,210</b>	<b>274,715</b>	<b>174,590</b>	<b>100%</b>

Source: CSO 2005

There are more males than females in each age group. Male adolescents are at greater risk of injury from motor vehicle accidents, injuries, poisoning and suicide. Children from lower income groups are most likely to have accidents in the home.

Immunisation is crucial in the prevention of a range of childhood illnesses. Improving national immunization uptake will be an important priority for the Directorate in 2006, based on uptake levels as illustrated in Table 4.2.3 below.

**TABLE 4.2.3: NATIONAL IMMUNISATION UPTAKE UP TO 24 MONTHS**

Vaccination		Diphtheria	Polio	Tetanus	Haemophilus Influenza Type b	Polio	Meningococcal Group C
	MMR	D3	P3	T3	Hib3	Polio 3	Men C3
Immunisation percentage uptake level for children born in September 2002	83	90	90	90	90	90	89

Source: National Disease Surveillance Centre Quarter 2 2005

All children need the foundations of a good education which focuses on personal development, health services which address their particular physical and mental health needs and access to a range of opportunities to develop positive relationships and supportive networks through sport, play, leisure and cultural activities. All children need the support of family and community (*The National Children's Strategy: Our Children – Their Lives, 2000*).

Nearly one in ten Irish children lived in consistent poverty, while one in four lived in relative poverty in 2001 (*Health in Ireland 2004*). These children, because of social exclusion / disadvantage, have additional needs as they experience barriers which prevent them from achieving a better quality of life.

Over a half of Ireland's young people begin experimentation with alcohol before the age of 12 years, with over one third of 15-16 year olds binge drinking three or more times in the previous month (*SLAN, 2003*).

In the *Irish Health Behaviour in School Aged Children Survey (HBSC) 2002*:

- 41% of young people (40% boys and 42% girls) reported ever having smoked a cigarette. (This is a fall of 8% since the last HBSC survey of 1999).
- 40 % of children report that they have never had an alcoholic drink. (This compares to 31% in 1998).
- 12% of young people reported using cannabis during their lifetime. (12% in 1999).
- 59% of boys and 38% of girls exercised four or more times per week.

Children and Adolescents are a particularly important target group for health promotion because initiatives can help form lifelong habits for healthy lifestyles.

Violence Against Women includes rape and sexual assault, domestic violence, prostitution and associated trafficking. Domestic violence has a profound effect on the entire family, including and especially children. Domestic violence destroys both women and children's lives. Sexual violence, which affects women, children and men, is a profoundly disturbing dimension of contemporary Irish society. Early, specialised intervention has been demonstrated to reduce the immediate and long term effects of trauma.

Considerable needs analyses and consultation processes to identify the needs of children and families have been undertaken to inform and shape national policy and influence the delivery of Children and Family Services. These processes continue to be undertaken in consultation / partnership with children and their families, representatives and communities to ensure that children have a 'voice', in keeping with *The National Children's Strategy: Our Children – Their Lives (2000)*, thereby promoting the development of person-centred, needs led services which reflect best practice.

#### 4.2.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services are provided in a variety of community and residential settings including the home, community, schools, health centres and acute hospitals, in partnership with communities, children, young people, families and carers, by a range of statutory, non-statutory, voluntary and community groups.

A range of universal health and social services are provided to the general population of children and young people. Additionally, targeted and specialist services are available to children, young people and their families who are considered to be in need or vulnerable for a variety of reasons. Interagency links are critical in this regard.

Children and Family services are broadly structured as:

- Child Health, including Immunisation.
- Community Development and Family Support Services, including services responsive to Domestic Violence.
- Child Protection and Welfare Services, which work to a strategy of early identification of vulnerable families and proper assessment of their needs, combined with targeting of appropriate support services.
- Specialised alternative care services including adoption, foster care and residential care.
- Pre-school Services.

Services provided include:

- |  |  |
|--|--|
| • Information / Health Promotion                                     | • Generic and Specialised Family Support           |
| • GP Services  | • Pre-School Inspection                            |
| • Antenatal education  | • School Health                                    |
| • Breastfeeding support  | • Fostering  |
| • Parenting Programmes   | • Adoption   |
| • Primary Immunisation Scheme and<br>Booster Immunisation Programmes | • Residential Child Care                           |
| • Child Health Surveillance and<br>Screening                         | • Young People Out of Home                         |
| • Early Intervention   | • Aftercare  |
| • Child Protection   | • Assessment, diagnosis and treatment              |
| • Home visiting and family support                                   | • Inpatient care                                   |
| • Health Education and Promotion for<br>children and their carers    | • Support services provided to Special<br>Schools  |
|  | • Services to respond to violence against<br>women |

#### 4.2.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are reflected within the individual Business Plans that support this National Service Plan.

#### 4.2.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experiences of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Develop a framework for integrated service delivery for children and families health and personal social services. *(Corporate Plan Action 1.7.5)*
- Ensure service provision is in line with best practice by reviewing special care and high support children's services. *(Corporate Plan Action 1.7.6)*
- Re-configure existing service structures to combine child health and child care protection approaches. *(Corporate Plan Action 1.7.5)*
- Identify, promote and implement models of best practice in children and families services. *(Corporate Plan Action 1.7.5)*
- Standardise information provision across children and family services. *(Corporate Plan 1.2.1)*
- Work in partnership with relevant Departments towards the implementation of the remaining health related components of the Children's Act. *(Corporate Plan Action 1.2.1)*
- Collaborate with the Irish Social Services Inspectorate (ISSI) in new approaches to service inspection and service monitoring. *(Corporate Plan Action 1.2.1)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Work to implement the recommendations set out by the National Breast Feeding Committee. *(Corporate Plan Action 2.3.6)*
- Work towards the achievement of national targets for childhood immunisation (Hib, e.g. measles eradication, completion of Hib campaign) and influenza vaccination. *(Corporate Plan Action 2.2.1, 2.2.2)*
- Work towards the achievement of the relevant targets set out in the Programme of Action for Children. *(Corporate Plan Action 1.7.5.)*
- Work towards implementing the relevant health-related actions for children and families as set out in the *National Anti-Poverty Strategy*. *(Corporate Plan Action 2.1.2, 2.4.1)*
- Address the needs of unaccompanied minors, having regard to the *Review of the Needs of Separated Children*. *(Corporate Plan Action 2.4.3)*
- Address the needs of young people leaving care, having regard to their particular vulnerability in the prevention of homelessness and social exclusion. *(Corporate Plan Action 1.7.5, 2.1.6)*
- Agree a national web-based approach to support information flow to young people. *(Corporate Plan Action 2.3.4)*
- Develop HSE action plan for the implementation of the *National Family Support Strategy*. *(Corporate Plan Action 1.7.7)*

- Work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID (Revitalising Areas by Planning, Investment and Development) / CLAR (Ceantair Laga Árd-Riachtanais) programmes. *(Corporate Plan Action 2.1.7)*
- Work towards the phased roll out of a Universal Hearing Screening programme, following agreement. *(Corporate Plan Action 2.3.1)*
- Implement the Personal Health Record project on a phased basis. *(Corporate Plan Action 2.3.1)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Develop child health and child care training on an inter-disciplinary basis, where appropriate. *(Corporate Plan Action 3.1.2)*
- Audit existing practices in relation to training and education and establish formal relationships with the centres involved. *(Corporate Plan Action 3.1.1)*
- Review the training needs of pre-school officers in line with the revised pre-school regulations. *(Corporate Plan Action 3.1.1)*
- Identify priority areas for children and families research, in collaboration with other stakeholders. *(Corporate Plan 3.1.2)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders.**

- Develop a National Charter of Rights for Children in Care. *(Corporate Plan Action 2.3.4, 1.7.5)*
- Involve patients, service users and the public in planning and monitoring of health services. *(Corporate Plan Action 4.1.1, 4.1.3)*
- Further develop partnerships and forums with the not-for-profit/ Voluntary / Community sector to optimise service delivery.
- Review working arrangements with the Voluntary Sector in addressing domestic violence. *(Corporate Plan Action 4.1.6)*
- Develop mechanisms to involve staff at all levels of the organisation in the planning and development of services. *(Corporate Plan Action 4.1.5)*
- Develop Management Information Systems to support service planning and delivery. *(Corporate Plan Action 4.4.2)*
- Identify measures to increase the organisational capacity for research and evaluation of the services for children and families.

**ACTIVITY**

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable. In working towards this, data will be sought on a monthly basis in respect of the following:

- High Support and Special Care Units activity

### FUNDED SERVICE DEVELOPMENTS

Additional funding of €8m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	<ul style="list-style-type: none"> <li>• Further implementation of the Children's Act 2001, taking cognisance of the Department of Justice, Equality and Law Reform proposals to government. (<i>Corporate Plan Action 1.2.1</i>)</li> </ul>	
	<ul style="list-style-type: none"> <li>• Support parents, children and families in the improvement of health and family well-being through the implementation of the National Family Support Strategy. (<i>Corporate Plan Action 1.7.7</i>)</li> </ul>	
<b>OBJECTIVE 2:</b> We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social inclusion.	<ul style="list-style-type: none"> <li>• Broaden the range of services provided to children and their families through the further strengthening of social work, community based services and the Family Welfare Conferencing system. (<i>Corporate Plan Action 1.7.5</i>)</li> </ul>	
	<ul style="list-style-type: none"> <li>• Implement HSE aspects of the recommendations of the Ferns Report.</li> </ul>	
<b>TOTAL</b>		<b>€8M</b>

#### 4.2.3.2 KEY ISSUES FOR THE YEAR AHEAD

- Capacity to respond to the introduction of further legislative and regulatory requirements e.g. Children's Act 2001 sections, Preschool Regulations, Adoption Bill.
- The introduction of the Family Support Strategy.
- Implications of reviews/reports associated with child protection.

#### 4.2.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

We will maintain the collection of the child care interim data set annually and the quarterly collection of Inter Country Adoption data.

#### 4.2.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.3 SERVICES FOR OLDER PEOPLE

### 4.3.1 CONTEXT

#### ROLE AND PURPOSE

Services for Older People aim to support older people to remain at home in independence for as long as is possible, or where this is not possible, in an alternative appropriate residential setting. A range of services is provided in partnership with older people themselves, their families, carers, statutory, non-statutory, voluntary and community groups. The principles of person-centredness and empowerment of service users underpin service delivery.

#### PROFILE

The 2005 Estimate of Population indicated that there were 460,706 older people (i.e. people aged > 65 years) in the country, representing 11% of the overall population. Table 4.3.1 below presents a profile of this population by age category and compares it to the 2002 Census, while Table 4.3.2 presents a profile of older people living alone in 2002.

**TABLE 4.3.1: OLDER PEOPLE POPULATION PROFILES 2002 AND 2005**

	Total Population	Total No. of Persons Aged > 65 Years	No. of Persons Aged 65-74 Years	No. of Persons Aged 75- 84 Years	No. of Persons Aged 85 Years and over	Percentage Population Aged > 65 Years
Ireland 2005	4,130,722	460,706	258,341	154,527	47,838	11%
Ireland 2002	3,917,203	436,001	245,603	148,672	41,726	11%
Difference No of People 2002-2005	213,519	24,705	12,738	5,855	6,112	
%age Difference No of People 2002-2005		+5.7%	+5.2%	+3.9%	+14.6%	

Source: CSO 2002 and 2005

**TABLE 4.3.2: PROFILE OF OLDER PEOPLE LIVING ALONE 2002**

	No. of People Living Alone	Percentage of All Persons in the Age Group
Total Persons > 65 years living alone	113,826	26%
Males Aged >65 years living alone	38,014	
Females Aged >65 years living alone	75,812	
Total Persons > 70 years living alone	88,411	29%
Males Aged >70 years living alone	27,169	
Females Aged >70 years living alone	61,242	

Source: Census 2002

The emerging changing demographic profile i.e. of an 'ageing' older people population, with over one in four older people living alone, together with increased life expectancies as outlined in Chapter 3 (Population Health Status), as well as 38% of pensioners living in the lowest 20% of households in terms of income, present particular challenges for future service provision, particularly the maintenance of quality of life and prevention of social exclusion.

Issues of isolation and loneliness impact in a silent way on the health and well being of older people and can only be addressed by working in partnership with the key stakeholders in both the statutory (e.g. education, local authorities) and voluntary sectors.

It is recognised that older people continue to have a zest for life and remain active, healthy and socially involved for longer, often with the support of statutory, non-statutory, voluntary and community groups. Emphasis is therefore on empowering older people in the promotion and maintenance of their own health and well-being in the community, supporting them to remain in their own homes and communities and anticipating their future needs.

The main causes of death in older people are circulatory disease, stroke and cancer. Infectious diseases (pneumonia and influenza) and chronic obstructive airways disease are the leading causes of death from respiratory disease in Ireland. Annually a vaccine is made available to key 'at risk' groups, including older people, to prevent pneumonia and influenza. Based on uptake levels as illustrated in Table 4.3.3 below, there is a need to further promote the uptake of this vaccination.

**TABLE 4.3.3: NATIONAL AVERAGE INFLUENZA IMMUNISATION UPTAKE 2004 - 2005**

Age Group - Years	Percentage Uptake GMS Population
65 - 69	49.1
70 - 74	57.6
75+	67.4

*Source: National Disease Surveillance Centre*

It is estimated that one in five people over the age of 80 years will develop dementia or dementia related illnesses.

With increasing life expectancies, older people may require admission to hospital services, thereby necessitating the development of clear care pathways between hospital and Primary, Community and Continuing Care services. Appropriate 'step-down' facilities to assist the transition home to the community need to be available, together with effective and integrated links between acute and other services to support a holistic and person-centred approach to care.

As the population ages the demand for long-term residential care beds continues to increase, resulting in waiting lists for these services.

Considerable needs analyses and consultation processes have been undertaken to identify the needs of older people. The findings have been used to inform and shape national policy and influence the delivery of Older People's Services. Additionally, the ongoing process of needs identification is undertaken in consultation and partnership with older people themselves, their families, carers and representatives, to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choice, and which reflect best practice.

#### **4.3.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED**

Services are provided across a continuum, from services at home and in the community through to high quality hospital and residential care services when required.

Services are provided in partnership with service users, their families and carers and a range of statutory, non-statutory, voluntary and community groups. The broad range of

Primary and Community based services are accessed, as well as specialist services, which include:

### Home and Community

- Information/Health Promotion
- General Practice including practice based nursing and other services
- Community Pharmacy
- Public Health and Home Nursing
- Dental/Aural/Ophthalmics
- Chiropody
- Home Help and Home Care Assistant
- Meals-on-wheels
- Day Centres/Clubs
- Support for Carers
- Additional Home Supports – Packages
- Assessment, supply and fitting of medical appliances
- Occupational Therapy
- Physiotherapy
- Speech and Language Therapy
- Continence Advice
- Nutritional Advice
- Grant Aid to Voluntary Organisations
- Special Housing Aid for the Elderly Scheme (Dept of the Environment)
- Boarding Out
- Respite Care
- Short-term Convalescent Care
- Community Rehabilitation

### Hospital Services

- Acute Services, including Departments of Medicine for Older People
- Rehabilitation Care
- Day Hospitals for older people
- Discharge Co-ordination

### Continuing Care

- Public long term residential care
- Private nursing homes

#### 4.3.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are reflected within the individual Business Plans that support this National Service Plan.

##### 4.3.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experiences of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Continue implementation of existing programmes to prevent and address the abuse of vulnerable older people. *(Corporate Plan Action 1.7.2, 1.7.3)*
- Enhance structures to facilitate the most appropriate responses to the vulnerability of older people. *(Corporate Plan Action 1.7.2, 1.7.3)*
- Develop and provide a more comprehensive range of home and community based care services and supports to meet the needs of older people, including the continued provision of home care packages. *(Corporate Plan Action 1.7.1, 1.8.1)*

- Develop and enhance flexible day care services that respond to the changing needs of older people. *(Corporate Plan Action 1.7.1)*
- Work with HSE staff, providers and relevant external organisations to improve the safety, effectiveness and quality of our services. (Irish Health Services Accreditation Board, SSI etc). *(Corporate Plan Action 1.10.1, 1.10.3)*
- Implement a standardised nursing home inspection process nationally. *(Corporate Plan Action 1.7.1)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Promote the uptake of the influenza vaccine among the population aged over 65 years. *(Corporate Plan Action 2.1.3, 2.1.8, 2.2.1, 2.3.1)*
- Provide community based health promotion programmes tailored to the needs of older people, in partnership with voluntary agencies (e.g. falls prevention programmes). *(Corporate Plan Action 1.7.1, 2.1.3)*
- Strengthen interagency / inter-sectoral working to ensure that the needs of older people are formally addressed and reflected in developing public policies, both locally and nationally. *(Corporate Plan Action 2.1.6, 2.1.7)*
- Strengthen measures to reduce the incidence of acquired infection in community and residential settings. *(Corporate Plan Action 1.10.1, 1.10.2, 1.10.3)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Build on existing models of good practice across the system to strengthen our capacity to effect timely and co-ordinated discharge from hospital for older people, ensuring pathways are defined by the needs of the individual rather than the organisation. *(Corporate Plan Action 1.2.1, 1.3.2, 1.4.1, 1.4.2, 1.7.1)*
- Further develop integration and collaboration arrangements across PCCC and hospital services to improve responsiveness to the needs of older people. *(Corporate Plan Action 1.2.1, 1.3.2, 1.4.1, 1.4.2, 1.7.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / voluntary / community sector and other stakeholders.**

- Implement an agreed national standardised assessment tool in community services, with particular reference to home supports, in order to simplify access to services for patients. *(Corporate Plan Action 1.2.1, 1.3.2, 1.7.1)*
- Involve patients, service users and the public in planning and monitoring of health services. *(Corporate Plan Action 4.1.1)*
- Continue to develop partnerships and forums with the not-for-profit / voluntary / community sector to optimise co-ordinated service delivery. *(Corporate Plan Action 1.4.1, 2.1.6, 4.1.6)*
- Continue the development of multi-disciplinary teams to ensure the development and delivery of person-centred and efficient services for older people. *(Corporate Plan Action 1.4.2, 3.4.1)*

## ACTIVITY

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable. In working towards this, data will be sought on a monthly basis in respect of the following:

- No. of Home Help Hours provided.
- No. of persons in receipt of home care packages.
- No. of nursing home inspections carried out.
- No. of persons in receipt of nursing home subventions.
- No. of persons in receipt of day care.

## FUNDED SERVICE DEVELOPMENTS

€60m has been provided for the commissioning of new units in acute and non-acute services, funded under NDP. Detailed allocation of this funding is not yet finalised but will include funding for the following:

Objective and Supporting Goal(s)	Actions to achieve	Resources
<p><b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.</p>	<p><b>Commissioning of new units in non acute services under NDP:</b></p> <ul style="list-style-type: none"> <li>• Provision of new beds at St. Ita's Hospital, Newcastlewest, Co. Limerick.</li> </ul>	<p>To be funded from €60m which has been provided for the commissioning of new units in acute and non-acute services, funded under NDP.</p>

### 4.3.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2006 include:

- The potential for a significant influenza outbreak.
- Implementation of agreed care standards in residential services.
- Demand for Older People's Services due to an increasing population aged over 65 years.

### 4.3.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

### 4.3.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.4 MENTAL HEALTH SERVICES

### 4.4.1 CONTEXT

#### ROLE AND PURPOSE

Mental Health Services span all life stages and include services for Children and Adolescents, Adults and Older Persons. In recent years we have seen increasing specialisation including Rehabilitation, Liaison and Forensic Psychiatric Services. The Service also fosters positive mental health promotion and maintains close links with the recently established Suicide Prevention Office.

Services are provided in partnership with persons with mental health needs, their families, carers, statutory, non-statutory, voluntary and locally based community groups with the aim of achieving the best quality of life for each individual through the provision of seamless, high quality person-centred services.

#### PROFILE

The 2005 Estimate of Population indicated that of the overall population of 4,130,722, there were 1,027,880 persons aged 0-17, representing 25% of the total population. There were 2,642,136 adults (i.e. people aged 18-64 years) in the country, representing 64% of the overall population. A total of 460,706 were aged 65 or over, accounting for 11% of the population.

Between 20% and 25% of the population (between approximately 528,400 and 660,500 adults 18-64 years) will be affected by a mental health problem (*Mental Health Commission Annual Report 2002*). Studies indicate that GPs are presented with the largest proportion of psychiatric morbidity (90% of diagnosed mental illness), leaving a smaller proportion (10%) to the specialised psychiatric services (*Planning for the Future, 1984*).

The Health Research Board annual analysis shows that almost 1% of the adult population (18-64 years) experience mental health difficulties that require hospital admission. Their findings also indicate a difference in hospital admission rates between socio-economic groups, with poorer sections of the community having a greater reliance on services. In 2004, depressive disorders had the highest rate of all admissions. Schizophrenia had the second highest rate of all admissions. It is estimated that 1 in 5 people over 80 years will develop dementia or dementia related illness.

The Central Statistics Office recorded 457 (356 males and 101 females) registered suicides in Ireland in 2004. 20.6% of all suicides were in the 25-34 age group, the largest cause of death in this age group.

Considerable needs analyses and consultation processes to identify the needs of persons with mental health needs have been undertaken to inform and shape national policy and influence the delivery of Mental Health Services. Research, for example, indicates that people who are homeless experience a higher rate of mental health problems than the general population. Additionally, the ongoing process of needs identification is undertaken in consultation/partnership with persons with mental health needs, their families, carers and representatives to ensure the development and delivery of person-

centred, needs led services which are responsive to user preferences and choices, and which reflect best practice.

#### 4.4.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Mental Health Services are provided across a continuum, from home and community based services to high quality community and inpatient acute mental health services and residential care services when required. The broad range of Primary and Community based services are accessed as well as specialised services, which include:

- Mental Health Promotion
- Primary Care
- GP/Community Pharmacy
- Acute Inpatient Care
- Outpatient Clinics
- Community Based Residences
- Rehabilitation
- Liaison Services
- Day Hospitals
- Day Centres
- Child & Adolescent Psychiatry
- Old Age Psychiatry
- Mental Health services for Homeless Persons
- Community Psychiatric Nursing
- Accident & Emergency crisis intervention nursing
- Detoxification
- Peer support groups
- Bereavement support
- Provision of appropriate responses to both suicide and parasuicide
- Forensic Psychiatry – including assessment, treatment, rehabilitation, satellite, outpatient and prison in-reach services.
- Outreach / Home Care Services
- National Counselling Service

A profile of mental health service provision is presented in Table 4.4.1 below.

**TABLE 4.4.1: PROFILE OF MENTAL HEALTH SERVICE PROVISION 2003**

Service Category	Number	Number of Places	Attendances
Out-Patient Clinics	235		238,650
Day Centres	110	2,357	426,576
Day Hospitals	66	1,090	171,196
Community Residences	418	3,210	

*Source: Health Research Board 2004, Report of Inspector of Mental Hospitals 2003*

#### 4.4.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are reflected within the individual Business Plans that support this National Service Plan.

##### 4.4.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experiences of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Assess implications of the Report of the Expert Group on Mental Health following publication, and implement recommendations on a prioritised basis. *(Corporate Plan Action 1.7.3)*
- Progress the implementation of the Mental Health Act 2001 in partnership with the Mental Health Commission and the Mental Health Act Implementation Group. *(Corporate Plan Action 1.7.4)*

- Expand and broaden community based mental health teams. *(Corporate Plan Action 1.3.2, 1.4.2, 1.7.3, 1.7.4)*
- Provide additional residential places in the community and in the Central Mental Hospital in the context of the Disability Package. *(Corporate Plan Action 1.7.8)*
- Support the re-engineering of services to community based models. *(Corporate Plan Action 1.3.2, 1.4.2, 1.7.3, 1.7.4)*
- Continue to develop a national Forensic Psychiatric Service framework. *(Corporate Plan Action 1.7.4)*
- Scope the implication on Mental Health Services of Part 2 of the Disability Act 2005. *(Corporate Plan Action 1.7.8)*
- Continue to support the move of acute mental health units from psychiatric hospitals to acute general hospitals. *(Corporate Plan Action 1.7.3, 1.7.4)*
- Deliver a high quality community based counselling therapy service for adults, as part of the range of psychological therapies provided for those who have experienced childhood abuse. *(Corporate Plan Action 1.7.3)*
- Further develop child and adolescent psychiatry inpatient units. *(Corporate Plan Action 1.7.3)*
- Strengthen links between Child and Adolescent Psychiatry Services and Children and Family Services.

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Implement phase 1 HSE elements of *Reach Out: Strategy for Action on Suicide Prevention (2005-2014)*. *(Corporate Plan Action 2.4.2)*
- Support initiatives that promote the reduction of stigmatisation associated with mental illness, and promote public understanding. *(Corporate Plan Action 2.1.3, 2.1.4, 2.1.6)*
- Work with Local Authorities and other relevant organisations to address the housing needs of persons with a mental illness. *(Corporate Plan Action 2.1.4, 2.1.6, 2.1.7)*
- Support non-statutory, voluntary and community groups to become more actively involved in mental health issues, particularly in the area of advocacy, through involvement with the Irish Advocacy Network and other relevant organisations. *(Corporate Plan Action 2.1.4, 2.1.6, 2.1.7, 4.1.6)*
- Continue to work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID / CLAR Programmes. *(Corporate Plan Action 2.4.1)*
- Rebalance resource availability in line with demonstrated population needs. *(Corporate Plan Action 2.1.2)*
- Continue to work towards the implementation of the relevant aspects of the Public Health (Tobacco) Acts within the mental health setting. *(Corporate Plan Action 2.3.2)*

### Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.

- Support those with acute episodic and enduring mental health difficulties through improved liaison and communication between Acute Hospital personnel and stakeholder networks. *(Corporate Plan Action 1.4.1, 1.4.2)*
- Strengthen an integrated service response to the homeless with mental illness. *(Corporate Plan Action 1.1.1, 1.4.1, 1.4.2)*

### Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders.

- Develop consumer panels and actively involve stakeholders in the planning, design and evaluation of future service provision. *(Corporate Plan Action 4.1.4)*
- Develop networks for users and carers and capacity build to empower service users. *(Corporate Plan Action 2.1.3, 2.1.6, 4.1.6)*
- Strengthen individual and community capacities by supporting key projects which promote mental health. *(Corporate Plan Action 2.1.3, 2.1.6, 4.1.6)*

#### ACTIVITY

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable. In working towards this, data will be sought on a monthly basis in respect of the following:

- No. of discharges from secondary to primary care.

#### FUNDED SERVICE DEVELOPMENTS

Additional funding of €26.2m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

€60m has been provided for the commissioning of new units in acute and non-acute services, funded under NDP. Detailed allocation of this funding is not yet finalised in respect of new units identified below.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	<ul style="list-style-type: none"> <li>• Further Implementation of the Mental Health Act 2001. <i>(Corporate Plan Action 1.7.4)</i></li> </ul>	€12.75m
	<ul style="list-style-type: none"> <li>• Provision of additional acute beds for Child &amp; Adolescent Psychiatry and the further enhancement of Child &amp; Adolescent Psychiatry services. <i>(Corporate Plan Action 1.7.3)</i></li> </ul>	€3.25m
	<ul style="list-style-type: none"> <li>• Enhance services across Mental Health &amp; Intellectual Disabilities. <i>(Corporate Plan Action 1.7.8)</i></li> </ul>	€2.25m
	<ul style="list-style-type: none"> <li>• Provision of additional long-stay/continuing care beds for Old Age Psychiatry Services. <i>(Corporate Plan Action 2.1.2)</i></li> </ul>	€2m
	<ul style="list-style-type: none"> <li>• Further enhancement of forensic psychiatry services. <i>(Corporate Plan Action 1.7.4)</i></li> </ul>	€1m

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	<ul style="list-style-type: none"> <li>Standardise remuneration for psychology trainees.</li> </ul>	€1m
	<ul style="list-style-type: none"> <li>Further enhancement of multi-disciplinary teams. (<i>Corporate Plan Action 1.3.2</i>)</li> </ul>	€1m
	<ul style="list-style-type: none"> <li>Further enhancement of Mental Health Promotion services and services provided by our Voluntary Partners. (<i>Corporate Plan Action 2.1.3, 2.1.4, 2.1.6</i>)</li> </ul>	€1m
	<ul style="list-style-type: none"> <li>Further enhancement of services for Homeless persons with Mental Illness. (<i>Corporate Plan Action 1.1.1, 1.4.1, 1.4.2</i>)</li> </ul>	€0.75m
	<ul style="list-style-type: none"> <li>Implement elements of <i>Reach Out: Strategy for Action on Suicide Prevention 2005-2014</i>. (<i>Corporate Plan Action 2.4.2</i>)</li> </ul>	€1.2m
	<p><b>Commissioning of new units in non acute services under NDP:</b></p> <ul style="list-style-type: none"> <li>Provision of a new unit in Our Lady's Hospital, Cashe, Co. Tipperary for the elderly mentally infirm, to include supervised residence/clinical accommodation and independent living units.</li> <li>Provision of a new dementia unit in Carndonagh, Co. Donegal.</li> </ul>	To be funded from €60m which has been provided for the commissioning of new units in acute and non-acute services, funded under NDP.
<b>TOTAL</b>		<b>€26.2M + NEW UNIT ELEMENT</b>

#### 4.4.3.2 KEY ISSUES FOR THE YEAR AHEAD

- Capacity to respond to the requirements set out in the Report of the Expert Group on Mental Health.
- Continued Implementation of the Mental Health Act 2001.
- Impact of Disability Act (2005) and the Education for Persons with Special Needs Act (2004).
- Capacity to rebalance resources based on identified need.

#### 4.4.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

Activity data will also be collected and provided for the Health Research Board and Inspector of Mental Hospitals. Where they exist, Consumer Panels/forums will continue to monitor and review services.

#### 4.4.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.5 PALLIATIVE CARE

### 4.5.1 CONTEXT

#### ROLE AND PURPOSE

Palliative Care is defined as the active total care of patients whose disease is no longer responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for patients and their families.

Palliative care:

- Affirms life and regards dying as a normal process.
- Neither hastens nor postpones death.
- Provides relief from pain and other distressing symptoms.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help family cope during the patient's illness and in their own bereavement.

The current delivery of palliative care services in the HSE varies from and within each Primary, Community and Continuing Care region and Hospital Network.

#### PROFILE

It is anticipated that the need for palliative care services will increase in the future. Population projections indicate that the population of over 65s will double in the period between 1996 and 2031. The 2002 census indicated that there were 436,001 (11.13%) people over the age of 65 in Ireland. This figure is expected to rise to 631,000 over the next 11 years. This prediction has significant implications for Palliative Care services, as ageing increases the risk of becoming patients or carers. New treatments will not only reduce mortality but also, in many cases, extend the period for which palliative care will be required.

People in receipt of Palliative Care services are predominantly those who have cancer. The number of cancer cases in Ireland, as with the rest of Europe, has shown a consistent rise over the last century and into the 21<sup>st</sup> century. Figures from the National Cancer Registry of Ireland show that cancer deaths totalled 7,621 in 2002. This increase is tempered by reductions in some individual rates of specific types of cancer in the various age cohorts.

Issues and factors that will challenge services in the future and affect the scale of need include:

- The extension of Palliative Care services to include patients with life-limiting illnesses other than cancer, such as advanced and progressive CVD, neurological, rheumatological and respiratory diseases. The National Advisory Council report estimated the numbers of persons with non-malignant conditions who could benefit from Specialist Palliative Care interventions as a possible 5000 per annum at current rates. Therefore, it is estimated that the extension of palliative care

services to include patients with non-malignant conditions would need a doubling of the existing services and their activity levels.

- Demographics and changing patterns of disease.
- Increased awareness and specialisation of Palliative Care services.
- Specialist interventions at an earlier part of the disease process.

Despite the obvious progress in developing palliative care services in Ireland, there are some groups in society whose needs need to be constantly reviewed and services put in place to address their needs. These can include the less affluent, older persons, children and ethnic/non national groups.

#### **4.5.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED**

The HSE has a statutory responsibility for planning and commissioning palliative care services on a national basis. In conjunction with the HSE, the voluntary sector in Ireland has been at the forefront of service development in the Palliative Care field over the last twenty years.

This partnership has been further developed through the decision making and planning approaches taken through the Development and Consultative Committees established in each former health board. These committees allow all key stakeholders the opportunity to engage in a partnership model, thus influencing funding utilisation, developments and monitoring of services on a continuous basis.

The provision of palliative care services in Ireland encompasses a broad range of interventions in multiple locations. This ranges from acute and sub-acute specialist palliative care inpatient units, community residential care, home and community based supports and bereavement supports. Services are accessed in a number of ways across the delivery system.

Palliative care services are structured in three levels of ascending specialisation. These levels refer to the expertise of the staff providing the service.

- Level One – Palliative Care approach: All health care professionals should appropriately apply palliative care principles.
- Level Two – General palliative care: At an intermediate level, a proportion of patients and families will benefit from the expertise of health care professionals who, although not engaged full time in palliative care, have had some additional training and expertise in palliative care.
- Level Three – Specialist palliative care: Specialist palliative care services are those services whose core activity is limited to the provision of palliative care.

An outline of services provided is listed below:

- Specialist Palliative Care Inpatient Units
- Home Care
- Day Services
- Specialist Palliative Care in Acute General Hospitals
- Community and other intermediate level of inpatient care in Community Hospitals
- Bereavement Support
- Education and Research

The component parts of these teams include involvement of some or all of the following: General Practice, Nursing, Occupational Therapy, Physiotherapy, Complementary, Artistic and Supportive Therapies, Volunteers, Pastoral Care, Dietetics and Creative Therapies.

## Current Service Profile

**TABLE 4.5.1: PROFILE OF PALLIATIVE CARE ACTIVITY 2004**

No. of specialist Inpatient units	8
No. of satellite units	3
Total no. of patients admitted	1,478
No. of Home Care Services	22
No. of patients seen	7,203
No. of intermediate beds in community hospitals	116
No. of patients admitted	540
No. of units offering day-care services	5
No. of patients attending	538
No. of day care attendees	5961

*\*Source: Baseline Palliative Care Study*

### 4.5.3 THE YEAR AHEAD

#### 4.5.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experiences of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Continue to implement recommendations of the *National Palliative Care Strategy*. (*Corporate Plan Action 1.7.9*)
- Work with the Department of Health and Children in the development of plans for paediatric palliative care. (*Corporate Plan Acton 1.7.10*)
- Continue to enhance the scope of day services on a national basis. (*Corporate Plan Acton 1.7.9*)
- Further develop the multidisciplinary home care approach. (*Corporate Plan Acton 1.3.2, 1.7.9, 3.4.1*)

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Develop standards for palliative care across specialist inpatient units, home care teams and community hospitals, in partnership with voluntary and statutory agencies. (*Corporate Plan Acton 1.10.1, 1.10.3, 4.1.6*)
- Identify palliative care priorities, in partnership with key stakeholders, in response to regional needs assessments. (*Corporate Plan Acton 2.1.2*)
- Identify opportunities to progress the availability of home care services. (*Corporate Plan Acton 1.3.2*)
- Continue to develop bereavement services. (*Corporate Plan Acton 1.7.9*)

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Continue to promote and develop multidisciplinary teamwork at all levels of service delivery. (*Corporate Plan Acton 1.4.1, 1.4.2, 1.7.9, 3.4.1*)
- Develop the Specialist educational programmes provided within Palliative Care Services. (*Corporate Plan Acton 1.7.9, 3.1.2*)

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders.**

- Reconfigure and strengthen Regional Committee structures. (*Corporate Plan Acton 4.1.6, 4.2.1*)
- Review partnership arrangements with voluntary and community organisations to ensure that there is a coordinated, effective, quality and evidence based delivery of services. (*Corporate Plan Acton 4.1.6*)
- Involve patients, service users and the public in planning and monitoring of health services. (*Corporate Plan Acton 4.4.1*)
- Review existing Palliative Care data and information systems. (*Corporate Plan Acton 4.3.2, 4.3.3, 4.4.2*)

**ACTIVITY:**

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable. Robust performance indicators will be developed in respect of palliative care services in 2006. In working towards this, data will be sought on a monthly basis in respect of the following:

- No. of patients treated in specialist inpatient units.
- No. of patients accessing Home Care services.
- No. of home visits/contacts.
- No. of patients accessing intermediate care in community hospitals.
- No. of patients accessing day care.
- No. of attendances at day care.

**4.5.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- The extension of Palliative Care services to address the needs of children and persons with non-malignant conditions.
- Implementing the recommendations of the *National Advisory Council Report 2001* on a national basis.
- Addressing the challenges of socially excluded groups and an increasingly multicultural society.
- Sustaining existing levels of service through strengthening of partnership arrangements with Voluntary organisations.

**4.5.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

**4.5.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.6 CHRONIC ILLNESS

### 4.6.1 CONTEXT

Services for people with **Chronic Illness** aim to promote quality of life and independence for people with chronic illness/conditions by ensuring they receive coordinated care and support that is planned in partnership with them, around their needs and choices.

Chronic conditions are defined as health problems that require ongoing management over a period of years or decades, and include: diabetes, heart disease, asthma, chronic obstructive pulmonary disease (COPD), cancer, HIV/AIDS, depression, and physical disabilities. (*source: WHO 2004*)

Common modifiable risk factors are unhealthy diet, physical inactivity and tobacco use. Non-modifiable risk factors are age and heredity. Intermediate risk factors are raised blood pressure, raised blood glucose, abnormal blood lipids and overweight/obesity (Ref: *Preventing Chronic Diseases a Vital Investment*, WHO 2005).

There are many other chronic conditions, but the one feature that unites them all is that they typically affect the social, psychological and economic dimensions of a person's life. Most are already receiving quality care, routinely, from health and social care services across the country. However, there is evidence that many individuals with complex conditions fail to have their needs met in a co-ordinated way.

Those with chronic conditions are significantly more likely to see their GP, to be admitted as inpatients, and to use more inpatient days than those without such conditions. The burden of chronic illness falls principally on the elderly, so as our population ages the incidence and prevalence of chronic diseases will increase.

It is important therefore that we increase our focus on the management of long-term conditions.

### PROFILE

We face the challenge of responding to the needs and expectations of increasing numbers of people with long term medical conditions. It is likely that up to three-quarters of people over 75 years are suffering from chronic illness, of whom nearly half (45%) have more than one condition:

- More older people are affected than younger people.
- People with more than one condition are high users of all health services, including those for emergencies.
- Incidence is highest among the most disadvantaged groups, such as unemployed people.
- As the population ages chronic diseases will continue to rise.
- At the moment, patients with multiple needs often receive unplanned and uncoordinated care, and are frequently admitted to hospital.
- Chronic Diseases affect women and men almost equally.

#### 4.6.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services for people with chronic illness/conditions are provided in both the Acute Hospital and Primary, Community and Continuing Care settings relative to disease and symptom presentation. As chronic conditions can present along the life cycle, depending on aetiology, services are provided accordingly within the current care group structure.

#### 4.6.3 THE YEAR AHEAD

##### 4.6.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Identify models of best practice which provide effective integrated care services for people with chronic illness and disseminate the learning within an agreed national approach. *(Corporate Plan Acton 1.4.2, 1.4.3, 2.3.5)*
- Enhance the scope and responsiveness of services to persons with Hepatitis C in line with the provisions of the Health Amendment Act (1996), with particular emphasis on providing a consistent national approach to service provision. *(Corporate Plan Acton 1.3.1, 1.3.2, 1.4.3)*
- Lead the development of an effective, systematic approach to the care and management of patients with a long-term condition in local health and social care communities, focusing initially on Diabetes and Asthma. *(Corporate Plan Action 1.4.2, 1.4.3, 2.3.5)*
- Develop a number of Chronic Obstructive Pulmonary Disease (COPD) 'Rapid Response Team' projects in the community, to work in partnership with NHO and primary care providers. *(Corporate Plan Action 1.3.2, 1.4.2, 1.4.3, 2.3.5)*
- Continue to support the implementation of the relevant provisions of the Cardiovascular Strategy. *(Corporate Plan Acton 1.4.3, 2.2.4)*
- Continue to support the implementation of the relevant aspects of the new National Cancer Strategy (when published). *(Corporate Plan Acton 1.4.3, 2.2.3)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Work with Health Promotion and Population Health to target lower socio-economic groups in regard to healthy lifestyle to promote healthy ageing. *(Corporate Plan Action 1.1.1, 2.1.2, 2.1.3)*
- Collaborate with Population Health and the Health Information and Quality Authority in needs assessment around Chronic Illness. *(Corporate Plan Acton 1.10.3, 2.1.2)*
- Work with the Department of Health and Children in the translation of policies and guidelines around specific conditions into action plans, with initial focus on the development of a National Diabetes Service framework. *(Corporate Plan Acton 1.4.2, 1.4.3, 2.3.5)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Work with NHO to develop appropriate care guidelines, pathways and protocols which support shared care arrangements for people with chronic illness and communicate the most up to date and accurate knowledge and information on chronic disease management to front line health professionals. *(Corporate Plan Action 1.4.2, 1.4.3, 1.10.6, 2.3.5, 3.1.2)*
- Support Local Health Offices in the development of appropriate PCCC team-working to provide a continuum of care for people with chronic illness. *(Corporate Plan Action 1.4.2, 1.4.3, 2.3.5, 3.4.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, and other stakeholders.**

- Expand and develop best practice 'Self Care and Management' programmes in partnership with key stakeholders (with initial focus on Diabetes and Asthma). *(Corporate Plan Action 1.4.2, 1.4.3, 2.3.5)*
- Promote awareness that patient expertise is a central component in the delivery of care to people with chronic disease. *(Corporate Plan Action 1.4.2, 1.4.3, 2.3.5)*
- Identify barriers to mainstreaming user-led self-management and develop plans to address same. *(Corporate Plan Action 1.4.2, 1.4.3, 2.3.5)*

**ACTIVITY**

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable.

Work will be undertaken in 2006 to develop appropriate performance indicators for Chronic Illness.

**4.6.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- Effective development of a National focus on Chronic Illness

**4.6.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

**4.6.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.7 SOCIAL INCLUSION

### 4.7.1 CONTEXT

#### ROLE AND PURPOSE

Social inclusion is synonymous with tackling poverty and health inequalities. The links between poverty and health inequalities are well documented and include the following;

- Prenatal mortality is three times higher in poorer families than in richer families.
- Mortality rates for those in the lowest socio-economic group are significantly higher for a wide range of illnesses.
- Hospitalisation for mental illness is significantly higher for those in the lower socio-economic groups.
- The incidence of chronic physical illness is significantly higher in the lower socio-economic groups.

The aim of Social Inclusion services is to improve access to mainstream and targeted health services, address inequalities in health between social groups and enhance the participation and involvement of socially excluded groups and local communities in the planning, design, delivery, monitoring and evaluation of health services. The challenge is to work in a creative, co-ordinated way across and between sectors in order to provide responsive and sustainable services to populations that are on the margins and at times invisible in society. Services are provided in partnership with individuals, families, communities, the voluntary and Non Government Organisation (NGO) sector and representatives. The positioning of Social Inclusion within the Primary Community and Continuing Care Directorate greatly facilitates service integration and the targeting that is required across services. Community Welfare Services are pivotal to addressing social exclusion and come within the Social Inclusion brief.

Social Inclusion services are underpinned by the National Anti Poverty Strategy and Equality legislation. The Government's geographically targeted social inclusion programmes, RAPID and CLAR, are targeted initiatives aimed at delivering existing resources to areas of maximum need and extend to a number of areas throughout the country. Social Inclusion services target the following groups;- Homeless people, Minority Ethnic Communities; Asylum Seekers; Refugees; Migrant Workers; Travellers; Drug Users, those from the Lesbian, Gay, Bisexual, Transsexual/Transgender communities, people with problematic and/or dependent alcohol use and persons with HIV/AIDS. Social inclusion also includes the range of Community Welfare Services.

#### PROFILE

The Mean Deprivation Index (4.6% Ireland) captures the key determinants of poverty and social exclusion in an area. The most important causes identified in the index are unemployment, isolation, lone parenthood, poor educational achievement and housing. Inequalities in health exist because of a combination of the foregoing factors. Poverty is one of the most important factors that influence health. It contributes to poor health both directly, through damp and inadequate accommodation, and indirectly, through poorer diet and higher stress. Being poor makes it difficult to access or afford adequate health care when needed and can reduce the opportunity and motivation to lead a healthy lifestyle. Some minority groups such as homeless people, travellers, prisoners and those from ethnic minority communities experience particular health problems.

The Government's second National Action Plan against Poverty and Social Exclusion (NAP/inclusion) is part of an EU strategy to make a decisive impact on poverty by 2010. It has been developed in consultation with the social partners – representatives of business, trade unions, community and voluntary sector etc and identifies 6 key areas for action:- unemployment, income adequacy, educational disadvantage, health, housing and disadvantaged rural and urban areas. Targets are set down that take account of the following groups at risk of poverty: older people, children, women, people with disabilities and new and emerging groups such as migrants and ethnic minorities. The key health targets are the following:

- a) To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, cancers, and injuries from poisoning by 2007.
- b) To reduce the gap in low birth weight rates for children between the lowest and highest socio-economic group by 10% by 2007.
- c) To reduce the gap in life expectancy between the traveller community and the whole population by at least 10% by 2007.

Needs, which include information, accommodation, health and welfare, employment, education and training, require a range of responses from the statutory and non-statutory sectors and from both voluntary and community groups.

### **Homeless**

Reasons for homelessness are multifaceted and complex, linked to structural issues such as poverty, generational unemployment and shortage of housing. Other factors include people being discharged from institutions without adequate preparation and plans, young persons leaving care, older people who are inappropriately placed in institutions and persons with mental health and addiction problems. Estimating the number of homeless can be very difficult due to either their transient existence, the fact that they are involuntarily sharing with family or friends or are not accessing homeless services (i.e. the hidden homeless), or the fact that housing waiting lists do not necessarily reflect the true level of need, given that many single people do not register, knowing they will be low on the priority list. In 2002, the Department of the Environment and Local Government estimated that there were 48,413 households on the housing waiting lists nationally, with 3,773 families (5,581 people) homeless. The Department of Environment, Heritage and Local Government are concluding a review to update these figures.

Under the Government's Integrated Strategy on Homelessness, Local Authorities and the HSE are regarded as jointly responsible for addressing the needs of people who are homeless. Local authorities have responsibility for the provision of accommodation for homeless persons, including hostel accommodation, as part of their overall housing responsibility, while the HSE has responsibility for the health and in-house care needs of homeless persons.

### **Ethnic Minorities**

The 2002 Census of Population indicated that there were 3,535,700 Irish nationals in the country, representing 91.6% of the overall population. Non-Irish nationals made up just 5.8% of the population in 2002, of whom 2.7% were UK nationals, followed by other EU nationals, nationals of other European countries, Asian, African and US nationals in that order. Table 4.7.1 below presents a profile of this population by nationality and gender.

**TABLE 4.7.1: USUALLY RESIDENT POPULATION\* 2002 BY MAIN NATIONALITY GROUP AND GENDER**

Nationality	No. of Persons			% Population
	Total	Male	Female	
Irish	3,535,700	1,754,700	1,781,000	91.6%
Dual Irish / Other	49,300	23,900	25,400	1.2%
United Kingdom	103,500	50,700	52,800	2.7%
Other European Union	30,000	14,000	16,000	0.8%
Rest of Europe	23,100	12,900	10,200	0.6%
Asia	21,800	12,000	9,800	0.6%
Africa	21,000	11,000	9,900	0.5%
United States of America	11,400	5,200	6,200	0.3%
Other Countries	11,200	5,700	5,500	0.3%
Multiple Nationality / No Nationality	3,100	1,600	1,500	0.08%
Not Stated	48,400	24,500	23,900	1.2%
<b>Total</b>	<b>3,858,500</b>	<b>1,916,200</b>	<b>1,942,300</b>	<b>100%</b>

\*Excludes visitors

Source: Census 2002

The particular needs of migrants and ethnic minorities require the provision of culturally appropriate services by an informed and culturally aware workforce.

### Travellers

The 2002 Census of Population indicates that there were 23,681 Irish Travellers in the country, representing 0.6% of the overall population. Table 4.7.2 below presents a profile of this population by age category and gender.

**TABLE 4.7.2: TRAVELLER POPULATION PROFILE 2002 BY AGE GROUP GENDER**

	Irish Travellers No. of Persons			% Population
	Total	Male	Female	
Children 0-17 years	11,725	5,981	5,744	50%
Adult 18 - 64 years	11,180	5,373	5,807	47%
Older people (> 65 years)	776	354	422	3%
<b>TOTAL</b>	<b>23,681</b>	<b>11,708</b>	<b>11,973</b>	<b>100%</b>

Source: Census 2002

When compared to the age profile of the overall population, the age profiles of the two populations differ markedly. While the young population aged 0-17 years accounted for 26% of the general population, the corresponding proportion was 50% for Travellers. Older Travellers (i.e. those aged 65 years and over) accounted for just 3% of the total Traveller population, compared with 11% for the general population.

The high birth rate prevalent in the Traveller Community contributes to both higher proportions in the younger age groups and consequentially lower proportions in the older age groups. In addition, the latter is also affected by higher mortality rates for the Traveller Community.

Living conditions impact on health status. Table 4.7.3 below presents an accommodation profile of Travellers.

**TABLE 4.7.3: ACCOMMODATION PROFILE OF TRAVELLERS 2002**

	Permanent Housing Units	Temporary Housing Units	No Description
Percentage of the overall Traveller population	58.6%	33.9%	7.5%

Source: Census 2002

Responses to the particular needs of Travellers are developed and delivered in partnership with Travellers themselves, their representative organisations, statutory, non-statutory, voluntary and community groups.

## Addiction Services

### Drug Misuse

Recent research on illegal drug use in Ireland showed cannabis as the most widely used drug, the highest prevalence rate being 8% among the adult population, as compared to 3% for ecstasy and 2% for cocaine. Cannabis use was higher among young adults (15-34 years) than older adults (35-64 years). 14,452 people were estimated as using heroin (*National Advisory Committee on Drugs (2003)*). In general, men report higher prevalence rates of drug use than women.

An analysis of drug misuse in Ireland from 1998-2002 by the Health Research Board found that the numbers treated for problem drug use and residing in the eastern region increased by 24% during that period, while the numbers treated for problem drug use residing outside the eastern region increased by 163%.

### Alcohol

*SLÁN, 2003* found that 30% of males and 22% of females consume over the recommended upper limit of 21 standard drinks for men and 14 for women, with higher levels in the younger age group. It also reported an increase from 1998 to 2002 in the number of people drinking six or more drinks on one drinking occasion, (defined as binge drinking by the World Health Organisation). This level of over-consumption of alcohol is also linked to educational achievement as illustrated in Table 4.7.4 below.

**TABLE 4.7.4: PERCENTAGE CONSUMING MORE THAN THE RECOMMENDED UPPER WEEKLY DRINKS LIMITS (14/21 STANDARD DRINKS) BY SEX, AGE AND EDUCATIONAL STATUS**

	Males	Males	Males	Females	Females	Females
	*ED1	ED2	ED3	ED1	ED2	ED3
18-34 yrs	44	34	35	27	27	26
35-54yrs	25	30	21	25	20	20
55+ yrs	28	20	34	8	20	22

Source: *National Health & Lifestyle Surveys 2003*

**\*ED1= some secondary education; ED2=complete secondary education; ED3 = some or complete third level education**

As a consequence, alcohol related problems present at different levels in the health service including attendance at Hospital A & E Departments, especially late at night and at weekends. Alcohol use during pregnancy is a growing concern. Alcohol is also involved in 42% of parasuicide cases (3,468 of all cases) in Ireland, with a higher incidence among males (46%) than females (38%). In 2003, there were 3,685 admissions to Psychiatric Inpatient Units and Hospitals for alcoholic disorders. This accounted for 16% of all admissions (Health Research Board 2004).

The harm experienced as a result of alcohol misuse has personal, economic and social consequences. The vast majority of alcohol harm occurs among the adult population. Young Irish men (18-29 age group) reported experiencing more acute harm (work, fights) than any other group in the population, while older men (50-64 age group) reported experiencing more chronic harm (home-life or marriage, health) than others. Young women (18-29 years) reported experiencing more negative consequences than older women, especially harming their work and friendships, getting into fights and having accidents.

Response to the particular needs of those dependent on drugs/alcohol requires a partnership approach across organisational boundaries by statutory, non-statutory, voluntary and community groups, together with clear strategies to prevent and reduce levels of drug/alcohol misuse and harm.

Considerable analyses and consultation processes to identify the needs of persons who are experiencing social disadvantage have been undertaken to inform and shape national policy and influence the delivery of services to minimise disadvantage. Additionally, the ongoing process of needs identification is undertaken in consultation/partnership with individuals, their families, representatives and communities, to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choice, and which reflect best practice.

#### **4.7.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED**

Services are provided across a continuum, from prevention services at home and in the community through to high quality hospital and residential care services when required. Specialist services are provided for people with specific needs arising from marginalisation. Services are provided in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups.

A broad range of Primary, Community based and specialist services are accessed including:

- Culturally appropriate health information/ health promotion including peer led initiatives and services
- Drugs Information Helpline
- Community Education
- Community work
- Primary Health Care including GP, Community Pharmacy and Public Health Nursing
- Multi Disciplinary Teams
- Antenatal care
- Community Welfare Services
- Mental Health Outreach Teams
- Targeted primary care and dental services within centres for homeless people
- Needle exchange/harm reduction
- Screening and Vaccination
- Primary Health Care for Travellers
- Psychology
- Cultural mediation Services
- Counselling
- Residential
- Outreach
- Day treatment
- Detoxification
- Rehabilitation
- Aftercare
- Relapse prevention
- Dedicated substance abuse services for young people
- Targeted alcohol detoxification and relapse prevention services within centres for homeless people

#### **4.7.3 THE YEAR AHEAD**

A number of actions that commenced in 2005 will continue to be progressed/implemented in 2006. Specific details are reflected within the individual Business Plans that support this national Service Plan.

#### 4.7.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Identify models of best practice that target improving access to services within and between health and social services. *(Corporate Plan Action 1.1.1, 1.2.1, 1.3.2, 1.10.6, 2.1.6, 2.4.3)*
- Identify mechanisms to enable marginalised people to participate in decision-making and planning regarding their own needs. *(Corporate Plan Action 1.1.1, 2.4.3, 4.1.1)*
- Develop a National Intercultural Strategy. *(Corporate Plan Action 1.1.1, 2.1.2, 2.1.4, 2.1.6, 2.1.7)*
- Work with the NHO to strengthen care planning and pathways to prevent homelessness among people being discharged from acute hospital services. *(Corporate Plan Action 1.1.1, 1.4.1, 1.4.2, 2.1.4, 2.1.6)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Continue to implement the National Drugs Strategy and the Homeless Strategy, following review. *(Corporate Plan Action 1.1.1, 2.1.4, 2.1.6, 2.3.7)*
- Promote and support the implementation of the Homeless Preventative Strategy. *(Corporate Plan Action 1.1.1, 2.1.4, 2.1.6, 2.3.7)*
- Promote the adoption of the Department of Health and Children's pilot ethnic identifier project across services to inform need and address barriers to access. *(Corporate Plan Action 1.1.1, 2.1.2, 2.4.3, 4.3.2, 4.3.3, 4.4.2)*
- Building on existing models of good practice, work towards the development of a national interpreting service in consultation with services users and staff. *(Corporate Plan Action 1.1.1, 1.2.1, 2.4.3)*
- Strengthen 'poverty proofing' mechanisms in the planning of services. *(Corporate Plan Action 1.1.1, 2.4.1)*
- Support and promote the National Traveller Health Study in partnership with travellers, their representatives and other key stakeholders. *(Corporate Plan Action 1.1.1, 2.1.2, 2.1.4, 4.1.1)*
- Work towards the implementation of the relevant aspects of the Reports of the *Strategic Task Force on Alcohol* (2002 & 2004). *(Corporate Plan Action 2.3.3)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Review and audit services in relation to the training and support needs of staff in the delivery of health services in a multi-cultural society. *(Corporate Plan Action 3.1.2, 3.3.1, 3.4.1)*
- Promote intersectoral training between and across the statutory and non statutory sector within the field of social inclusion services. *(Corporate Plan Action 2.1.4, 3.1.2)*

- Support and promote the inclusion of service users as peer trainers in appropriate settings. *(Corporate Plan Action 1.1.1, 3.1.2, 4.1.1)*
- Lead and promote the dissemination of models of good practice through the training, development and support of staff. *(Corporate Plan Acton 1.10.6, 3.1.2, 4.1.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organization in partnership with service users, patients, staff, not for profit / voluntary/community sector and other stakeholders.**

- Build upon and develop a range of consultation and participation mechanisms for service users. *(Corporate Plan Acton 1.1.1, 2.4.3, 4.1.1)*
- Develop partnership working with NGO's that targets community capacity building to enhance user information, consultation, participation and empowerment. *(Corporate Plan Acton 2.1.4, 2.1.6, 2.1.7, 4.1.1)*
- Develop feedback and evaluation loops with staff and users on service planning, monitoring and evaluation. *(Corporate Plan Acton 4.1.1, 4.1.5)*
- Work with housing providers to develop sustainable and appropriate housing and support packages. *(Corporate Plan Acton 2.1.4, 2.1.6, 2.4.1)*
- Develop a national social inclusion policy for the HSE in partnership with the key stakeholders including service users, staff, statutory and non statutory sectors. *(Corporate Plan Acton 1.1.1, 2.3.7, 2.4.3, 4.1.1, 4.1.5, 4.1.6)*

### ACTIVITY

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable. In working towards this, data will be sought on a monthly basis in respect of the following:

#### Addiction

- No. of clients in methadone treatment.
- No. of clients in residential detoxification.
- No. of clients availing of harm reduction services.

#### Adult Homeless

- No. of clients presenting to Homeless Persons Unit.
- No. of clients presenting for rental assistance.

### FUNDED SERVICE DEVELOPMENTS

Additional funding of €7m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	<b>Travellers Health:</b> <ul style="list-style-type: none"> <li>Further implementation of the Traveller Health Strategy. (<i>Corporate Plan Action 1.1.1, 1.2.1, 1.3.2, 1.10.6, 2.1.6, 2.4.3</i>)</li> <li>Expansion of Primary Healthcare for Travellers' Projects. (<i>Corporate Plan Action 1.1.1, 1.2.1, 1.3.2, 1.10.6, 2.1.6, 2.4.3</i>)</li> <li>Conducting All Ireland Traveller Health Study and roll out of the ethnic identifier pilot. (<i>Corporate Plan Action 1.1.1, 2.1.2, 2.1.4, 4.4.1</i>)</li> </ul>	€2m
	<b>Homeless Services:</b> <ul style="list-style-type: none"> <li>Strengthen Adult Homelessness services, with a particular focus on the revenue funding associated with the adult homeless strategy partnership with Local Authorities. (<i>Corporate Plan Action 1.1.1, 2.1.4, 2.1.6, 2.3.7</i>)</li> </ul>	€2m
	<b>Drugs &amp; HIV Services</b> <ul style="list-style-type: none"> <li>Further expansion of harm reduction services. (<i>Corporate Plan Action 1.1.1</i>)</li> <li>Expansion of Tier 3 teams.</li> <li>Broadening of Treatment services with a particular focus on under 18's services and response to cocaine and polydrug use.</li> </ul>	€3m
<b>TOTAL</b>		<b>€7M</b>

#### 4.7.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2006 are:

- Dispersal system for asylum seekers and refugee applicants i.e. opening of direct provision without planning and consultation with HSE, and length of time families remain in direct provision.
- Impact of Department of Justice, Equality and Law Reform decisions on applications of Irish Born Children.

#### 4.7.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

#### 4.7.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 4.8 PERSONS WITH DISABILITIES

### 4.8.1 CONTEXT

#### ROLE AND PURPOSE

Services for persons with disabilities seek to enable each individual with a disability to achieve his/her full potential and maximise independence, including living as independently as possible. Disability Services are needs led, person-centred and underpinned by the principle of equity. A range of services are provided in partnership with people with disabilities, their families, carers, statutory, non-statutory, voluntary and locally based community groups.

#### PROFILE

The 2002 Census of Population indicated that there were 323,707 people with a disability (i.e. people with a physical, mental or emotional condition) in the country, representing 8% of the overall population. Table 4.8.1 below presents a profile of this population by age category.

**TABLE 4.8.1: PROFILE OF PERSONS WITH A DISABILITY**

	Total Population	Total Number of Persons with a Disability	Number of Persons with a Disability Aged 0-17 years	Number of Persons with a Disability Aged 18-64 years	Number of Persons with a Disability Aged >65 years	Percentage Population with a Disability
Ireland 2002	3,917,203	323,707*	22,346	165,665	135,696	8.0%

*\*Includes all disabilities -physical, mental or emotional conditions*

*Source: Census 2002*

This data also indicates that the prevalence of disability increases significantly with age, from a 2% prevalence rate in young people (aged 0-17 years), to a 7% rate in the 18-64 years group, to a 31% rate in the 65 years and over group.

The needs of people with Intellectual Disability are identified and planned for through the National Intellectual Disability Database. This database details the existing level of specialised health service provision and an assessment of need for the upcoming five-year period.

The 2005 Annual Report of the National Intellectual Disability Database Committee shows a total register of 24,917 persons. A profile of this group is presented in Table 4.8.2 below.

**TABLE 4.8.2: PROFILE OF PERSONS WITH AN INTELLECTUAL DISABILITY**

Degree of Disability	No of Persons			Percentage
	Total	Male	Female	
Mild	8,457	4,807	3,650	33.9%
Moderate	9,536	5,195	4,341	38.3%
Severe	3,971	2,262	1,709	15.9%
Profound	1,054	566	488	4.2%
Not Verified	1,899	1,128	771	7.6%
<b>TOTAL</b>	<b>24,917</b>	<b>13,958</b>	<b>10,959</b>	<b>100.0%</b>

*Source: Annual Report of the National Intellectual Disability Database Committee 2005*

Of the 24,917 persons registered on the National Intellectual Disability Database, needs have been identified for the period 2006-2010 as outlined in Table 4.8.3 below.

**TABLE 4.8.3: NEEDS OF PERSONS WITH AN INTELLECTUAL DISABILITY**

Service Requirement	No of Persons
Persons currently without major component of service	2,270
Persons requiring service enhancement / change	11,590
Persons with unmet need for residential support services	1,803
Persons within Psychiatric Services requiring Intellectual Disability Services	297
Persons with no identified service requirements in period to 2009	516
<b>TOTAL</b>	<b>16,476</b>

Source: Annual Report of the National Intellectual Disability Database Committee 2005

The remaining 8,441 persons identified on the National Intellectual Disability Database are deemed to be in receipt of adequate services.

Specifically, needs have been identified in respect of day, residential support and residential services as outlined in Table 4.8.4 below.

**TABLE 4.8.4: PROFILE OF NEEDS OF PERSONS WITH AN INTELLECTUAL DISABILITY**

	Persons currently without Services		Persons requiring service enhancement/change	
	No of places required 2006-2010	No of places required 2006	No of places required 2006-2010	No of places required 2006
<b>Day Placements</b>	284	284	10,311 (7,217)*	8,986 (6,379)*
<b>Residential Support Services (e.g. respite services)</b>	1,840	1,759	1,251	1,232
<b>Residential Places</b>	2,008	1,763	3,095	3,005

Source: Annual Report of the National Intellectual Disability Database Committee 2005

**\*Health service related places**

Implementation of the Physical and Sensory Disability Database, which is a tool that supports the identification of the numbers of persons requiring, or expecting to require, a range of specialised services to address aspects of their disabilities, commenced in 2002. A preliminary analysis of data (which excludes the HSE Northern Area and HSE East Coast Area) has been undertaken by the Health Research Board and use of that data here is cognisant of the interpretation qualifications specified in their preliminary report. Participation in the Database is voluntary and therefore, the numbers of persons requiring services may be greater than reflected.

There were 22,429 persons registered on the database at June 2005. Profiles of this group are presented in Tables 4.8.5 and 4.8.6 below. Responsibility for the provision of services to persons over 65 years lies with Older Peoples' Services and are not included in this profile.

**TABLE 4.8.5: PROFILE OF PERSONS WITH A PHYSICAL OR SENSORY DISABILITY**

Age Profile	No of Persons			Percentage
	Total	Male	Female	
0-17 years	7,039	4,343	2,696	31%
18-65 years	15,390	7,427	7,963	69%
<b>TOTAL</b>	<b>22,429</b>	<b>11,770</b>	<b>10,659</b>	<b>100%</b>

Source: National Physical and Sensory Disability Database June 2005

**TABLE 4.8.6: PROFILE OF PERSONS WITH A PHYSICAL OR SENSORY DISABILITY BY TYPE OF DISABILITY**

Type of Disability	No of Persons			Percentage %
	Total	Male	Female	
Physical Disability Only	17,723	9,298	8,425	79%
Hearing Loss / Deafness Only	1,494	726	768	7%
Visual Disability Only	1,250	638	612	6%
Primary Speech and Language Disability Only	313	215	98	1%
Combined Disability Types	1,648	893	755	7%
<b>TOTAL</b>	<b>22,428*</b>	<b>11,770</b>	<b>10,659</b>	<b>100%</b>

Source: National Physical and Sensory Disability Database June 2005

**\*1 person did not provide a response**

The top three most frequently reported diagnoses were multiple sclerosis (9%), cerebral palsy (7%) and diabetes (7%). Needs of the 22,429 persons registered on the National Physical and Sensory Disability Database, have been identified as outlined in Table 4.3.7 below.

**TABLE 4.8.7: PROFILE OF NEEDS OF PERSONS WITH A PHYSICAL AND SENSORY DISABILITY**

Service Requirement	Number of people awaiting Assessment for Services	Number of people Assessed but Waiting for Services
Day Services / Activities*		2238
Personal Assistance	6,882 (43% of this group require more than one type of service in this category)	382 (17% of this group require more than one type of service in this category)
Respite Services	4,693 (41% of this group require more than one type of service in this category)	223 (11% of this group require more than one type of service in this category)
Residential Services**		685
Support Services***	13,076 (61% of this group require more than one type of service in this category)	1,569 (16% of this group require more than one type of service in this category)
Technical Aids / Appliances		9,345 (requests for a least one future technical aid/ appliance)

Source: National Physical and Sensory Disability Database June 2005

\*In addition to those not currently receiving day services/activities but requiring these supports (2238), there are 3,473 people who require some change to their existing day service/activity.

\*\* In addition to those not currently receiving residential services but requiring these supports (685), there are 200 people who require some change to their existing residential service.

\*\*\* Support services include therapeutic, intervention and rehabilitation services.

Considerable needs analyses and consultation processes to identify the needs of persons with disabilities have been undertaken to inform and shape national policy and influence the delivery of Disability Services. Additionally, the ongoing process of needs identification is undertaken in consultation/partnership with persons with disabilities, their families, carers and representatives to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choices, and which reflect best practice. Intellectual Disability Consultative and Development Committees and Regional Co-ordinating Committees on Physical and Sensory Disabilities will continue to inform the process in 2006.

#### 4.8.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services are provided in a variety of community and residential settings in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups. The broad range of Primary and Community based services are accessed as well as specialist services, which include:

- Assessment, Diagnostic and Early Intervention Services.
- Children's Services, including pre school supports.

- Residential and Respite Services including home respite and day services.
- Specialist Support Services, including interdisciplinary and outreach services.
- Rehabilitation Training, including Sheltered Occupational Services and Activation.
- Aids and Appliances.
- Allowances, including Mobility, Domiciliary and Blind Welfare.
- Information and advice, advocacy, counselling and general support.

In 2005, 24,078 persons (96.6% of the total population registered on the National Intellectual Disability Database, compared to a service provision level of 93.8% in 2004) with an intellectual disability were in receipt of services. Table 4.8.8 below presents a profile of this service provision.

**TABLE 4.8.8: 2005 SERVICE PROVISION FOR PERSONS WITH AN INTELLECTUAL DISABILITY**

Service Provision	No of Persons in Receipt of Services
Day Services	15,976
Residential Services-5 or 7 Day	7,677
Residential Support Services only	29
Resident in Psychiatric Hospital	396
Multi-disciplinary Support Services (including Early Intervention Services)	18,399
In receipt of no service	323
No identified service requirements	516

*Source: Annual Report of the National Intellectual Disability Database Committee 2005*

Table 4.8.9 below presents a profile of service provision for persons with a Physical or Sensory Disability in 2005.

**TABLE 4.8.9: 2005 SERVICE PROVISION FOR PERSONS WITH A PHYSICAL OR SENSORY DISABILITY**

Service Provision	Number of Persons in Receipt of Services
Therapeutic, Intervention and Rehabilitation Services	17,865
Personal Assistance and Support Services	5,903
Day Services and Activities	11,605
Respite Services	
• Planned Respite	2,255
• Emergency Respite	336
Technical Aids and Appliances	14,255
Residential Services	662

*Source: National Physical and Sensory Disability Database June 2005*

### 4.8.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are reflected within the individual Business Plans that support this National Service Plan.

#### 4.8.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experiences of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Enhance measures to improve access and use of acute hospital services by people with Intellectual Disabilities and people with higher support needs. (*Corporate Plan Action 1.1.1*)

- Establish clear pathways for people with disabilities and their families, to enable them to access services effectively. *(Corporate Plan Action 1.1.2)*
- Reconfigure services for children with developmental delay to reflect requirements under the Education for Persons with Special Educational Needs Act 2004 (EPSEN) and the Disability Act 2005, specifically in relation to the Individual Education Plan (IEP) Process. *(Corporate Plan Action 1.1.2)*
- Continue joint working with the Department of Education and Science to enhance the provision of education services for adults with disabilities, to increase the level of pre-school provision and to introduce new appeals processes as envisaged in EPSEN. *(Corporate Plan Action 1.4.1)*
- Continue joint working with Statutory Agencies in relation to needs assessment, where identified need encompasses the broader determinants of health, but which is outside the remit of health provision, such as housing. *(Corporate Plan Action 1.4.1)*
- Work closely with the Department of Justice, Equality and Law Reform to administer a scheme of grant aid support for voluntary sector projects. *(Corporate Plan Action 1.4.1)*
- Provide additional day, residential and respite services for people with Autism and Intellectual Disabilities and specialist services for people with challenging behaviours. *(Corporate Plan Action 1.1.2)*
- Provide additional home support, personal assistance, rehabilitative training, aids and appliances and residential services for people with Physical and Sensory Disabilities. *(Corporate Plan Action 1.1.2)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Maintain and develop National Disability Databases to identify current and future health care and related support service trends and needs. *(Corporate Plan Action 2.1.2)*
- Identify opportunities to integrate current disability database structures, following review. *(Corporate Plan Action 2.1.2)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Co-operate with third level institutions involved in the expansion in professional therapy training places, specifically in relation to clinical placements and course content. *(Corporate Plan Action 3.1.1)*
- Promote a learning environment through the implementation of continuous professional development, learning needs analysis, professional supervision, and internal/external training. *(Corporate Plan Action 3.1.2)*
- Provide specific training for disability staff involved in meeting obligations under the EPSEN and the Disability Act. *(Corporate Plan Action 3.1.2)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organization in partnership with service users, patients, staff, not for profit/voluntary/community sector and other stakeholders.**

- Enhance links with service users by promoting their involvement in planning, consultative and decision making forums. *(Corporate Plan Action 4.1.1)*
- Restructure consultative forums with partnership agencies to reflect new HSE Structures. *(Corporate Plan Action 4.1.6, 4.2.1)*
- Work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID/CLAR Programmes. *(Corporate Plan Action 4.1.6)*
- Work with statutory, non-statutory, community and voluntary groups to address the housing needs of persons with disabilities. *(Corporate Plan Action 4.1.6)*
- Refine and develop monitoring systems to record and collate information on expenditure of funding in Disability Services and the outcomes in relation to service provision. *(Corporate Plan Action 4.4.2)*
- Develop the Disability Databases to include Disability allowances. *(Corporate Plan Action 4.4.2)*

**ACTIVITY**

In 2006, we will build on existing data and information suites in the system to support the development of a minimum data set, where applicable. In working towards this, data will be sought on a monthly basis in respect of the following:

- No. of Personal Assistance hours provided.
- No. of persons benefiting from home-based and centre-based respite.
- No. of persons in receipt of Domiciliary Care Allowance.
- No. of persons in sheltered work.
- No. of persons in rehabilitative training.

**FUNDED SERVICE DEVELOPMENTS**

Additional funding of €73.8m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

€60m has been provided for the commissioning of new units in acute and non-acute services, funded under NDP. Detailed allocation of this funding is not yet finalised in respect of new units identified below.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	<b>Services for Persons with Intellectual Disability and Autism - €39.5m to:</b> <ul style="list-style-type: none"> <li>• Provide 255 additional residential places. <i>(Corporate Plan Action 1.1.2)</i></li> <li>• Provide approximately 535 new day places. <i>(Corporate Plan Action 1.1.2)</i></li> <li>• Provide approximately 85 additional respite places. <i>(Corporate Plan Action 1.1.2)</i></li> <li>• Meet costs associated with moving individuals to more appropriate placements. <i>(Corporate Plan Action 1.1.2)</i></li> </ul>	€37.3m  €2.2m
	<b>Persons with Physical and Sensory Disability - €11.8m to:</b> <ul style="list-style-type: none"> <li>• Provide approximately 80 new places for people with significant disabilities who are currently placed in inappropriate settings. <i>(Corporate Plan Action 1.1.2)</i></li> <li>• Provide approximately 250,000 extra hours of home support and personal assistance. <i>(Corporate Plan Action 1.1.2)</i></li> <li>• Employment of 3 Resource Officers to assist persons with sensory disabilities and for the provision of assistive / adaptive technology for people with sensory disabilities. <i>(Corporate Plan Action 1.1.2)</i></li> </ul>	€11.3m  €0.5m
	<b>Additional Disability Support Services Intellectual, Physical and Sensory Disability/Autism - €22.5m to:</b> <ul style="list-style-type: none"> <li>• Enhance the level and range of multi-disciplinary support services available to adults and children with intellectual, physical and sensory disabilities and those with autism, with a priority in 2006 on enhancing the assessment and support services for children with disabilities. <i>(Corporate Plan Action 1.1.2)</i></li> <li>• Address core under funding and core staffing issues. The principles underpinning the allocation of this funding are to be the subject of further discussion between the relevant officials in the Department and the HSE. <i>(Corporate Plan Action 1.1.2)</i></li> </ul>	€12.5m  €10m
	<b>Commissioning of new units in non acute services under NDP:</b> <ul style="list-style-type: none"> <li>• Provision of a new unit in COPE Foundation, Cork for intellectual disability support. <i>(Corporate Plan Action 1.1.2)</i></li> </ul>	To be funded from €60m which has been provided for the commissioning of new units in acute and non-acute services, funded under NDP.
<b>TOTAL</b>		<b>€73.8M + NEW UNIT ELEMENT</b>

#### 4.8.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2006 include:

- The impact on services of the *Disability Act 2005* and *Education for Persons with Special Educational Needs Act 2004*.
- Implementation of the Comptroller and Auditor General's recommendations contained in the report on the *Arrangements with Nonprofit Bodies Delivering Health Services to Persons with Disabilities*.
- Compliance with the *National Standards for Disability Services*.
- Provision of specialist services for specific groups, particularly those with multiple disabilities, persons with autistic spectrum disorder, challenging behaviours and significant physical disabilities.

**4.8.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

Service delivery will continue to be monitored through the collation and reporting of data collected directly from service providers and by information generated from the National Intellectual Disability, Physical and Sensory Disability and Occupational Guidance Databases.

**4.8.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 5.0 NATIONAL HOSPITALS' OFFICE

### 5.0.1 CONTEXT

#### ROLE AND PURPOSE

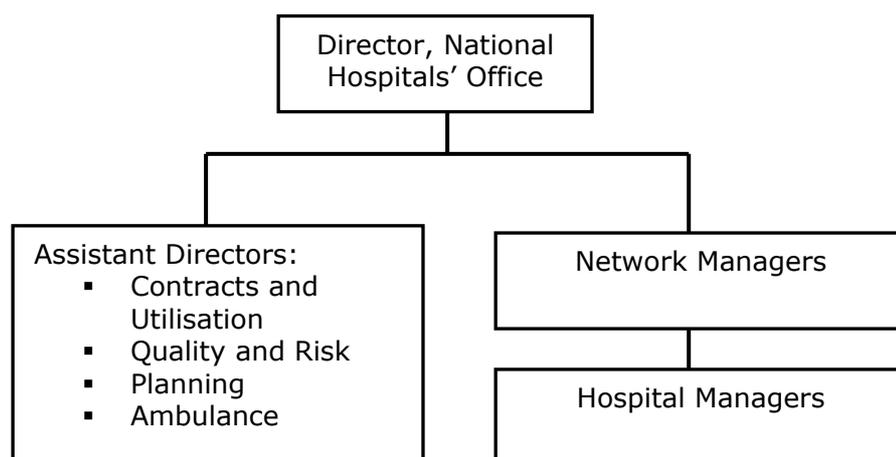
The role of the National Hospitals' Office (NHO) is to manage and co-ordinate the delivery of acute hospital services in the 53 statutory and non-statutory acute hospitals and to manage the Ambulance and Pre-Hospital Emergency Care Services.

#### NEEDS ANALYSIS

A profile of the population and population health challenges are detailed in Chapter 3.

### 5.0.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The NHO management structure is set out diagrammatically as follows:



There are 53 public acute hospitals, with a total of 13,771 beds (at October 2005), distributed as follows:

Hospital Name	Inpatient beds	Day beds	Total no beds
<b>Network 1</b>			
Waterford Regional Hospital, Co. Waterford			
Wexford General Hospital, Co. Wexford			
St. Luke's County Hospital, Kilkenny			
South Tipperary General Hospital, Clonmel, Co. Tipperary			
Our Lady's Hospital, Cashel, Co. Tipperary			
Lourdes Orthopaedic Hospital, Kilcreene, Co. Kilkenny			
Total in Network 1	1,283	119	1,402
<b>Network 2</b>			
Cork University Hospital, Cork			
Unified Maternity Services, Cork			
St. Mary's Orthopaedic Hospital, Cork			
Mallow General Hospital, Co. Cork			
Kerry General Hospital, Tralee, Co. Kerry			
Bantry General Hospital, Co. Cork			
Mercy University Hospital, Cork			
South Infirmary/Victoria University Hospital, Cork			
Total in Network 2	1,805	190	1,995

Hospital Name	Inpatient beds	Day beds	Total no beds
<b>Network 3</b>			
Our Lady of Lourdes Hospital, Drogheda, Co. Louth Louth County Hospital, Co. Louth Our Lady's Hospital, Navan, Co. Meath Monaghan General Hospital, Co. Monaghan Cavan General Hospital, Co. Cavan			
Total in Network 3	871	105	976
<b>Network 4</b>			
Sligo General Hospital, Co. Sligo Letterkenny General Hospital, Co. Donegal			
Total in Network 4	626	59	685
<b>Network 5</b>			
University College Hospital, Galway Merlin Park Regional Hospital, Galway Mayo General Hospital, Castlebar, Co. Mayo Portiuncula Hospital, Ballinalsoe, Co. Galway Roscommon County Hospital, Co. Roscommon			
Total in Network 5	1,322	88	1,410
<b>Network 6</b>			
Midland Regional Hospital, Mullingar, Co. Westmeath Midland Regional Hospital, Tullamore, Co. Offaly Midland Regional Hospital, Portlaoise, Co. Laois			
Total in Network 6	533	70	603
<b>Network 7</b>			
Mid Western Regional Hospital, Dooradoyle, Limerick Mid Western Regional Maternity Hospital, Limerick Mid Western Regional Hospital, Ennis, Co. Clare Mid Western Regional Hospital, Nenagh, Co. Tipperary Mid Western Regional Orthopaedic Hospital, Croom, Co. Limerick St. John's Hospital, Limerick			
Total in Network 7	849	118	967
<b>Network 8</b>			
St. Vincent's University Hospital, Elm Park, Dublin St. Michael's Hospital, Dun Laoghaire, Co. Dublin St. Colmcille's Hospital, Loughlinstown, Co. Dublin National Maternity Hospital Holles St, Dublin Hume Street Hospital, Dublin St. Luke's Hospital, Rathgar, Dublin Royal Victoria Eye and Ear, Adelaide Road, Dublin			
Total in Network 8	1,201	85	1,286
<b>Network 9</b>			
St. James's Hospital, Dublin The Adelaide & Meath Hospital incorporating the National Children's Hospital, Tallaght, Dublin Naas General Hospital, Co. Kildare Coombe Women's Hospital, Dublin Our Lady's Hospital for Sick Children, Crumlin, Dublin			
Total in Network 9	2,125	143	2,268
<b>Network 10</b>			
Mater Misericordiae, Dublin Beaumont Hospital, Dublin Connolly Hospital, Blanchardstown, Dublin Rotunda Hospital, Dublin The Children's Hospital, Temple Street, Dublin St. Mary's, Cappagh Orthopaedic			
Total in Network 10	1,959	220	2,179
<b>Total Beds in All Networks</b>	<b>12,574</b>	<b>1,197</b>	<b>13,771</b>

A comprehensive range of assessment, diagnosis, treatment and rehabilitation services are provided on a regional, supra-regional or national basis through the acute hospitals. Designated national specialist services incorporate areas of care such as heart / lung transplantation, liver transplantation, cochlear implants, metabolic screening, bone marrow transplants, adult cystic fibrosis, spinal injuries, paediatric cardiac services, medical genetics, renal transplantation and haemophilia. Supra-regional services include neurosurgery and cardiac surgery, as well as complex cancer surgeries and radiotherapy.

In addition to direct service provision, there are a number of arrangements in place with other service providers in Ireland and abroad for the delivery of specific services. These include agreements to provide clinical services such as renal dialysis, paediatric cardiothoracic surgery, lung transplantation and radiotherapy.

Acute hospitals play a key role in undergraduate and post graduate training and education for medical and health service professionals. Hospitals are also involved in clinical and related research activities, involving close links with universities and other third level institutions.

### 5.0.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are reflected within the individual Business Plans that support the National Service Plan.

#### 5.0.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

The HSE's Corporate Plan sets out four objectives, along with supporting goals and high level actions to be taken over the life of the Plan (2005 – 2008). During 2006, the National Hospitals' Office and Acute Hospitals will pursue the following actions:

**Corporate Objective 1: We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

##### *Equitable Access*

- Work with PCCCD to continue, and to enhance, measures to improve access and use of acute hospital services by people with intellectual disabilities and people with higher support needs. *(Corporate Plan Action 1.1.1)*
- Prioritise equity of access and regional self sufficiency as key elements of the allocation of resources within the acute services. *(Corporate Plan Action 1.1.3)*

##### *Waiting Times*

- Review outpatient services nationally and begin implementation of the resulting recommendations. *(Corporate Plan 1.3.1.)*
- Develop specific proposals to ensure that those requiring hospital care receive it in a timely manner in accordance with defined needs. *(Corporate Plan 1.3.2)*
- Work with the National Treatment Purchase Fund (NTPF) to target a reduction in waiting times. *(Corporate Plan 1.3.3)*
- Use data from the National Patient Treatment Register to improve both planning and access to services. *(Corporate Plan 1.3.3.)*

##### *Integration*

- Promote integrated working within and between hospital networks and between secondary and tertiary levels of acute care. *(Corporate Plan 1.4.2)*
- Develop better integration and collaborative arrangements between hospitals and primary, community and continuing care services, thus ensuring continuity of care for service users in their interaction with health and personal social care

services. This will build on existing models of good practice within the system, e.g. in relation to diabetes and asthma. *(Corporate Plan 1.4.2)*

- Establish specific processes / mechanisms with PCCCD to look at the management and care of older people. *(Corporate Plan 1.4.2)*
- In conjunction with PCCCD and Population Health, agree a national approach to the management of chronic illness and establish a number of pilot projects, initially developing integrated care pathways for the following conditions:
  - Chronic Obstructive Pulmonary Disease (COPD).
  - Diabetes.\* *(Corporate Plan 1.4.3.)*  
*\*in the context of the forthcoming National Diabetes Strategy*

#### *Reorganisation of services*

- Demonstrate parity of treatment in our relationships with all hospitals, based on the following principles:
  - Appropriate resource allocation.
  - Alignment of clinical decision making and accountability.
  - Standardised performance measurement in line with the National Performance Monitoring Framework. *(Corporate Plan 1.5.1)*
- Continue to give effect to national strategy and policy in service areas under the remit of the NHO, with particular reference to optimising the commissioning of additional bed capacity, as per the Acute Hospital Bed Capacity Report. *(Corporate Plan 1.5.1)*
- Commence implementation of the recommendations arising from the National Renal Review, once published. *(Corporate Plan 1.5.1)*
- Commence implementation of the recommendations arising from the National Review of Cystic Fibrosis services. *(Corporate Plan 1.5.1)*
- Work with all relevant stakeholders to develop an agreed approach to the future development of national neuroscience services. *(Corporate Plan 1.5.1.)*
- Commence implementation of the recommendations arising from the Review of Tertiary Paediatric services. *(Corporate Plan 1.5.1)*
- Establish formal mechanisms to engage with General Practitioners on the development and delivery of hospital services. *(Corporate Plan 1.5.1)*
- Develop and pilot clinical networks in relation to the following services / specialties initially:
  - Vascular services. (as per Comhairle Report)
  - Obstetrics. *(Corporate Plan 1.5.1.)*
- Develop a plan to spread the learning and improvements from the pilot sites to the rest of the hospital system, on a phased basis. *(Corporate Plan 1.5.1)*
- Implement a set of targeted, evidence based interventions for patients with Acute Myocardial Infarction in three pilot sites initially. *(Corporate Plan 1.5.1)*
- Review and revise utilisation of existing acute hospital beds, facilities and equipment so that patient care is optimised. *(Corporate Plan 1.5.1)*
- Play a key role in the negotiation of new contracts with Consultants and other key staff groups. *(Corporate Plan 1.5.1)*

- Commence the reorganisation of services arising from:
  - The implementation of the European Working Time Directive.
  - The recommendations of the Report of the National Task Force on Medical Staffing.
  - The introduction of revised contractual arrangements for non-consultant hospital doctors, consultants and other staff groups.
  - Changes to the organisation of medical education and staffing. (*Corporate Plan 1.5.1*)
- Lead the implementation of the National Radiotherapy Plan and examine the potential for securing additional radiotherapy services, pending the full implementation of the plan. (*Corporate Plan 1.5.1*)
- Contract with the private sector providers for specific services, with particular emphasis on ensuring quality of care and value for money. (*Corporate Plan 1.5.2*)
- Establish a forum to enable the involvement of the independent hospital sector in service development, emergency planning, information exchange and the identification of potential areas for service agreements. (*Corporate Plan 1.5.2*)
- Approve proposals under the 1,000 beds initiative which satisfy the assessment criteria established by the HSE. (*Corporate Plan 1.5.2*)

#### *Primary Care*

- Consider new models of providing diagnostic services, e.g. through extending hours of service or through partnerships with the private sector. (*Corporate Plan 1.6.2*)
- Improve access for patients referred by GPs to hospital based services, e.g. outpatients. (*Corporate Plan 1.6.2*)

#### *Community and Continuing Care Services*

- Building on existing good practice models of discharge planning in the system, work with PCCCD to provide appropriate outreach to ensure that patients have the support they need in the community, on discharge from hospital. (*Corporate Plan 1.7.1*)
- Work with PCCCD to implement all relevant aspects of the Palliative Care Strategy. (*Corporate Plan 1.7.9*)
- Collaborate with the DoHC and PCCCD to further develop plans for paediatric palliative care. (*Corporate Plan 1.7.10*)

#### *A&E Services*

- Continue to implement the A&E 10-point plan and improve accident and emergency services to reduce significantly the unacceptable delays many patients encounter when they require admission, by focusing on:
  - reducing the time taken to treat patients in A&E.
  - improving hospital efficiency and discharge procedures. (*Corporate Plan 1.8.1*)
- Commence implementation of the recommendations arising from the Process Mapping exercise in A&E services. (*Corporate Plan 1.8.1*)
- Consider the recommendations of the Paediatric Emergency Services Network once their Report is published. (*Corporate Plan 1.8.1*)

*Quality, Safety and Risk Management*

- In consultation with key stakeholders across our services, agree high priority areas for action to improve patient safety. *(Corporate Plan 1.10.1)*
- Pursue, develop and implement quality standards throughout our services, driving a culture of safety, review and audit at all levels. *(Corporate Plan 1.10.1)*
- All public hospitals will be encouraged and supported to participate in the National Accreditation Programme. *(Corporate Plan 1.10.1)*
- Put in place measures for reporting of adverse incidents and events associated with blood quality and safety, in compliance with the requirements of the EU Blood Quality and Safety Directive. *(Corporate Plan 1.10.1)*
- Put measures in place for testing, labelling and traceability of blood and blood products, for quality management systems in blood establishments and hospital blood banks. *(Corporate Plan 1.10.1)*
- Develop and implement a plan to action the recommendations of the report entitled The Prevention of Transmission of Blood-Borne diseases in the Health Care setting (expected publication early 2006). *(Corporate Plan 1.10.1)*
- Implement EU Directive 2004/23/EC setting standards of quality and safety for tissues and cells for human application. *(Corporate Plan 1.10.1)*
- Establish a focus on patient safety, strengthen incident reporting and complaints management, share the learning from incidents that occur and work to develop national solutions addressing key patient safety issues. *(Corporate Plan 1.10.1)*
- Using examples of best practice currently in the hospital system, develop and implement systems to support best practice in medication safety in 3 pilot sites. *(Corporate Plan 1.10.1)*
- Develop a plan to spread the learning and improvements from the pilot sites to the rest of the hospital system on a phased basis. *(Corporate Plan 1.10.1)*
- Work with design teams and capital project teams to eliminate or mitigate design features which pose a risk to patients or staff and to incorporate features which minimise or reduce risks. *(Corporate Plan 1.10.1)*
- Establish a strong working relationship with the Health and Safety Authority, Health Information and Quality Authority (HIQA), Irish Health Services Accreditation Board, Irish Medicines Board, Medical Council, State Claims Agency and other relevant external organisations in pursuit of the quality / safety agenda to improve the safety, effectiveness and quality of our services. *(Corporate Plan 1.10.1)*
- Agree the content of, and develop a standardised approach to, medical records, including a retention policy. *(Corporate Plan 1.10.1)*
- Review procedures and systems for risk management, infection control and waste management and develop a national plan which implements best practice. *(Corporate Plan 1.10.2)*
- Reduce the incidence of hospital acquired infections through continued implementation of SARI and improved hospital hygiene. *(Corporate Plan 1.10.2)*

- Undertake a survey of hospital acquired infection prevalence to give validated, internationally comparative data for Ireland for the first time. *(Corporate Plan 1.10.2)*
- Work in close collaboration with the Irish Health Services Accreditation Board to roll out validated Infection Control Standards and Hygiene Standards nationally. *(Corporate Plan 1.10.2)*
- Implement the recommendations of the National Hospital Hygiene Audit, including the development of a suite of relevant policies, procedures and guidelines, a public information campaign, training initiatives, and minor capital investment to improve the building and equipment infrastructure. *(Corporate Plan 1.10.2)*
- Conduct further national audits of hospital hygiene. *(Corporate Plan 1.10.2)*
- Act on the Good Practice notes contained in the Comptroller and Auditor General's report on Waste Management in Hospitals. *(Corporate Plan 1.10.2)*
- Engage with Universities, third level institutions and other agencies in the conduct of research and development to inform planning, design and delivery of services. *(Corporate Plan 1.10.5)*
- Work in collaboration with the Irish Medicines Board to implement their guidance in relation to the Manufacturing of Medical Devices within Healthcare Institutions. *(Corporate Plan 1.10.6)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Continue to participate in the Major Emergency Planning activities of the HSE. *(Corporate Plan 2.1.9)*
- Continue to support the national roll out of BreastCheck and the national Cervical Screening Programme. *(Corporate Plan 2.2.3)*
- Continue implementation of all relevant aspects of the Cardiovascular Strategy. *(Corporate Plan 2.2.4)*
- Commence implementation of the new National Cancer Strategy, once published. *(Corporate Plan 2.2.4)*
- Continue to encourage hospitals to participate in the Health Promoting Hospitals initiative. *(Corporate Plan 2.3.1)*
- Identify priority actions for hospitals to implement the Report of the National Task Force on Obesity. *(Corporate Plan 2.3.3)*
- Work to implement the recommendations of the National Breast Feeding Committee. *(Corporate Plan 2.3.6)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Continue to support Continuous Medical Education (CME) and Continuous Professional Development. (CPD) *(Corporate Plan 3.1.1)*
- Ensure compliance with regulatory and professional bodies in relation to standards of clinical practice and training. *(Corporate Plan 3.1.2)*

- Building on best practice initiatives currently in place, develop and roll out a national training programme to address the issue of violence in the workplace. *(Corporate Plan 3.3.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders.**

- In line with best practice, improve information access for service users and utilise their feedback effectively in the development and enhancement of services. *(Corporate Plan 4.1.1)*
- Focus on developing the Clinicians in Management Initiative. *(Corporate Plan 4.1.5)*
- Participate in robust monitoring mechanisms in respect of delivery and standards of care. As part of this, we will specifically focus on casemix (increasing the blend rate to 40%\* in 2006) and on management of public / private mix. *(Corporate Plan Action 4.4.2)*  
\*This will be phased in in maternity and paediatric hospitals and in A&E at lower, but continually increasing, blend rates.
- Introduce and implement a series of uniform data standards / definitions and validation procedures to ensure consistency of approach nationally and validity of information for use in planning and performance reviews. *(Corporate Plan 4.4.2)*
- Commence performance improvement initiatives within and between hospital networks, which recognise and reward optimum performance. *(Corporate Plan 4.4.2)*

## ACTIVITY

Data will be sought on a monthly basis, in respect of the following:

### National Level Activity

Discharges	National		
	Target 2005	* Projected 2005 Outturn	**Target 2006
Total Inpatient discharges	564,320	574,104	580,963
Total day case discharges	504,213	512,082	532,185
<b>Total discharges</b>	<b>1,068,533</b>	<b>1,086,186</b>	<b>1,113,148</b>

Activity	National		
	Target 2005	* Projected 2005 Outturn	**Target 2006
Total number of births	58,871	58,408	58,410
Total number of A&E attendances	1,230,908	1,261,069	1,258,616
<b>Total number of OPD attendances</b>	<b>2,519,047</b>	<b>2,596,274</b>	<b>2,610,323</b>

### Network Level Activity

Inpatient discharges	National By Network	
	* Projected 2005 Outturn	**Target 2006
Network 1	68,536	69,950
Network 2	81,449	85,686
Network 3	47,843	47,153
Network 4	36,356	37,100
Network 5	68,609	67,423
Network 6	33,549	34,053
Network 7	47,058	47,000
Network 8	45,045	45,045
Network 9	79,273	79,273
Network 10	66,386	68,280
<b>National Total</b>	<b>574,104</b>	<b>580,963</b>

Day Case Discharges	National by Network	
	* Projected 2005 Outturn	**Target 2006
Network 1	30,292	31,700
Network 2	82,500	88,350
Network 3	24,775	32,603
Network 4	48,600	48,800
Network 5	52,983	55,776
Network 6	21,520	21,820
Network 7	30,273	30,790
Network 8	39,648	39,648
Network 9	99,656	99,656
Network 10	81,835	83,042
<b>National Total</b>	<b>512,082</b>	<b>532,185</b>

Number of Births	National by Network	
	* Projected 2005 Outturn	**Target 2006
Network 1	6,639	6,802
Network 2	7,071	7,090
Network 3	4,969	4,750
Network 4	3,097	3,100
Network 5	6,442	6,448
Network 6	3,315	3,315
Network 7	4,420	4,450
Network 8	7,723	7,723
Network 9	7,937	7,937
Network 10	6,795	6,795
<b>National Total</b>	<b>58,408</b>	<b>58,410</b>

A&E Attendances	National by Network	
	* Projected 2005 Outturn	**Target 2006
Network 1	153,392	153,335
Network 2	164,521	168,346
Network 3	109,201	103,540
Network 4	61,439	62,850
Network 5	116,304	115,966
Network 6	86,811	86,811
Network 7	108,272	108,000
Network 8	121,565	121,565
Network 9	170,385	170,385
Network 10	169,179	167,818
<b>National Total</b>	<b>1,261,069</b>	<b>1,258,616</b>

Outpatient Attendances	National by Network	
	* Projected 2005 Outturn	**Target 2006
Network 1	226,859	227,547
Network 2	309,853	310,705
Network 3	163,605	155,788
Network 4	137,875	137,380
Network 5	226,347	224,559
Network 6	130,479	133,479
Network 7	171,235	169,000
Network 8	303,216	309,812
Network 9	506,876	506,876
Network 10	419,929	435,177
<b>National Total</b>	<b>2,596,274</b>	<b>2,610,323</b>

\* Projected 2005 outturn calculated from actual activity levels at end of September 2005

\*\*Actual activity may vary, as additional developments come on stream during the year.

In relation to activity, the NHO will particularly focus on the following during 2006:

- Acute hospital inpatient and day case activity
- Outpatient services
- Accident and Emergency services
- Waiting Lists
- Casemix

Additional areas for specific monitoring in 2006 are:

- Monitoring of service developments
- National Treatment Purchase Fund
- Renal dialysis
- A&E 10 point plan
- Management of outpatient waiting lists

### FUNDED SERVICE DEVELOPMENTS

Additional funding of €29.78m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

€60m has been provided for the commissioning of new units in acute and non-acute services, funded under NDP. Detailed allocation of this funding is not yet finalised in respect of new units identified below.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.	<b>CANCER:</b> <ul style="list-style-type: none"> <li>• Lead the implementation of the National Radiotherapy plan and examine the potential for securing additional radiotherapy services, pending the full implementation of the plan. (<i>Corporate Plan 1.5.1</i>)</li> <li>• Commence implementation of the new National Cancer Strategy, once published. (<i>Corporate Plan 2.2.4</i>)</li> <li>• Continue to support the national Cervical Screening Programme. (<i>Corporate Plan 2.2.3</i>)</li> <li>• As part of planning patient transport services, develop proposals, in conjunction with PCCCD, to support patients who have to travel long distances to access specialist services, with particular focus in 2006 on those travelling for radiotherapy treatment. (<i>Corporate Plan Action 1.1.1</i>)</li> </ul>	€9m
	<b>RENAL:</b> <ul style="list-style-type: none"> <li>• Commence implementation of the recommendations arising from the National Renal Review, with particular focus in 2006 on supporting the costs of provision of dialysis services and a living related donor renal transplant programme. (<i>Corporate Plan 1.5.1</i>)</li> </ul>	€8m
	<b>CYSTIC FIBROSIS:</b> <ul style="list-style-type: none"> <li>• Commence implementation of the recommendations arising from the National Review of Cystic Fibrosis services. (<i>Corporate Plan 1.5.1</i>)</li> </ul>	€4.78m
	<b>NEUROLOGY &amp; NEUROPHYSIOLOGY:</b> <ul style="list-style-type: none"> <li>• Work with all relevant stakeholders to develop an agreed approach to the future development of national neuroscience services and commence implementation of agreed priorities. (<i>Corporate Plan 1.5.1.</i>)</li> </ul>	€3m
	<b>OBESITY:</b> <ul style="list-style-type: none"> <li>• Identify priority actions for hospitals to implement the Report of the National Task Force on Obesity and commence implementation of agreed priorities. (<i>Corporate Plan 2.3.3</i>)</li> </ul>	€3m

Objective and Supporting Goal(s)	Actions to achieve	Resources
<p><b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.</p>	<p><b>NEW UNITS:</b> Continued commissioning of a number of new units in acute hospital facilities throughout the country, including at the following locations:</p> <ul style="list-style-type: none"> <li>▪ St. Vincent's Hospital, Dublin (including A&amp;E; treatment / diagnostic facilities; 4 new ICU beds and 12 additional day care beds)</li> <li>▪ Midland Regional Hospital at Tullamore (new hospital development, increasing capacity by 32 inpatient beds and 21 day beds)</li> <li>▪ Midland Regional Hospital, Portlaoise (expansion of A&amp;E services)</li> <li>▪ Cork University Hospital (amalgamation of maternity services; day procedures including 35 day beds)</li> <li>▪ Mercy University Hospital (expansion of A&amp;E services)</li> <li>▪ Our Lady of Lourdes Hospital, Drogheda (upgrade of A&amp;E services)</li> <li>▪ Our Lady's Hospital for Sick Children, Crumlin (MRI unit)</li> <li>▪ Cavan General Hospital (theatres and 21 inpatient places)</li> <li>▪ Louth County Hospital, Dundalk (provision of 2 modular theatres)</li> <li>▪ Wexford General Hospital (additional 19 inpatient beds)</li> <li>▪ University College Hospital, Galway (including cardiothoracic; orthopaedics; radiotherapy – 22 additional beds; burns unit – 3 additional beds; ICU – 3 additional beds)</li> </ul>	<p>To be funded from €60m which has been provided for the commissioning of new units in acute and non-acute services, funded under NDP.</p>
<b>TOTAL</b>		<b>€29.78M + NEW UNITS ELEMENT</b>

### 5.0.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key Issues for 2006 include:

- Levels of emergency medical admissions, impacting on scheduled, elective workload.
- Demand on national centres in meeting the needs of their catchment population for general acute services.
- Attendance levels at A&E departments.
- Over dependence on the acute hospital sector due to the under development of primary, continuing and community care services.

### 5.0.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

In addition, specifically, the National Hospitals' Office, in the development of their performance management approach, have identified a number of key areas for particular focus in 2006 where there is scope for greater efficiency and improved standards in service delivery. The performance of each hospital in the areas outlined below will be monitored during 2006. The detailed monitoring mechanisms and associated performance indicators will be outlined in the Hospital Network Business plans (Level 1) and in the individual hospital Business Plans (Level 2) for 2006. The overall objective for the hospitals in 2006 will be to maintain or achieve performance in the areas outlined below that is in line with international norms and international best practice:

- Hospital Acquired Infections.
- Hospital Hygiene.
- Waiting times for admission from A&E departments.

- Patient "flow" through the acute hospital:
  - Average length of stay.
  - Day case surgery.

Financial incentives will be put in place for hospitals to improve performance under each of these areas. The National Hospitals' Office will operate a fund to reward hospitals for performance improvements. The details of the scheme will be outlined in the Level 1 and Level 2 business plans.

#### **5.0.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this National Service Plan.

## 5.1 AMBULANCE SERVICES

### 5.1.1 CONTEXT

#### ROLE AND PURPOSE

The role and purpose of the Ambulance Service is to provide a clinically appropriate and timely pre-hospital care and transportation service. Pre-hospital Emergency care and transportation services are provided as an integral part of a continuum of care for patients/clients. The provision of high quality ambulance services requires the National Ambulance Service to operate in partnership with a wide range of statutory and private organisations. It also involves working closely with other health care providers at primary and community level, and in both acute and community care settings.

Core roles and responsibilities include the provision of:-

- Pre Hospital Emergency Medical Services.
- Non-emergency patient / client transport services.
- Routine non-ambulant patient transport within the health care sector.
- Health Service Communications and Command & Control structure.
- National inter-hospital critical care transport.
- Integral elements of the Health Service Response to major emergencies.
- Pre-hospital specialist professional training and related services.

### 5.1.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Ambulance Services are broadly categorised into two distinct services, Emergency Medical Services (EMS) in response to requests for services through the 999 / 112 emergency network and non-emergency patient transport services (PTS) in response to the needs of the community across all health care sectors.

Strategically, ambulance services are provided from a network of ambulance stations linked by radio and data communications at a series of regional control centres.

The Emergency Ambulance Service operates a vehicle fleet of 300 frontline emergency ambulances. In 2005 it has responded to approximately 645,000 calls, of which 239,000 were emergency / urgent calls and 406,000 were routine / patient transport.

Regional Service	Location H.Q.	AMB Stations	Control Centre	Area Covered (by County)
<b>Southern</b>	Cork	18	2	Cork / Kerry
<b>South Eastern</b>	Kilkenny	11	1	Kilkenny, Waterford, Wexford, Carlow, Tipperary
<b>Western</b>	Castlebar	10	3	Galway, Mayo, Roscommon
<b>North Western</b>	Ballyshannon	11	1	Donegal, Leitrim, Sligo
<b>Midwestern</b>	Limerick	9	1	Limerick, Clare, Tipperary (N)
<b>Eastern</b>	Dublin	10	3	Dublin, Kildare, Wicklow
	Dublin	10		Dublin City
<b>North Eastern</b>	Navan	8	1	Meath, Louth, Monaghan, Cavan
<b>Midland</b>	Tullamore	6	1	Westmeath, Laois, Offaly, Longford
<b>TOTAL</b>		<b>93</b>	<b>13</b>	

### 5.1.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are reflected in the individual Business Plans at regional and service level.

#### 5.1.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

During 2006, the National Ambulance Service will pursue the following actions towards achieving the HSE's Corporate Objectives:

**Corporate Objective 1: We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Implement the pre-hospital training programmes of the National Ambulance Training School, with priority to the roll-out of the Emergency Medical Technician – Advanced (EMTA) to meet the needs of the pilot regional areas identified. *(Corporate Plan Action 1.9.1)*
- Implement the deployment of the EMT Advanced grades in line with agreed deployment needs for enhanced delivery of service. *(Corporate Plan Action 1.9.1)*
- Evaluate and continue the roll-out of the Community First Responder Programmes in the HSE Areas in which it operates, to supplement and improve emergency response times. *(Corporate Plan Action 1.9.1)*
- Evaluate and continue the roll out of fast response units as part of national strategy to improve service delivery and response times. *(Corporate Plan Action 1.9.1)*
- Develop programmes to replace current on call arrangements which will enhance employees' working environment and improve service delivery and response times. *(Corporate Plan Action 1.9.1)*
- Progress the development of the National Neonatal Transport service, pending agreement of current proposals with DoHC. *(Corporate Plan Action 1.9.2)*
- Consider the implications of the Technical Review of the Ambulance Command & Control Systems in light of the National Digital Radio Procurement programme currently being undertaken by CMOD, Department of Finance. *(Corporate Plan Action 1.9.2)*
- Develop a new national fleet management system to improve national coordination and standardisation of fleet management. *(Corporate Plan Action 1.9.2)*
- Complete a needs analysis and strategic plan for a patient transport scheme and plan the migration to a separate role, to be implemented on a phased basis. *(Corporate Plan Action 1.9.2)*
- As part of planning patient transport services, develop proposals, in conjunction with PCCCD, to support patients who have to travel long distances to access specialist services. *(Corporate Plan Action 1.1.1)*
- Establish and implement an ambulance fleet upgrade and replacement programme in line with National and European Standards. *(Corporate Plan Action 1.9.2)*

- Develop an interim National Ambulance Service Headquarters. *(Corporate Plan Action 1.9.2)*
- Introduce a new National Ambulance Service Uniform across the regions. *(Corporate Plan Action 1.9.2)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Develop and maintain emergency planning arrangements in the Ambulance Service. *(Corporate Plan Action 2.1.9)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- We will progress developments in the National Ambulance Training School to meet the current and future demands on EMT and EMT Advanced training, with particular emphasis on driver development training. *(Corporate Plan Action 3.1.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

- We will develop and implement a National Ambulance Service structure. *(Corporate Plan Action 4.2.1)*

## ACTIVITY

The table below presents key activity measures / performance indicators in relation to the Ambulance Service.

### Ambulance Calls

Activity	OUT-TURN 2005*	TARGET 2006
Emergency and urgent calls (EMS)	239,000	250,000
Non Emergency Patient Transport (PTS)	406,000	426,000

\* Projected, based on Quarter 3 activity reports

## FUNDED SERVICE DEVELOPMENTS

Additional funding of €2m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<p><b>OBJECTIVE 1:</b> We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.</p>	<p><b>PRE-HOSPITAL EMERGENCY / AMBULANCE SERVICES:</b></p> <ul style="list-style-type: none"> <li>• Implement the pre-hospital training programmes of the National Ambulance Training School, with priority to the roll-out of the Emergency Medical Technician – Advanced (EMTA) to meet the needs of the pilot regional areas identified. <i>(Corporate Plan Action 1.9.1)</i></li> <li>• Implement the deployment of the EMT Advanced grades in line with agreed deployment needs for enhanced delivery of service. <i>(Corporate Plan Action 1.9.1)</i></li> <li>• Develop programmes to replace current on call arrangements which will enhance employees working environment and improve service delivery and response times. <i>(Corporate Plan Action 1.9.1)</i></li> <li>• Progress the development of the National Neonatal Transport service, pending agreement of current proposals with DoHC. <i>(Corporate Plan Action 1.9.2)</i></li> <li>• Enhance air ambulance services in the context of the Service Level Agreement between the HSE and the Air Corps.</li> </ul>	<p>€2m</p>
<b>TOTAL</b>		<b>€2M</b>

### 5.1.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues, as outlined in the *Strategic Review of the Ambulance Service 2001*, include:

- The lack of standardisation in the national ambulance service, specifically in respect of communications and dispatch systems.
- The need to separately manage the core components of EMS and PTS.
- The need for further enhancement of the staff training and development programmes.

### 5.1.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

### 5.1.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans that support this National Service Plan.

## **6.0 CORPORATE FUNCTIONS AND SUPPORTS**

The Corporate Functions and Supports section of this National Service Plan includes separate sections in respect of the following:

- Population Health
- Shared Services
- Human Resources
- Information and Communications Technology
- Finance
- Estates Management
- Corporate Support Services

## 6.1 POPULATION HEALTH

### 6.1.1 CONTEXT

#### ROLE AND PURPOSE

A population health approach promotes and protects the health of the whole population or subgroups, with particular emphasis on reducing health inequalities. The Population Health Directorate will lead, inform and support the population health approach within the Executive, influencing and providing an advocacy role with other Government Departments, State Agencies and external service providers.

A key role of the Directorate will involve providing knowledge, information and evidence to support corporate decision making and strategic planning; in response to identified needs. The Directorate will support the re-engineering of service delivery in a manner which increases its impact on health and social well being and the achievement of value for money. It will also develop equality based and culturally appropriate responses to the new and emerging needs of a diverse population, widespread inequalities in health, key health challenges including obesity, alcohol and drug misuse, an ageing population and the growing burden of chronic diseases.

The population health approach implies a greater focus on a social model of health, which acknowledges the range of factors which affect health.

### 6.1.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The Population Health Directorate is structured into six Assistant Directorates; Strategic Planning, Health Intelligence, Health Promotion, Emergency Planning, Environmental Health and Health Protection. In addition the Directorate includes the National Office for Suicide Prevention. The Health Protection Surveillance Centre is part of the Directorate, as are the area Public Health Departments and Departments of Health Promotion.

#### Strategic Planning

The Strategic Planning function leads on the development of plans at Directorate level and works with other Directorates in the formulation of plans on a Population Health basis. The function includes needs assessment for health and health services and developing the capacity and skill base in needs assessment across the organisation. The function is a focus for monitoring and evaluation within the Directorate and leads for the Directorate on Social Inclusion and Health Inequality Initiatives.

#### Health Intelligence

Health intelligence in its widest sense means developing and using knowledge to improve health outcomes for the population.

The main elements of the population health function that relate specifically to Health Intelligence are as follows:

- Health Information and Surveillance: This includes analysis of existing Health Information, with critical comment, and working to standardise the collection and use of data from the system, while minimising the collection burden.
- Evidence Based Health Care, Research and Development: This involves working with internal and external structures and agencies to ensure that the quality and standards of service provision, research and development throughout the health services are aligned with best evidence, population health values and goals and are conveyed in an effective manner into the planning and evaluation functions of the health service.
- Health Technology Assessment: In the context of the health intelligence function this prioritises providing all those who make decisions in the HSE with high-quality information on the costs, effectiveness and population health impact of health care treatments and tests.
- Knowledge management: While related to the areas noted above, this is a further step, ensuring that the underlying assumptions on which decision making is predicated are aligned with the changing environment.
- Linkages: Part of the strategic function of health intelligence is to work towards uniting the currently disparate organisational "parts" into a synergistic "whole" that prioritises population health. It also prioritises linking health care professionals with relevant health care information and assistance.

## Health Promotion

The Health Promotion function of the Directorate provides expert advice to the Director of Population Health, ensuring objectives relating to health promotion are realised. The function has a key role to play in contributing to national strategy, Service and Business Plans, frameworks and standards for health promotion. The function ensures systems are in place and implemented to support performance management and quality assurance of health promotion at all levels.

Responsibilities previously executed by the Health Promotion Unit of the Department of Health & Children have been transferred to the HSE. These include Health Promotion National Campaigns, storage, distribution and printing of health promotion materials, funding of voluntary agencies and facilitation of partnerships with key national statutory agencies, Voluntary Agencies and the Community Sector.

## Emergency Planning

The Population Health Directorate leads the development and maintenance of Major Emergency Planning. In this regard, the HSE and the DoHC have formed a national steering group to oversee the development and implementation of all emergency plans. This steering group will ensure that all plans are regularly updated to reflect the most up to date advice coming from the Health Protection Surveillance Centre (HPSC) and the World Health Organisation (WHO) and will periodically set up expert groups to advise them.

HSE national, regional and local emergency plans are embedded within the services of the NHO and PCCC. The national office for emergency planning in population health will co-ordinate the development of emergency planning with the staff in both of these directorates.

## Environmental Health

Environmental health refers to the theory and practice of assessing, correcting and preventing factors in the environment that can potentially adversely affect the public health of the present population and future generations.

The environmental health concept and approach integrates controls on all these factors in the environment that threaten public health, many of which are subject to control by statutory agencies.

The aim of this service is to ensure the development, adoption and implementation of policies, including a national environmental health plan, that will deliver a national, comprehensive, cohesive and integrated food and environmental control service. The fostering of relationships between the statutory and voluntary agencies and communities is an integral part of this process.

## Health Protection

Health Protection plays a critical role in protecting people from infectious diseases and in preventing harm when environmental hazards are involved. It also prepares for new and emerging threats, such as a bio-terrorist attack or virulent new strain of disease. Health protection is involved in supporting preventive medical activities. In addition to the role in reducing the dangers to health from infections and environmental hazards, it also provides support to, and works in partnership with, others who also have health protection responsibilities and provides expert advice to the Department of Health and Children and Government.

## Suicide Prevention

In response to recommendations in *Reach Out: A Strategy for Action on Suicide Prevention (Phase I 2006-2008)*, the Directorate has established a National Office for Suicide Prevention. The office has four functions:

- To oversee the implementation of *Reach Out*.
- To commission appropriate research into suicide prevention.
- To co-ordinate suicide prevention efforts around the country.
- To consult with organisations and interested parties on current evidence/good practice and new initiatives.

## Health Promotion Departments

Health Promotion services are based on identified need, in settings such as education, workplace (including hospitals), health care and communities. The services seek to improve the health of individuals and communities across a wide range of population groups. In addressing risk factors and issues including mental health promotion, sexual health promotion, tobacco control, alcohol use, drug use, physical activity, nutrition and accident prevention, service providers engage in partnerships with statutory, non statutory, community and voluntary agencies. Services include programmes, initiatives and information to strengthen community development, reorient health services, develop personal skills, strengthen public policy and create supportive environments.

## Public Health Departments

The function of Public Health Departments includes formal needs assessment, evaluation of services and supporting evidence based planning and delivery of services. The Departments provide strategic advice on environmental health and are responsible for

communicable disease prevention and control. The Departments work with NHO and PCCC services in their area on emergency planning.

### 6.1.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are included within the individual Business Plans that support this national Service Plan.

#### 6.1.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 1: We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Develop a system of networking and support in the area of population health intelligence with those who are involved in special interest clinical groups/ patient groups. *(Corporate Plan Action 1.1.1)*
- Work in association with the new Population Health Observatory.
- Establish a role within the HSE to tailor content of operational information systems (especially care-related systems), with particular regard to supporting efforts to tackle health inequalities and small area study and planning. *(Corporate Plan Action 1.1.1, 2.1.2)*
- Work with the Equality Authority to continue the development of a national equality and diversity strategy and action plan. *(Corporate Plan Action 1.1.1)*
- Conduct an audit of equality issues under each of the nine grounds in the Equal Status Acts 2000 to 2004. *(Corporate Plan Action 1.1.1)*
- Develop a national intercultural strategy for the health services under the *National Action Plan Against Racism 2005-2008*. *(Corporate Plan Action 1.1.1)*
- Develop a response to the recommendations of the reports of the Equality Authority *Implementing Equality for Lesbians, Gays and Bisexuals* and *Access to Health Services for Transsexual People*, the National Economic and Social Forum, *Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues* and the HSE North West area's study of Lesbian, Gay and Bisexual people's experiences of health services. *(Corporate Plan Action 1.1.1)*
- Identify priority services requiring needs assessment in conjunction with NHO and PCCC. *(Corporate Plan Action 1.1.3)*
- Lead the HSE implementation of the National Diabetes Policy and the implementation of the Public Health Emergency Plan (PHEP). *(Corporate Plan Action 1.4.3)*
- Develop integrated approaches to chronic disease management with PCCC and NHO, initially focusing on Chronic Obstructive Pulmonary Disease (COPD) and Diabetes. *(Corporate Plan Action 1.4.3)*
- Lead the on-going implementation of the Cardiovascular Strategy across the two service pillars. *(Corporate Plan Action 1.4.3)*

- Lead the implementation and further development of the National Cancer Strategy. *(Corporate Plan Action 1.4.3)*
- Lead the National Review of Renal Services. *(Corporate Plan Action 1.5.1)*
- Contribute to the development of the National Radiotherapy Plan. *(Corporate Plan Action 1.5.1)*
- Reorganise hospital emergency planning to provide improved capability to respond to national emergencies. *(Corporate Plan Action 1.5.1)*
- Contribute to the development of a Primary Care Action Plan. *(Corporate Plan Action 1.6.1)*
- Work with service pillars to reconfigure services to improve children's health. *(Corporate Plan Action 1.7.5)*
- Work with the A&E Review Group to develop a minimum data set for monitoring and evaluating A&E Departments. *(Corporate Plan Action 1.8.1)*
- Work with internal reform mechanisms and relevant external agencies to facilitate and support service delivery and a working environment based on best evidence.
- Work to reduce the incidence of hospital-acquired infection; publish and implement standard protocols, establish surveillance for MRSA infections and carry out on-going audits. Review and implement hospital cleaning and infection control standards in acute hospitals, and commence same in non-acute facilities. Establish clearly identified policies and plans for each hospital and Local Health Office. Initiate specific campaigns for high risk infections and undertake the Clean Hands campaign and similar public hygiene campaigns. *(Corporate Plan Action 1.10.2)*
- Establish specific links with the Health Information and Quality Authority (HIQA) with regard to health information and quality as this relates to facilitating evidence-based practice to enable quality improvements. *(Corporate Plan Action 1.10.3)*
- Document and use an inventory of the range of health related databases held by the HSE and other agencies to ensure that best use is made of existing information. *(Corporate Plan Action 1.10.3)*
- Commence an audit of current research activity within the HSE. *(Corporate Plan Action 1.10.5)*
- Develop a research strategy that takes into account health services research not currently covered within the clinical trials legislation and that also facilitates national research projects. This to include governance and ethics processes. *(Corporate Plan Action 1.10.5)*
- Work together with agencies such as HRB, HIQA, Department of Health and Children and other HSE directorates to develop clarity of roles and a collaborative base for common actions in regard to population health priorities. *(Corporate Plan Action 1.10.6)*
- Commence development of a system to ensure that robust health technology assessment mechanisms are put in place at national level for the HSE. *(Corporate Plan Action 1.10.6)*

- Develop a collaborative approach with quality and risk structures in the HSE to ensure that full use is made of risk information and to support an evidence-based approach in addressing clinical and other health care risks. *(Corporate Plan Action 1.10.6)*
- Develop modelling of scenarios to improve decision making in emergency planning. *(Corporate Plan Action 1.10.6)*

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Develop a robust reformed structure to support the Directorate's function. *(Corporate Plan Action 2.1.1)*
- Consolidate current strategic health intelligence resources:- identify existing human and other resources within the HSE and establish mechanisms for co-ordinated deployment. *(Corporate Plan Action 2.1.1)*
- Develop a governance framework for Health Intelligence in alignment with National HSE Governance and governance structures within the national directorate of population health. *(Corporate Plan Action 2.1.1, 4.4.1)*
- Establish jointly with partners in iHIQA /HIQA and colleagues in HSE, and others, plans to address specific requirements of strategic health information services. *(Corporate Plan Action 2.1.1, 2.1.4)*
- Work with the two service pillars proofing plans for a Population Health approach. *(Corporate Plan Action 2.1.2)*
- Work with the other planning sections to formulate a needs assessment and planning cycle. *(Corporate Plan Action 2.1.2)*
- Commence national needs assessments in identified priority areas. *(Corporate Plan Action 2.1.2)*
- Work in partnership with the women's health council to develop approaches to gender mainstreaming for planning and delivery of all services. *(Corporate Plan Action 2.1.2)*
- Further strengthen health promotion services. *(Corporate Plan 2.1.3)*
- Work with other sectors to improve health. *(Corporate Plan Action 2.1.4)*
- Initiate a sustainable anti-stigma campaign relating to mental health, with a focus on encouraging young men in particular to seek help. *(Corporate Plan Action 2.1.4, 2.3.1)*
- Develop and utilise Health Impact Assessment (HIA) capacity. *(Corporate Plan Action 2.1.5)*
- Promote the development of a national comprehensive and integrated food control and environmental control service and advance the implementation of the National Environmental Health Action Plan. *(Corporate Plan Action 2.1.7)*

- Reduce threats from communicable diseases; further develop protocols and guidelines for surveillance, prevention and control, strengthen the capacity of the service, implement the Computerised Infectious Diseases Reporting system nationally, and develop a more unified approach to control and prevention of communicable diseases. *(Corporate Plan Action 2.1.8)*
- Reduce threats to public health by prioritising the prevention, surveillance and control of Hepatitis. Develop a strategy for prevention and control of Hepatitis B and C in 2006. *(Corporate Plan Action 2.1.8)*
- Standardise approaches to emergency planning nationally, develop national programme of exercises and increase training. *(Corporate Plan Action 2.1.9)*
- Work with PCCC towards increasing childhood vaccination rates to the national target of 95%. *(Corporate Plan Action 2.2.1)*
- Complete the Hib vaccine catch-up campaign and commence planning for the introduction of a hib booster. *(Corporate Plan Action 2.2.1)*
- Progress the development of a national I.T. system for childhood vaccination. *(Corporate Plan Action 2.2.1)*
- Undertake a comprehensive campaign to improve the uptake of annual influenza vaccine in at risk populations and health service workers to 70% for the winter of 2006 / 2007. *(Corporate Plan Action 2.2.1)*
- Develop and implement a national plan for an influenza pandemic.
- Procure a stock pile of Avian Flu vaccines and increase stock level of anti-virals. *(Corporate Plan Action 2.2.1)*
- Work with the Department of Health and Children in developing a programme and time table for the eradication of measles and rubella. *(Corporate Plan Action 2.2.2)*
- Support the national roll out of Breast Check and, in association with the NHO, prepare for the national Cervical Screening Programme rollout. *(Corporate Plan Action 2.2.3)*
- Audit the current implementation of the Cardiovascular Strategy across the country. *(Corporate Plan Action 2.2.4)*
- Promote positive health by working in partnership with key stakeholders in a variety of settings, including schools, workplaces, communities and home. *(Corporate Plan Action 2.3.1)*
- Develop a national framework to address tobacco use, in consultation with key stakeholders. This will also include guidelines and quality standards for smoking cessation services. *(Corporate Plan Action 2.3.3)*
- Work with the service pillars to develop an integrated approach to alcohol and other substance abuse and to commence implementation of the recommendations in the *Reports of the Strategic Task Force on Alcohol (2002 and 2004)*. *(Corporate Plan Action 2.3.3)*
- Lead the development of a national Sexual Health Strategy and Action Plan. *(Corporate Plan Action 2.3.3)*

- Continue to concentrate on key lifestyle factors, such as obesity, diet, alcohol, exercise and sexual health. *(Corporate Plan Action 2.3.3)*
- Support parents, children and families in particular in the improvement of their children's health and family well being. *(Corporate Plan Action 2.3.4)*
- Continue to promote and support a breast feeding culture in Ireland, in line with the recommendations of the National Breast Feeding Committee in *Breast Feeding in Ireland A Five Year Action Plan (2005)*. *(Corporate Plan Action 2.3.6)*
- Work with NHO, PCCC and other agencies to reduce substance abuse by progressing implementation of the recommendations of *Building on Experience: National Drug Strategy 2001-2008* and the *Report of the Working Party on Treatment of Under 18 Year Olds Presenting To Treatment Services With Serious Drug Problems (2005)*. *(Corporate Plan Action 2.3.7)*
- Assist with the deployment of health information management mechanisms to support tracking of the health targets in the *National Anti-Poverty Strategy (1997-2007)*. *(Corporate Plan Action 2.4.1)*
- Focus on reducing health inequalities through the development of the National Equality and Diversity Strategy and implementation of the *National Anti Poverty Strategy (1997-2007)*, for groups in the population who have specific health needs e.g. traveller health. *(Corporate Plan Action 2.4.1)*
- Begin to implement actions identified in Phase I (2006-2008) of *Reach Out: A Strategy for Action on Suicide Prevention*. *(Corporate Plan Action 2.4.2)*
- Continue to address the health needs of asylum seekers. *(Corporate Plan Action 2.4.3)*

**Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

- Explore the possibility of professionalising emergency planning through a degree programme. *(Corporate Plan Action 3.1.1)*
- Commence specific training and development for Health Intelligence to meet specific knowledge and skill requirements. *(Corporate Plan Action 3.1.1)*
- Work with other Directorates to develop an improved capacity and skill base in needs assessment across the organisation. *(Corporate Plan Action 3.1.2)*
- Work closely with educational and training institutions at undergraduate and post graduate levels, ensuring a co-ordinated approach to the training of personnel and to meet staffing requirements. *(Corporate Plan Action 3.1.2)*
- Ensure that all staff have the knowledge, skills and attributes required to deliver quality health and personal social services, with particular relevance to population health. *(Corporate Plan Action 3.1.2)*
- Continue to improve the quality of working life for our staff. *(Corporate Plan Action 3.3.1)*
- Work with colleagues to facilitate structures, processes and enabling technologies for effective team-working. *(Corporate Plan Action 3.4.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

- Facilitate the participation of, and partnership with, groups identified in the Equal Status Acts 2000 to 2004, by supporting the development of a national approach to consumer participation. *(Corporate Plan Action 4.1.1)*
- Establish, through the National Office for Suicide Prevention, a regular national forum to listen to the views of key stakeholders in the area of suicide prevention and present research evidence and best practice approaches to the forum. *(Corporate Plan Action 4.1.1, 4.1.5)*
- Continue the transition of emergency planning from the Department of Health and Children to HSE. *(Corporate Plan Action 4.2.3)*
- Ensure the smooth transition of functions from the Department of Health and Children. *(Corporate Plan Action 4.2.3)*
- Initiate specific actions in pursuit of relevant components of the National Health Information Strategy. *(Corporate Plan Action 4.3.3)*
- Lead the development of clinical cardiac disease management systems to support patient care, quality assurance, surveillance, research and service planning. *(Corporate Plan Action 4.4.2)*
- Work with colleagues within the HSE to support and enable a strategic and business planning approach, based on best available information and evidence. *(Corporate Plan Action 4.4.5)*

## FUNDED SERVICE DEVELOPMENTS

### Emergency Planning

Additional funding of €10m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<p><b>OBJECTIVE 2:</b> We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address.</p> <p><b>Supporting Goal: 2.1</b> We will develop a population health approach at all levels of the delivery system.</p>	<p>The additional funding will be used to:</p> <ul style="list-style-type: none"> <li>• Purchase antivirals and vaccines. <i>(Corporate Plan Action 2.2.1)</i></li> <li>• Purchase PPE, Antibiotics, Flu Kits and other consumables and equipment required to manage an influenza pandemic. <i>(Corporate Plan Action 2.2.1)</i></li> <li>• Provide appropriate training and exercises. <i>(Corporate Plan Action 2.1.9)</i></li> </ul>	€10m
<b>Total</b>		<b>€10m</b>

### **6.1.3.2 ISSUES FOR THE YEAR AHEAD**

Key issues for 2006 include:

- National agreement for restructuring Health Promotion and Public Health Departments.
- Development of structures and staffing to support the Assistant Directorates.
- Development and staffing of the new office for Emergency Planning.

### **6.1.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

The Population Health Directorate will also conduct specific national service evaluations and, through its health intelligence function, will monitor the incidence of infectious disease.

### **6.1.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

The population health approach means that the effectiveness of our services must be measured against the primary goals of improving the health and well being of the population.

The contribution of research toward this goal has been recognised at the highest level in Ireland and in other health care systems.

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible.

Specifically in 2006, the Population Health Directorate will seek to expand the research and development capacity of the Executive and support the further development of national performance indicators.

It will also specifically aim to improve capacity in economic evaluations and health impact assessment. It will develop working relationships with iHIQA/HiQA, third level institutions and other key stakeholders, including the Institute of Public Health and the population health observatory, with the aim of improving the information and knowledge base used for decision making.

Specific details are included within the individual Business Plans that support this national Service Plan.

## 6.2 NATIONAL SHARED SERVICES

### 6.2.1 CONTEXT

#### ROLE AND PURPOSE

The introduction of a new National Shared Services (NSS) for the Health Service Executive will be a key enabler in transforming the administration support processes by consolidating and standardising support processes and functions.

The objective of the NSS is to deliver customer focussed services which support frontline health service managers and thus allows them to concentrate on their core business of health and social care service delivery. The introduction of a NSS will be focused toward the achievement of economies of scale, value for money and improved quality of service.

The delivery of service in the areas identified for inclusion within the National Shared Services remit are currently administered from eight different sites consistent with the former Health Board structures. Multiple delivery systems are in place, supported by business processes which have developed largely independently of one another over time. In addition, there is an absence of standardisation in terms of the ICT platforms in use across the current service delivery structure.

Site	Service
Kilkenny	Financial Services
Manorhamilton	Human Resources
Swords	ICT & Procurement
Finglas	Primary Care Reimbursement Service (PCRS)
Dr. Steevens' Hospital	Mutli-functional

### 6.2.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

There are two operational sites that currently provide services on a shared services basis for specific functions within the health sector, namely Primary Care Reimbursement Service (formerly General Medical Services Payments Board) and Shared Services Eastern Region (SSER, formerly Eastern Health Shared Services) which provide shared services to the former three Area Health Boards and the ERHA in the eastern region. The progression of a smooth transition of these operations into National Shared Services is a key objective of the 2006 Service Plan.

Operation	Location	Current Scope
PCRS	Finglas	National
SSER	Dr. Steeven's Hospital	Eastern Region

The Primary Care Reimbursement Service calculates and makes almost all payments for services which are provided in the community by General Practitioners, Community Pharmacists, Dentists and Optometrists/Ophthalmologists under the following schemes:

- General Medical Services
- Drug Payments Scheme (DPS)
- Long Term Illness Scheme (LTI)
- Dental Treatment Services (DTSS)
- European Economic Area (EEA)
- High Tech Drugs (HTD)

- Primary Childhood Immunisation Scheme
- Health Amendment Act 1996 – Persons with Hepatitis C
- Methadone Treatment Scheme
- Community Ophthalmic Services Scheme

Shared Services Eastern Region provides services to HSE employees and management of the former eastern region in areas including: HR; Finance; Information & Communications Technology; and Procurement & Materials Management.

### **6.2.3 THE YEAR AHEAD**

#### **6.2.3.1 OUTSTANDING ACTIONS FROM 2005**

- The transition of Shared Services Eastern Region, Primary Care Reimbursement Service and identified functions from the Department of Health and Children into National Shared Services will continue in 2006.
- Planning processes for the transition of SSER and PCRS commenced in 2005 and work will continue on into 2006 to effect the transition. Work will also continue to migrate identified functions from the Department of Health and Children.

#### **6.2.3.2 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES**

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

- Establish the National Shared Services model. *(Corporate Plan Action 4.3.1)*
- Establish a road map for implementation of National Shared Services *(Corporate Plan Action 4.3.1)*
- Finalise a strategic implementation plan for each of the five functions within National Shared Services. The implementation plan will include an outline of the agreed scope of operations, underlying implementation approach, risk management strategies, dependencies and contingencies, etc. *(Corporate Plan Action 4.3.1)*
- Finalise and implement a business process migration plan for each of the proposed functions within National Shared Services. The process migration plan will identify processes and sub – processes to be migrated to National Shared Services *(Corporate Plan Action 4.3.1)*

#### **6.2.3.3 KEY ISSUES FOR THE YEAR AHEAD**

- Establishment and mobilisation of National Shared Services sites.
- Population of NSS sites with appropriately skilled personnel.
- Establishment of clear governance arrangements for NSS within National Structures.
- Effective transition and integration of the Primary Care Reimbursement Service and Shared Services Eastern Region into National structures.

**6.2.3.4 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

**6.2.3.5 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that shared service delivery is evidenced based, in line with best practice and capable of delivering on both value for money and the most effective outcomes. Specific details are included in the individual Business plans that support the National Service plan.

## 6.3 HUMAN RESOURCES

### 6.3.1 CONTEXT

#### ROLE AND PURPOSE

The role and purpose of the HR Directorate is to develop and support an organisational structure and culture that is client/patient focused and empowers staff to realise their potential in a safe and healthy work environment.

The Directorate will take the lead in the development of HR policies, practices and procedure to ensure their standard application to staff throughout the sector. The importance of full engagement with our staff and contractors is recognised. The need to build further on initiatives such as the Action Plan for People Management (APPM), the Clinicians in Management initiative (CIM) and the Partnership framework is also recognised.

We work in partnership with all stakeholders to ensure that the HSE is a good employer with a motivated, skilled and flexible workforce, capable of delivering high quality services to meet the changing needs of the population.

#### EMPLOYMENT CONTROL

In line with the provisions relating to the HSE Estimates for 2006 notified to the Board by the Tánaiste, the Human Resource Directorate will ensure that sufficiently robust systems are in place and operated throughout the HSE, and the wider public health service, to effectively manage employment levels.

As part of this control system, we will:

- Ensure that any additional employment in 2006 is directly and only linked with approved and funded service developments and activity levels.
- Ensure that priority is afforded within this control system to front line service staff.
- Ensure that staffing resources are re-deployed within the HSE to maximum effect, having regard to the efficiencies and synergies arising from the reform process.
- Agree with the Department of Health & Children arrangements for the transfer of the employment control framework and seek resolution of legacy issues pre-dating HSE establishment.

### 6.3.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

HR services include:

- Employee/Management development
- Workforce Planning
- Employment Control
- Recruitment/Selection
- Personnel Administration
- Organisational Development
- Employee Relations
- Industrial Relations
- Retirement Planning
- Superannuation
- HR Policy/Strategy development.

Currently, the Department of Health and Children provides certain HR policy interpretation, and executive services, and these will continue to be transferred to the Executive during 2006.

### 6.3.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed in 2006. Specific details are reflected within the individual Business Plans that support this national Service Plan.

#### 6.3.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

The overall aim for 2006 is to make progress on realising the following objectives of the HSE Corporate Plan.

#### **Corporate Objective 3: We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.**

##### *Training & Development*

- Audit of existing practice in relation to training and education. *(Corporate Plan Action 3.1.1)*
- Support the HSE Board's initiative in research on the appropriate linkages between the Education sector, service delivery and research at a strategic level. *(Corporate Plan Action 3.1.1)*
- Develop an action research based Leadership Development Programme for the organisation. *(Corporate Plan Action 3.1.2)*
- Develop a suite of standardised training and development programmes. *(Corporate Plan Action 3.1.2)*
- Further develop and mainstream the use of Management Competency Frameworks (MCFs) and Personal Development Planning (PDP). *(Corporate Plan Action 3.1.2)*
- Support the transition to team based working through the provision of appropriate development opportunities and the review and roll out of team based performance management. *(Corporate Plan Action 3.1.2)*
- Develop a national policy for the support of HSE staff in the pursuit of further qualifications and to optimise the return on investment in this area. *(Corporate Plan Action 3.1.2)*
- Develop a standardised induction programme across the HSE. *(Corporate Plan Action 3.1.2)*
- Maximise the potential for the deployment of e-learning within the organisation. *(Corporate Plan Action 3.1.2)*

##### *Recruitment & retention*

- Evaluate the continued development of policies and procedures to reflect best practice recruitment and selection and to ensure compliance with the Public Service Recruitment Act (2004). *(Corporate Plan Action 3.2.1)*

- Begin the transition of appropriate recruitment processes to a shared services environment. *(Corporate Plan Action 3.2.1, 4.3.1)*
- Further develop a national approach to meet specific recruitment challenges, particularly in relation to Nurses and Health & Social Care Professionals. *(Corporate Plan Action 3.2.1)*
- Advance the establishment of a centralised vetting unit to work with the Gardai vetting unit. *(Corporate Plan Action 3.2.1)*
- Develop a specific superannuation scheme for the HSE.
- Assess the current superannuation processes throughout the system and begin the transition of appropriate processes to a shared services environment.
- Develop and implement performance and service level agreement metrics for recruitment. *(Corporate Plan Action 3.2.1)*

#### *Working environment*

- Expand family-friendly working practices, where feasible. *(Corporate Plan Action 3.3.1)*
- Further mainstream equality and diversity policies, including testing the awareness across the HSE of existing policies in this area. *(Corporate Plan Action 3.3.1)*
- Survey employees on attitudes to the working environment. *(Corporate Plan Action 3.3.1)*
- Further develop and mainstream the partnership approach, (through partnership committees) particularly in relation to the management of change. *(Corporate Plan Action 3.3.2)*
- In conjunction with the Health Service National Partnership Forum, develop best practice guidelines for implementing change through partnership. *(Corporate Plan Action 3.2.2)*

#### *Team working*

- Develop models of team-working, including further development of the Clinicians in Management Initiative, to contribute to enhanced team working and service delivery, with models of team-working for each service developed and implementation plans agreed. *(Corporate Plan Action 3.4.1)*
- Expand the number of locations using the Team Based Performance Management initiative. *(Corporate Plan Action 3.4.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

#### *Structures*

- Manage the transition from the existing HR organisation structures to the reformed integrated structure. *(Corporate Plan Action 4.2.1)*
- Integrate the HR functions/capabilities of the relevant streamlined agencies into the new HR structure. *(Corporate Plan Action 4.2.1)*

- Work towards the development of HR Shared Services in conjunction with the Shared Services Directorate through an agreed Implementation Plan. *(Corporate Plan Action 4.2.1)*
- Develop and communicate a Corporate HR strategy for the HSE, incorporating an Employee Charter. *(Corporate Plan Action 4.2.1)*
- Develop a code of conduct and confidentiality for staff and contractors.

#### Strengthening Accountability

- Develop management information systems to support service planning and delivery and implementation of appropriate systems, following the review of the PPARS project. *(Corporate Plan Action 4.4.2)*
- Enhance and extend the coverage of the existing Performance Management Frameworks to ensure better planning and delivery of services.
- Support line management in achieving optimum contributions from individuals and teams, through clarification of roles and responsibilities and effective management of performance. *(Corporate Plan Action 4.1.5)*

#### Organisational development

- Ensure that change and organisational development continues to be managed effectively throughout the HSE, maximising the benefits of moving to a unified health system. *(Corporate Plan Action 4.2.1)*
- Working with Health Service National Partnership Forum (HSNPF), develop a protocol for managing major organisation change. *(Corporate Plan Action 4.2.1)*
- Identify and deliver synergies and benefits as we progress the development of the HSE through structured support for senior managers to facilitate organisational change and development. *(Corporate Plan Action 4.2.2)*
- Work with the Department of Health and Children on the management of a phased transition of functions from the Department of Health and Children and streamlined agencies, with a schedule of roles and functions for transfer. *(Corporate Plan Action 4.2.3)*

### FUNDED SERVICE DEVELOPMENTS

Additional funding of €9m has been allocated in respect of funded service developments for 2006.

This is an initial identification of the allocation of resources, pending agreement of a more detailed distribution, following negotiation by and with the relevant directors.

Objective and Supporting Goal(s)	Actions to achieve	Resources
<b>OBJECTIVE 3:</b> We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.	This funding will be used to support	
	• Medical education and training. <i>(Corporate Plan Action 3.1.1, 3.1.2)</i>	€3.2m
	• Clinical Placement for Physiotherapists, Occupational Therapists and Speech and Language Therapists. <i>(Corporate Plan Action 3.1.2)</i>	€2.0m
	• Undergraduate midwifery and integrated childrens' / general nursing degree programmes. <i>(Corporate Plan Action 3.1.1)</i>	€3.8m
<b>TOTAL</b>		<b>€9.0m</b>

### **6.3.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- Developing and maintaining a partnership and participative approach throughout the health sector.
- Maintaining a positive Industrial Relations environment.
- Effective transition and integration of HR executive functions from the Department of Health and Children.

### **6.3.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

The HR Directorate will also be responsible for monitoring achievement of the objectives of the APPM and for the HR contribution to the Executive's reporting in accordance with the Performance Verification Process of the national social partnership agreement.

Health service resource monitoring data will be maintained on a monthly and quarterly basis.

### **6.3.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that HR service delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan. Building on the pilot work already completed, HR Benchmarking proposals will be finalised in 2006.

## 6.4 INFORMATION AND COMMUNICATIONS TECHNOLOGY

### 6.4.1 CONTEXT

#### ROLE AND PURPOSE

The primary aim of the Information and Communications Directorate is to support the creation of an adaptive and innovative health system by harnessing the capacity of current and emerging technologies. The ICT Directorate provides services to other Directorates, Business Units, and external service providers who provide health and social services. The service is managed on a national basis by the ICT Directorate and is delivered through locally based ICT resources. ICT services embrace all voice, video data communications technologies and provide the necessary services and facilities to enable the Executive achieve its corporate objectives.

The work undertaken by the ICT Directorate is to:

- Develop, operate and manage ICT infrastructure.
- Provide ICT support and advice as required.
- Facilitate and provide business analysis services throughout the Executive.
- Provide project management services to assist in the implementation of ICT projects.
- Evaluate, procure and implement ICT solutions, equipment and services to satisfy identified service needs.
- Support the development of national strategies and implementation of relevant national programmes.
- Adopt a partnership approach to work with other services in the Executive to support the delivery of the Executive's services.
- Adopt a partnership approach with other external service providers, State Departments and agencies to support the delivery of the health and social services, for example; external service providers in the Acute Hospital Sector; Department of Finance; Department of An Taoiseach; Department of Social and Family Affairs; Department of the Environment, Heritage and Local Government; and the General Register Office.

The ICT Directorate is a support service, providing a robust and reliable infrastructure, while supporting, modernising and improving services through the introduction and continuous exploitation of ICT. The value of this ICT investment will be optimised in conjunction with extensive reform of work practices by all health professionals in the delivery system.

### 6.4.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

ICT services are provided through a combination of national programmes, management and support. Currently there is significant use of appropriate strategic sourcing in the provision of services. Further progress has been made in recent years of external hosting and managed service arrangements. Software applications, the majority of which are supported by 'in-house' operations staff, are critical to the delivery of a range of direct patient/user and clinical/administrative services.

### 6.4.3 THE YEAR AHEAD

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006.

The HSE Corporate Plan 2005-2008 sets out four Corporate Objectives which will inform the annual National Service Plan actions for the different Directorates and Business Units throughout the organisation.

#### 6.4.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Work with the Population Health Directorate to assist with the identification of epidemiological needs. *(Corporate Plan Action 2.1.2)*
- Continue to work towards achieving the Government Action Plan for the use of ICTs to support social inclusion in the Information Society.

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

- Establish a national ICT governance structure. *(Corporate Plan Action 4.2.1)*
- Complete the audit of the HSE ICT infrastructure and plan a unified enterprise-wide technical architecture to support the implementation of national systems and services. *(Corporate Plan Action 4.4.2)*
- Work with partners and stakeholders to clarify the overall identification needs of the health service, leading to an overall strategy for health service identification. *(Corporate Plan Action 4.3.2)*
- Building on the work commenced in 2004, the Health Services Portal will be further developed by the provision of a single intranet service for the HSE. *(Corporate Plan Action 4.3.2)*
- Phase 1 of the Integrated Patient Management System (iPMS) will be implemented in the HSE – North West, HSE – North East, HSE – South and Tullamore General Hospital in 2006. *(Corporate Plan Action 4.4.2)*
- Phase II, the development of the new National Hospital Information System, will be designed and tested by the end of 2006. *(Corporate Plan Action 4.4.2)*
- The procurement of the National Laboratory System will be completed and implementation will commence in 2006. *(Corporate Plan Action 4.4.2)*

#### 6.4.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2006 are:

- To develop and implement short term ICT solutions to meet critical business needs in respect of management and control reporting.

- Continue to ensure a strategic National approach to all developments, particularly in terms of interoperability.
- Work with other Directorates and partners in care to ensure the ICT elements of all developments are clearly identified from the outset.

#### **6.4.3.3 MONITORING MECHANISMS**

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework.

#### **6.4.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that ICT services delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

## **6.5 FINANCE**

### **6.5.1 CONTEXT**

#### **ROLE AND PURPOSE**

The Finance Directorate provides strategic and operational financial support and advice at all levels across the HSE. This includes the development of policies for financial planning, and control, and supporting and assuring the implementation of these policies throughout the management system. The Directorate is also responsible for the preparation and interpretation of monthly, bi monthly and annual financial reports.

The introduction of revised accounting arrangements in January 2005 associated with the Chief Executive Officer of the HSE becoming the Accounting Officer for the Executive's Vote has had particular implications for the Directorate in supporting the CEO in his role, and in respect of the working and reporting arrangements on behalf of the Executive with the Department of Health and Children, the Department of Finance, the Comptroller and Auditor General and the Paymaster General.

### **6.5.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED**

Finance, and financial support services, are currently delivered by staff in the finance departments / functions of the Executive's areas and the streamlined agencies.

- Strategic and financial governance
- Financial policy definition/ assurance
- Financial planning and budgeting
- Financial management and control
- Management reporting
- Financial systems development
- Forecasting/modelling
- Preparation of Annual Financial Statement
- Financial risk management
- Financial Compliance
- Contracting and procurement advice
- Capital Financing
- Bank reconciliation
- Cash management
- Vote management

### **6.5.3 THE YEAR AHEAD**

A number of actions that commenced in 2005 will continue to be progressed / implemented in 2006. Specific details are included within the individual business plans that support the National Service Plan.

### 6.5.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders.**

#### *Structure*

- Finalise the shape of the national finance structure, defining new roles at a national level. *(Corporate Plan Action 4.2.1)*
- Recruit into the new structure and undertake appropriate team working initiatives to support the new modes of working. *(Corporate Plan Action 4.2.1)*
- Build excellence in finance management at a national level.

#### *Transformation*

- Plan and implement transformation of the finance function from the former board/ERHA structures to an integrated function, in line with the HSE business objectives. *(Corporate Plan Action 4.2.2)*
- Further develop relationships with the service areas to support the business of the HSE.

#### *Leverage the capital base*

- Support the development of frameworks for joint venture with the private sector. *(Corporate Plan Action 4.4.5)*
- Provide analytical support to the services in assessing proposals. *(Corporate Plan Action 4.4.5)*
- Assess strategic opportunities in the asset base. *(Corporate Plan Action 4.4.5)*

#### *Drive value in procurement*

- Develop national structure and information base from which to drive value for the organisation through materials management. *(Corporate Plan Action 4.2.1)*
- Implement a national structure focused on logistics, category management and business support.
- Develop a shared services approach within the context of the overall procurement process. *(Corporate Plan Action 4.3.1)*
- Target initiatives in high value areas to drive value. *(Corporate Plan Action 4.3.4)*

#### *Financial control*

- Establish timely standard and consistent reporting and forecasting of voted expenditure. *(Corporate Plan Action 4.4.4)*
- Establish clear levels of financial accountability. *(Corporate Plan Action 4.4.4)*
- Develop systems to support vote accounting reporting. *(Corporate Plan Action 4.4.4)*
- Develop systems and process to enable Income & Expenditure reporting at National level. *(Corporate Plan Action 4.4.4)*

*Finance regulations*

- Roll out Purchase to Pay Financial Procedures and regulations and develop further national standard regulations.

*Financial Reporting*

- Develop a corporate reporting system to integrate the finance data from all HSE areas and the voluntary agencies to provide data for managers, Directors and the Board as well as meeting our external reporting requirements. *(Corporate Plan Action 4.4.2)*
- Establish consistency and standardisation in Financial and Management reporting. *(Corporate Plan Action 4.4.2)*
- Establish standard accounting policies in accordance with best business practice.

*Appropriation account*

- Establish appropriation account format and reporting requirements.
- Establish accounting principles / process for appropriation accounts.
- Undertake a project to develop Vote reporting within the HSE. This is incorporated in the scope of the FISP project and can be delivered in the context of a revised implementation plan for FISP having regard to the objectives of the HSE. *(Corporate Plan Action 4.4.2)*

*VFM program*

- Lead the development of the VFM program of the HSE for 2006. *(Corporate Plan Action 4.4.2)*
- Develop plan in conjunction with the appropriate Directorates. *(Corporate Plan Action 4.4.2)*
- Oversee implementation of plan.

**6.5.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- Establishment of an integrated national financial management system.

**6.5.3.3 MONITORING MECHANISMS**

Service plan monitoring will take place in accordance with the National Performance Monitoring Framework.

The Finance Directorate has particular monitoring functions in respect of the Accounting Officer obligations of the Chief Executive Officer.

**6.5.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES**

A range of on-going and new research, quality, evaluation and value for money initiatives will ensure that financial services delivery is evidence based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included in the Business Plans that support the National Service Plan.

## 6.6 ESTATES MANAGEMENT

### 6.6.1 CONTEXT

The Health Services Executive (HSE) inherited a large, geographically dispersed and technologically varied facilities infrastructure. This estate, although far from uniform in origin and quality, is required to sustain a diverse range of services that strive for equity of access and uniformity of standard.

The Estates Management function currently resides within the Finance Directorate of the HSE on an interim basis.

### ROLE AND PURPOSE

The role of the HSE Estates Management function is to manage our Healthcare Facilities to create and sustain a physical environment from which quality health services can be delivered. Areas of responsibility, with regional variances include:

- Technical advice and guidance
- Estates management
- Facilities risk & quality assurance
- Environmental, energy and waste management
- Capital programme - development, procurement and management
- Facilities service development
- Property management
- Maintenance management
- Fire Safety
- Health & Safety

### 6.6.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

- Capital planning and management of the rolling 5 year capital investment Framework.
- Strategic and operational management of the health estate.
- Implementation of the "Health Services Infrastructure" reform project.

### 6.6.3 THE YEAR AHEAD

#### Outstanding actions from 2005

A number of projects and actions commenced in 2005 will continue to be progressed in 2006. Specific details are reflected within the individual business plans.

#### 6.6.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES:

**Corporate Objective 2: We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.**

- Continue fire, health and safety and risk management assessments of premises in support of staff and their working environment. *(Corporate Plan Action 1.10.1)*
- Contribute to wider organisational risk management process. *(Corporate Plan Action 1.10.1)*

- Ongoing implementation of Manual Handling Training Programme and fire safety drills. *(Corporate Plan Action 1.10.1)*
- Continue to assist service areas to prioritise and address facilities risk management needs. *(Corporate Plan Action 1.10.1)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

- Manage the Capital Programme under the National Development Plan 2000-2006 and Capital Framework 2005-2009. *(Corporate Plan Action 4.4.5)*
- Complete comprehensive review of the assets of the Executive (including land). *(Corporate Plan Action 4.4.5)*
- Work with service pillars to expand and renew the capital base of the HSE with a view to supporting the achievement of care objectives, including identification of key sites nationally to drive the development of integrated primary care. *(Corporate Plan Action 4.4.5)*
- Develop an integrated in-house technical support for the management and development of the asset base.
- Continue the development of in-house functions, engineering, physical resources, fire, health and safety and administrative support, to meet the needs of service areas.
- Continue the provision of environmental management advice and support in relation to energy management, waste management and water quality.
- Implement the Integrated National System for Capital Projects Information, Reporting and Exchange (INSPIRE). *(Corporate Plan Action 4.4.2)*
- Contribute to the development of other national information systems projects as regards the Estate. *(Corporate Plan Action 4.4.2)*

#### **6.6.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- Date of Capital Plan Approval and project approval timescales
- Policy on the advancement of projects affected by revenue constraints

#### **6.6.3.3 MONITORING MECHANISMS**

Service plan monitoring will take place in accordance with the National Performance Monitoring Framework.

In addition, new protocols and operating procedure are being developed to support the delivery of a standardised service across the HSE.

#### **6.6.3.4 EVALUATION, RESEARCH, QUALITY AND VFM INITIATIVES**

The "Health Service Infrastructure" strategic management project encompasses these areas in a single initiative that addresses all estate processes.

The project objectives, process and deliverables are fully documented in the project proposal and terms of reference.

## 6.7 CORPORATE SUPPORT SERVICES

### 6.7.1 CONTEXT

The development of the HSE as a single organisation to deliver a unitary system for health and personal social services requires us to embark on a programme of significant change and development. To support the development of the HSE a range of corporate support services are required to ensure that the organisation functions to its maximum capacity, and that service delivery agents are supported with best policy direction and expert professional support in the execution of their respective responsibilities.

### ROLE AND PURPOSE

Each corporate support service provides specialist support and advice, as appropriate.

### 6.7.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Support services provided include:

- Consumer services (including appeals, complaints, Freedom of Information and data protection initiatives)
- Quality and accreditation
- Risk Management
- Communications
- Parliamentary Affairs
- Strategic, Corporate, Service Planning & Performance Monitoring
- Change Management
- Reform Implementation support
- Organisational Development

### 6.7.3 THE YEAR AHEAD

How these support services are delivered varied substantially across the delivery agencies prior to the establishment of the HSE. Work is ongoing on the final design for each of these support services. Each Corporate Support area has its own detailed Business Plan. Outlined below are the organisation wide priorities for 2006. These actions will be translated in greater detail in the respective business plans and implementation will be in partnership with the service delivery areas.

#### 6.7.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

**Objective 1: We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.**

- Improve the safety, effectiveness and quality of our services in collaboration with relevant external organisations (e.g. Irish Health Services Accreditation Board (IHSAB), Mental Health Commission, Health and Safety Authority, Social Services Inspectorate etc). (*Corporate Plan Action 1.10.1*)

- Develop national framework to standardise HSE approach to quality, risk and consumer services. *(Corporate Plan Action 1.10.1)*
- Commence work on the development of a Risk Management Strategy. *(Corporate Plan Action 1.10.1)*
- Establish a strong working relationship with the Health Information and Quality Authority (HIQA) in pursuit of the quality / safety agenda. *(Corporate Plan Action 1.10.3)*
- Implement statutory complaints framework. *(Corporate Plan Action 1.10.4)*
- Ensure best evidence is used in decision making. *(Corporate Plan Action 1.10.6)*

**Corporate Objective 4: We will develop the HSE as a dynamic, effective and learning organisation, in partnership with service users, patients, staff, not-for-profit / Voluntary / Community sector and other stakeholders.**

- Ensure involvement of the public and consumers of services in planning and monitoring health services. *(Corporate Plan Action 4.1.1)*
- Further develop and enhance HSE's Parliamentary Affairs Division, working closely with the Department of Health and Children, in supporting the Ministerial accountability to the Oireachtas.
- Establish Regional Health Offices to continue and enhance the process of engagement and consultation with members and representatives of the public, and with patients and users of services. *(Corporate Plan Action 4.1.2)*
- Develop and commence implementation of a National Customer Care Strategy. *(Corporate Plan Action 4.1.3)*
- Further develop mechanisms for engagement with the public. *(Corporate Plan Action 4.1.4)*
- Develop mechanisms to involve staff at all levels of the organisation in the planning and development of services. *(Corporate Plan Action 4.1.5)*
- Continue to develop partnerships and forums with the not-for-profit/ Voluntary/ Community sector to optimise service delivery. *(Corporate Plan Action 4.1.6)*
- Strengthen the new organisational structures of the HSE and ensure that change continues to be managed effectively throughout the organisation. *(Corporate Plan Action 4.2.1)*
- Support implementation of new organisational structures. *(Corporate Plan Action 4.2.1)*
- Establish a Communications Unit to provide a full internal and external communications service for the HSE. *(Corporate Plan Action 4.2.1)*
- Identify and deliver synergies and benefits as we progress the development of the HSE. *(Corporate Plan Action 4.2.2)*
- Ensure the smooth transition of functions from the Department of Health and Children and streamlined agencies. *(Corporate Plan Action 4.2.3)*
- Agree and implement a Code of Governance. *(Corporate Plan Action 4.4.1)*

- Review HSE business model and implement recommendations of review.  
(Corporate Plan Action 4.4.3)

### **6.7.3.2 KEY ISSUES FOR THE YEAR AHEAD**

- Developing, implementing and agreeing frameworks for the Executive in respect of each of these support services

### **6.7.3.3 MONITORING MECHANISMS**

Service plan monitoring will take place in accordance with the National Performance Monitoring Framework.

In addition, on a quarterly basis, reports will be produced by the HSE Parliamentary Affairs Division in respect of:

- Volume of questions received.
- Number of direct replies.
- Number replied to within the period.

Included in the HSE Annual Report will be a section on complaints management.

### **6.7.3.4 EVALUATION, RESEARCH, QUALITY AND VFM INITIATIVES**

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that corporate support services delivery is evidence-based, in line with best practice and capable of delivering on both value for money and the most effective outcomes. Specific relevant details are included in the individual business plans that support the NSP.

## APPENDIX 1: HEALTH AND SOCIAL POLICY STRATEGY DOCUMENTS AND OTHER SOURCES

### POLICY DOCUMENTS

- *A Strategy for Equality, Report of the Commission on the Status of People with Disabilities* (1996). Dublin: Stationery Office
- Amnesty International (Irish Section) (2003) *Mental Illness: The Neglected Quarter*. Dublin
- *Audit of Structures and Functions in the Health System* (2003). Dublin: Stationery Office
- *Building an Inclusive Society: Review of the National Anti Poverty Strategy under the Programme for Prosperity and Fairness* (2002). Dublin: Stationery Office
- Chief Executive Officers of the Health Boards Physical Activity Group (1997) *Promoting Physical Activity: A Strategy for Health Boards in Ireland*. Dublin: Office for Health Gain
- Denyer, S., Thornton, L., and Pelly, H. (1999) *Best Health for Children – Developing a Partnership with Families*. Manorhamilton: National Conjoint Child Committee, Health Board Chief Executive Officers
- Department of Health (1984) *The Psychiatric Services: Planning for the Future*. Dublin: Stationery Office
- Department of Health (1988) *The Years Ahead – A Policy for the Elderly. Report of the Working Group on Services for the Elderly*. Dublin: Stationery Office
- Department of Health (1989) *A Charter of Rights for Hospital Patient: Putting the Patient First*. Dublin: Stationery Office
- Department of Health (1990) *Needs and Abilities, A Policy for the Intellectually Disabled: Report of Review Group on Mental Handicap Services*. Dublin: Stationery Office
- Department of Health (1993) *Report of the Review Group on the Ambulance Service*. Dublin: Stationery Office
- Department of Health (1994) *National Breastfeeding Policy for Ireland*. Dublin: Stationery Office
- Department of Health (1996) *Towards an Independent Future: Report of the Review Group on Health and Personal Social Services for People with Physical and Sensory Disabilities*. Dublin: Stationery Office
- Department of Health (1996) *Cancer Services in Ireland: A National Strategy*. Dublin: Stationery Office
- Department of Health and Children (1997) *Enhancing the Partnership: Report of the Working Group on the Implementation of the Health Strategy in relation to Persons with a Mental Handicap*. Dublin: Stationery Office.
- Department of Health and Children (1998) *Report of the Commission on Nursing*. Dublin: Stationery Office.
- Department of Health and Children (1998) *Report of the National Task Force on Suicide*. Dublin: Stationery Office
- Department of Health and Children (1999) *The National Health & Lifestyle Surveys: Survey of Lifestyle, Attitudes and Nutrition (SLAN) and The Irish Health Behaviour in School-Aged Children Survey (HBSC)*. Dublin: Stationery Office
- Department of Health and Children (1999) *Children First: National Guidelines for the Protection and Welfare of Children*. Dublin: Stationery Office
- Department of Health and Children (1999) *Building Healthier Hearts: The Report of the Cardiovascular Health Strategy Group*. Dublin: Stationery Office.
- Department of Health and Children (2000) *Development of Services for Symptomatic Breast Disease, Report of the Sub-Group to the National cancer Forum*. Dublin: Stationery Office

- Department of Health and Children (2000) *National Health Promotion Strategy 2000 – 2005*. Dublin
- Department of Health and Children (2000) *The National Children's Strategy: Our Children – Their Lives*. Dublin: Stationery Office
- Department of Health and Children (2000) *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin
- Department of Health and Children (2000) *Towards a Tobacco Free Society: Report of the Tobacco Free Policy Review Group*
- Department of Health and Children (2001) *Primary Care A New Direction*. Dublin: Stationery Office
- Department of Health and Children (2001) *Quality and Fairness, A Health System For You*. Dublin: Stationery Office
- Department of Health and Children (2001) *Youth Homelessness Strategy*. Dublin: Stationery Office
- Department of Health and Children (2001) *First Report of the Working Group on Child and Adolescent Psychiatric Services* Dublin: Stationery Office
- Department of Health and Children (2001) *National Standards for Children's Residential Centres*.
- Department of Health and Children (2001) *Making Knowledge Work for Health: A Strategy for Health Research*. Dublin
- Department of Health and Children (2002) *Report of the Advisory Committee on Palliative Care*. Dublin: Stationery Office
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