Health Service Executive

National Operational Plan 2013

Implementing the National Service Plan 2013

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Health Service Executive

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Introduction

INTRODUCTION

Context

The Health Service Executive's National Service Plan 2013 (NSP2013), approved by the Minister on 9th January 2013, sets out the type and volume of services to be delivered by the Executive in 2013 and is informed by the Department of Health's (DoH) *Statement of Strategy 2011 – 2014* and *Future Health:. A Strategic Framework for Reform of the Health Service 2012 – 2015*, both of which set out the Government's priorities for the health services. The HSE is committed to supporting the *Programme for Government* change agenda which will bring about significant changes to the way health services are managed and delivered in 2013 and beyond.

This National Operational Plan has therefore been developed to support the implementation of NSP2013 by setting out a national position for each main care group / programme in order to guide the translation of national policy into the four Regional Service Plans and the three Hospital Group Plans:

- HSE Dublin Mid Leinster
- HSE Dublin North East
- HSE South
- HSE West
- Mid Western Regional Hospitals' Group
- Galway and Roscommon Hospitals' Group
- Louth Meath Hospital Group

It is recommended that the NSP2013 is read in conjunction with this Operational Plan.

Reforming Our Health Services

In November 2012, the Minister for Health published *Future Health,* the framework for health reform. This framework, based on Government commitments in its *Programme for Government*, outlines the main healthcare reforms that will be introduced in the coming years as key building blocks for the introduction of Universal Health Insurance in 2016.

NSP2013 will be implemented while the HSE structural and health service reforms as outlined in *Future Health* are being progressed. This includes changes to the way that hospital services, including our smaller hospitals are funded and managed, the disaggregation of childcare services from the HSE and the establishment of a Child and Family Support Agency, establishing a new Directorate structure, the establishment of a Patient Safety Agency and ensuring that our social care services including Mental Health, Disability and Primary Care are fit for purpose. *Future Health* seeks to support innovative ways of care delivery and in particular integrated care pathways. All this must be achieved under the most stringent fiscal constraints experienced for decades and cognisant of health trends and drivers of change such as:

- Demographic and societal change
- Rising expectations and demands
- New medical technologies, health informatics and telemedicine
- Spiraling costs of healthcare provision

The health services continue to experience very significant budgetary challenges alongside increased demands for services. We also face the dual challenge of reducing costs while at the same time improving outcomes for our patients. We will continue to introduce models of care across all services / care groups which treat patients at the lowest level of complexity and provide services at the least possible unit cost, led by our clinical leaders under the HSE National Clinical Care Programmes.

The continued implementation of health sector reform is essential to ensure:

- A public health service that is leaner, more efficient and better integrated to deliver maximum value for money and respond to public needs.
- Continuity of service delivery in the context of significantly reduced staff numbers.

Summary of the HSE Financial Position in NSP2013

The 2013 gross voted Estimate for the HSE is €13,404.1m, a net increase of €71.5m (0.5%) on the 2012 budget. This net increase includes new spending and unavoidable pressures of €748m and savings of €721m. Since 2008, the HSE has seen a 22% total reduction to the HSE budgets (or €3.3bn) with staffing levels reducing by over 11,268 WTEs since its peak employment levels (September 2007). To date, cost reductions have been achieved by reducing pay and staff numbers as well as savings in the cost of community drug schemes and procurement. This year will require further savings in each of these headings.

The objective of the financial framework supporting the NSP2013 is to ensure that all areas have budgets that are achievable while delivering the reductions continued within the estimate to avoid a mid-year financial crisis and deliver a balanced vote. The HSE Board has an absolute obligation to address this and therefore choices have to be made in determining the budget allocations for 2013 with a view to ensuring sustainable budgets especially in the hospital sector which has struggled in recent years to break even. The approach for 2013 places priority on rebasing hospitals in budgetary terms, maintaining community services budgets and driving further cost efficiencies in primary care schemes (PCRS).

The measures relate predominantly to reductions in pay (€286m, not including the additional €150m to be determined as part of the PSA), non-pay (€43m) and primary care schemes (€383m). This level of reduction will require considerable management focus to deliver in 2013. The Estimate provides €390.9m to address incoming deficits and €90m to cover demographic deficits. Investment of €35m is available for Mental Health services and €20m for Primary Care.

Table 1 shows how the budgets have been initially allocated by national care group / programme.

Table 1: Breakdown of Budgets by Care Group / Programme

Care Group by Programme	2012 Budget €m	2013 Budget €m	% Variance
Acute	3,978	4,117	3.5%
PCRS	2,518	2,562	1.7%
Primary Care	372	400	7.6%
Children and Families	544	541	-0.5%
Mental Health	711	733	3.1%
Disability	1,554	1,535	-1.2%
NHSS – A Fair Deal	994	998	0.4%
Older People	403	392	-2.6%
Palliative Care	73	72	-1.6%
Social Inclusion	115	114	-1.0%
Multi Care Group	482	477	-1.1%
Other	81	77	-4.6%
Total Care Group	11,824	12,018*	1.6%

*These figures will further reduce when the €150m additional pay reduction target is applied.

Financial Performance

Clear planning and strong financial management and control are key to ensuring successful delivery through the transition to the reformed health landscape. Building the finance capacity and supporting system development are critical. The most critical success factor for 2013 will be that budget holders identify and respond to any service and financial issues as they arise, and are supported in taking all necessary action. Experience in the past has seen these issues accumulate and remain unaddressed. This must change in 2013.

NSP2013 seeks to address legacy issues to the extent that an attempt has been made to give each budget holder a realistic budget for 2013 in the context of the service levels in 2012. In rebalancing budgets, the HSE has assessed performance in 2012 under a number of headings including cost reduction, management of absenteeism, achievement of service targets and productivity. The percentage change in hospital budgets has been nuanced based on these criteria.

No budget holder has been allowed to plan for a deficit. All deficits must be addressed in the planning phase and decisions made to address these where they exist in the context of the available funds. Each budget holder has been asked to confirm this at the start of the year and will be held accountable for performance. A process is ongoing to ensure that cost reduction targets, particularly at hospital level, are agreed in line with deliverability.

Despite funds made available to address structural deficits, there will still be a requirement to identify areas to reduce cost to ensure the NSP2013 can be delivered within the agreed budget for 2013. This will require a consistent approach to the identification, planning, management and reporting of cost reduction initiatives as part of the service planning process, and throughout the year to reflect changing circumstances and the impact of new service pressures in year.

Summary of the HSE Workforce Position in NSP2013

Government policy on public service numbers requires that, by the end of 2013, the health service achieves a workforce of 98,955 whole time equivalents (WTEs). This is a very challenging target given the level of staff reductions that have been achieved in recent years. NSP2013 provides for investment of an additional 1,025 WTEs in a number of key prioritised areas as well as the completion of the 2012 mental health investment programme (400+ posts).

In order to reach the end of 2013 ceiling target and to deliver on these critical service developments, it will be necessary to achieve a reduction of almost 4,000 WTEs or 4% of our workforce which equates to the loss of the equivalent of approximately 6.4 million working-hours on an annual basis. The overall net reduction required by the end of 2013 will be 2,400 WTEs. Staff reductions will be pursued throughout 2013 through natural turnover (retirements and resignations) and such other targeted measures or initiatives as may be determined by Government in relation to the health sector or the wider public service.

Employment Control

The challenge for the health service in 2013 is to achieve the overall end of year reduction in staff numbers in a managed way, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed. In addition to reductions resulting from normal staff turnover, it is expected that the Government will set out a number of other mechanisms which can be used in a targeted way to contribute to the achievement of the necessary overall reduction, such as a targeted voluntary redundancy programme across the public sector. The HSE will target a reduction in staffing levels of 1,500 WTEs as part of this.

Robust and responsive employment control, with accountability at regional and service manager level, continues to be a key driver for 2013. An indicative employment control ceiling (Table 2) was set out in NSP2013. Once notification of the final Employment Control Framework (ECF) for 2013 is received, refinement of the ECF budgets and associated ceilings will be undertaken to ensure there is clarity on the level of reduction to be achieved in the course of the year. Any adjustments to these ceilings will be made only to take account of specific service development needs and in the context of the overall employment target being achieved.

One of the biggest challenges to implementation of NSP2013 is the delivery of these headcount reduction targets. Reconfiguration and integration of services, reorganisation of existing work and redeployment of current staff will need to underpin the employment control framework in order to implement Government policy on public service numbers and costs within budgetary allocations. The 2013 employment control framework will also address workforce issues such as overtime and agency usage and costs, cost of allowances, and cost of absenteeism.

Table 2: Indicative Employment Ceilings 2012 and 2013

Ceiling Dec 2012	Projected Dec 2012 outturn	2012 Mental Health	Additional prioritised posts 2013	Reduction required	Ceiling Dec 2013
101,970	101,400*	409	1,025	3,839	98,955

* Since publication of NSP2013, early indications indicate a slightly worse off end-of-year position

In establishing ceilings it is essential that they are considered in conjunction with budget setting and service levels. We will ensure that the total staff cost reductions and associated headcount reductions required from the hospital sector for example, are deliverable and aligned.

Measures will be implemented in a manner as to maximise the protection of frontline services but inevitably staff reductions of this magnitude have the potential to impact on the level of services delivered.

There will be a focused approach to the management of the staffing resource in order to deliver on the service objectives of this plan, while controlling payroll and related costs. The *Public Service Agreement* (PSA) remains a key enabler to further reduce the cost of labour, deliver cost reductions and payroll savings and to manage the change agenda in 2013. There is a dependency on further savings to be delivered by the PSA extension. During the year, the HSE will work with the DoH and the Department of Public Expenditure and Reform who have lead responsibility for this.

The *Revised Health Sector Action Plan 2012-2013* notes that the continuing commitment of all those working in the health service is essential to deliver the maximum level of safe services possible for the public, within reduced funding and employment levels, while at the same time implementing a wide-ranging reform agenda. Continued staff co-operation will be required with organisational changes within the HSE such as new governance and management structures, and the establishment of additional hospital groups. Specifically the following objectives will be advanced:

- Specific priority work practice changes for identified health disciplines
- Systematic reviews of rosters, skill-mix and staffing levels
- Increased use of redeployment
- Further productivity increases
- A focused approach to addressing staff absenteeism and implementing revised new sick leave arrangements
- Greater use of shared services and combined services, coupled where necessary, in terms of costs and efficiency, to the use of external sourcing in order to deliver cost-effectiveness and best value for money, while protecting frontline service delivery
- Greater integration of the human resources functions of the statutory and voluntary sectors to remove duplication, achieve better efficiencies and allow for greater use of shared services within and across emerging structures.

We will also engage in national level talks between Government and Public Sector trade unions to agree measures to further accelerate savings under PSA. Other important areas to address include:

European Working Time Directive (EWTD) - The plan requires a particular focus in the acute hospital service on the achievement of compliance with the EWTD amongst the non-consultant hospital doctor (NCHD) workforce, in line with the Implementation Plan submitted by Ireland to the European Commission in 2012.

Agency and Overtime Policy - There will be a particular focus on significantly reducing the volume of both agency and overtime usage across all staff functions. Where the budget allows, agency staff may be used only where no alternative is possible and where there is a short-term critical service need. Agency staff will not be used to support service levels beyond those agreed in NSP2013 or to substitute for staff losses as a result of the need to reduce health sector employment.

Medical Manpower - Since 2009, there has been a significant increase in employment levels for medical consultants. This growth, and the costs associated, makes it appropriate to review NCHD capacity and to focus on reducing medical overtime and agency / locum costs.

Human Resource (HR) Shared Services - Each service delivery unit will have access to efficient, responsive HR shared services to support employee and industrial relations, performance management, organisational and workforce development, recruitment, and transactional HR support. Improved business processing, enhanced turnaround times and productivity will continue to be the objective of HR services. HR services will continue to introduce increased levels of standardisation in high level processing activities utilising available resources and technology.

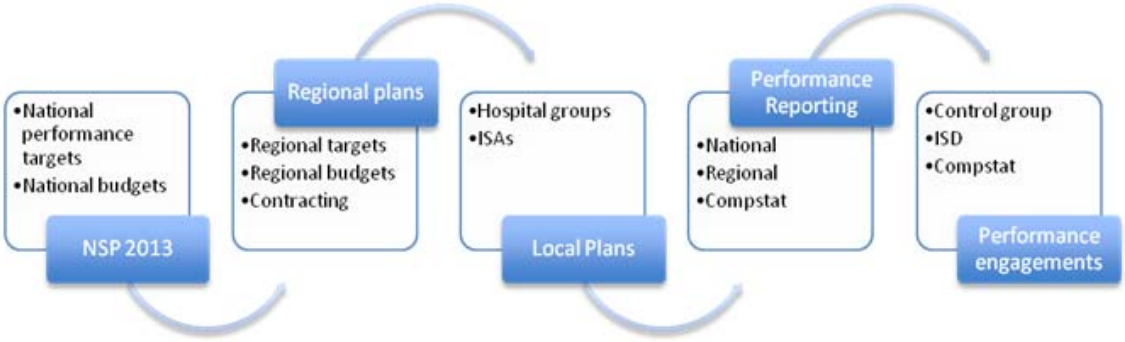
Improving Performance Management

A key priority as the health system continues to reform is to ensure that financial, workforce and service performance is actively managed and reported on in a timely manner. Building on the work of recent years, the 2013 accountability framework will ensure that performance will be measured against agreed plans which must be managed in the context of cost reduction, absenteeism, achievement of service targets and productivity. Information will be required at all levels in the system, therefore these plans will be monitored through a range of processes, including scorecard metrics. CompStat will support performance management at local service delivery unit level as it continues to be embedded in the operational system, for hospitals and community services. Service managers will be held to account and under performance will be addressed. A process to identify and define a holistic performance framework and reporting requirements for 2013 is in process and is cognisant of the changing accountability environment.

It is essential to have clear and transparent performance expectations in place with those agencies funded by the HSE. Funded agencies will be managed through improved service arrangement schedules which will include greater linkages to national priorities and increased transparency in relation to corporate overheads and senior salaries.

This plan sets out health and personal social services to be delivered at national care group / programme level. Each chapter contains a list of priorities, key actions and measures which will provide information about progress throughout the year. It supports the translation of the NSP2013 into regional and local service plans, which should also be read in conjunction with this plan when published. The business plans have been developed under a structured and rigorous process to ensure that these plans:

- Improve governance and control
- Define a clear plan for delivery
- Are consistent in their application of national priorities
- Integrate the budgeting and service planning process, and
- Test service deliverability.



NATIONAL SCORECARD

National Performance Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Emergency Care % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	Quality, Access and Activity	Health Protection % of children 24 months of age who have received three doses of 6 in 1 vaccine	95%
			% of children 24 months of age who have received the MMR vaccine	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	100%		% of first year girls who have received the third dose of HPV vaccine by August 2013	80%
Elective Waiting Time No. of adults waiting more than 8 months for an elective procedure	0		Child Health % of new born babies visited by a PHN within 48 hours of hospital discharge	95%
No. of children waiting more than 20 weeks for an elective procedure	0		% of children reaching 10 months in the reporting period who have had their child development health screening on time before reaching 10 months of age	95%
Colonoscopy / Gastrointestinal Service No. of people waiting more than 4 weeks for an urgent colonoscopy	0		Child Protection and Welfare Services % of children in care who have an allocated social worker at the end of the reporting period	100%
No. of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	0		% of children in care who currently have a written care plan, as defined by *Child Care Regulations 1995*, at the end of the reporting period	100%
Outpatients No. of people waiting longer than 52 weeks for OPD appointment	0		Primary Care No. of PCTs implementing the national Integrated Care Package for Diabetes	51
Day of Procedure Admission % of elective inpatients who had principal procedure conducted on day of admission	75%		No. of primary care physiotherapy patients seen for a first time assessment	139,102
% of elective surgical inpatients who had principal procedure conducted on day of admission	85%		Child and Adolescent Mental Health % on waiting list for first appointment waiting > 12 months	0%
Re-Admission Rates % of surgical re-admissions to the same hospital within 30 days of discharge	< 3%		Adult Acute Mental Health Services Inpatient Units No. of admissions to adult acute inpatient units	14,044
% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%		Disability Services Total no. of home support hours (incl. PA) delivered to adults and children with physical and / or sensory disability	1.68m
Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%		No. of persons with ID and / or autism benefitting from residential services	8,172
Stroke Care % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	50%		Older People Services No. of people being funded under the Nursing Home Support Scheme (NHSS) in long term residential care at end of reporting period	22,761
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%		No. of persons in receipt of a Home Care Package	10,870
ALOS Medical patient average length of stay	5.8		No. of Home Help Hours provided for all care groups (excluding provision of hours from HCPs)	10.3m
Surgical patient average length of stay	4.5% reduction		% of elder abuse referrals receiving first response from senior case workers within 4 weeks	100%
HCAI Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	< 0.060		Palliative Care % of specialist inpatient beds provided within 7 days	92%
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5		% of home, non-acute hospital, long term residential care delivered by community teams within 7 days	82%
Cancer Services % of breast cancer service attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals *(% offered an appointment that falls within 2 weeks)*	95%		Social Inclusion % of individual service users admitted to residential homeless services who have medical cards.	>75%
% of patients attending lung cancer rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral	95%		Finance Variance against Budget: Income and Expenditure	≤ 0%
% of patients attending prostate cancer rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral	90%		Variance against Budget: Income Collection / Pay / Non Pay / Revenue and Capital Vote	≤ 0%
Emergency Response Times % of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 85%)	> 70%		Human Resources Absenteeism rates	3.5%
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 85%)	> 68%		Variance from approved WTE ceiling	≤ 0%

Quality and Patient Safety

QUALITY AND PATIENT SAFETY

Introduction

At a time of significant economic constraint it is of critical importance that the HSE renews its focus on the quality and safety of care provided to people who access our services. This section of the service plan sets out how the Quality and Patient Safety (QPS) Directorate will support the system in improving quality and patient safety. A critical principle is that quality and patient safety is the responsibility of everyone who comes to work for the HSE every day. We must do our job and we must strive to improve what we do constantly. We are committed to building the capacity of key leaders across our healthcare system through the Diploma in Leadership in Quality Improvement and the associated site specific training so that quality improvement is embedded throughout the delivery system.

We are focused on the development and implementation of safe quality healthcare, where all service users attending our services receive high quality care and treatment at all times, are treated as individuals with respect and dignity, are involved in decisions about their own care, have their individual needs taken into account, are kept fully informed, have their concerns addressed, and are treated / cared for in a safe environment based on best international practice. The Quality and Patient Safety Directorate will continue to work with the DoH in setting up a Patient Safety Agency.

Our patient charter, *You and Your Health Service,* is an indication of our commitment to inform and empower service users to actively look after their own health, and to influence the quality of healthcare in Ireland.

In June 2012, the *National Standards for Safer Better Healthcare* were launched. Standards help to set public, provider and professional expectations and enable everyone involved in healthcare to play a vital part in safeguarding patients, and deliver continuous improvement in the quality of care provided. We will continue to work with service providers to support their progress in implementing the national standards and improving their performance against standards. We will continue to work with HIQA, the Mental Health Commission (MHC) and other regulatory bodies and all our partners to support frontline services in driving quality improvement and ensuring that the overall burden of regulation and standards are managed in a coherent fashion. The Quality and Patient Safety Directorate will seek assurance that standards and recommended policies / guidelines, developed by the HSE, are implemented.

The Quality and Patient Safety Directorate will continue to work with the DoH on approving national clinical guidelines through the National Clinical Effectiveness Committee. To support the services, at this time of significant change in structures and practices within the organisation, the work on implementing best practice clinical governance across all services will continue in 2013. This will embed structures and processes that guarantee leadership at all levels of the organisation is progressing quality and patient safety and is accountable for it. The Quality and Patient Safety Directorate is committed to continuing stakeholder engagement.

2013 Key Priorities

- Build leadership capacity for quality improvement in the healthcare system.
- Develop a strong system of integrated corporate and clinical governance, including a programme to support Clinical Directors to achieve maximum effectiveness in their roles.
- Support implementation of the National Standards for Safer Better Healthcare.
- Strengthen patient and service user input and advocacy through Quality and Patient Safety Audits.
- Report on National Clinical Audits in the areas of Surgical Mortality, Intensive Care Units (ICU) and establishing an Orthopaedic Joint Registry.
- Promote risk management as everyday practice across all services, and enhance the way we manage and learn from incidents.
- Monitor and analyse data to provide intelligence to support the quality improvement process and learning, and provide evidence based information to aid decision making for services.
- Improve prevention, control and management of healthcare associated infections (HCAI) and improve antimicrobial stewardship.

- Develop and implement a framework for Quality and Safety to cover all stages of the chain from Organ Donation to Transplantation (EU Directive August 2012).
- Support the development of a quality paediatric service.

2013 Actions

Priority Area	Action 2013	End Q
Capacity Building for Quality Improvement	Develop expertise in patient safety and quality improvement in a cohort of frontline healthcare professionals and staff through the delivery of a series of training programmes on quality improvements and patient safety - Initial cohorts will be healthcare professionals within leadership positions e.g. Clinical Directors, Directors of Nursing, Chief Executive Officers (CEOs) and frontline clinical and management staff	Q1-Q4

	- Develop three national patient safety initiatives and establish collaboratives:
	  - Safe Site Surgery
	  - Line Infections
	  - Pressure Ulcers
		Q1-Q4

Quality and Safety Clinical Governance Development	Support the continuous development of strong corporate and clinical governance accountability arrangements through the QPS clinical governance development initiative. Priorities: - Build clinical leadership capacity - Develop cultures supportive of clinical governance - Focus on systems and methodologies for clinical governance	Q4
	Support identified services in creating a culture where quality and safety is everybody's primary goal	Q3
	Map the quality and safety (clinical governance) committees across the system to establish where clinical and social care actions are aligned within a clinical governance system and where developments are required	Q3
	Clinical Directors Programme - Develop a Clinical Director core competency training programme	Q1
	- Establish and embed structured clinical directorates with authority and accountability	Q3
	- Align work and focus of Clinical Directorates with core priorities, including implementation of National Clinical Programmes	Q2
	- Align clinical directorates with hospital groupings once these are finalised and agreed	Q1
	- Ensure local performance management of Clinical Directors	Q3
	- Establish a support resource for Clinical Directors	Q1
Supporting Implementation of National Standards and Guidance for Safer Better Healthcare	Provide leadership and support in partnership with service providers to enable implementation of the National Standards - Translate the National Standards into core quality elements for each Standard	Q1-Q4
	- Develop an ICT Quality and Performance Improvement Tool to support assessment against the National Standards	Q1-Q4
	- Develop an implementation plan for the Quality and Performance Improvement Tool	Q1-Q4
	Support implementation and guidance on: - Healthcare Records Management	Q1-Q4
	- *Integrated Care: A Practical Guide to Discharge and Transfer from Hospital*	Q1-Q4
	- Standardised inpatient Medication Prescription and Administration Record (MPAR)	Q1-Q4
	- Decontamination of Reusable Invasive Medical Devices	Q1-Q4
	- National Consent Policy	Q1-Q4
	Patient Radiation Protection Regulatory Requirements - Ensure patients are adequately protected from unnecessary harmful effects of ionising radiation through issuing of national guidelines, external clinical audit, monitoring of incidents, and liaising with other regulatory bodies	Q1-Q4
Advocacy and Service User Involvement	Develop and implement best practice models of customer care, and service user involvement throughout the HSE in line with the *National Strategy for Service User Involvement* and the *National Healthcare Charter, You and Your Health Service*	Q3
	The National Healthcare Charter, You and Your Health Service - Design service specific patient surveys to measure patient experience based on principles outlined in charter	Q4

Priority Area	Action 2013	End Q
	⌐ Support services with the development of implementation plans for the National Healthcare Charter and related projects	Q2
	⌐ Disseminate *It's Safer to Ask* booklet	Q1
	⌐ Establish and work in collaboration with the network of Patient Safety Champions	Q2
	⌐ Roll out open disclosure policy to acute hospitals	Q4
	⌐ Issue guidelines on patient feedback following a review of *Your Service Your Say* and incorporate the guidelines for the management of complaints and the dissemination of learning from complaints	Q1
	⌐ Administer the Narcolepsy Support Scheme	Q1-Q4
	⌐ Appoint Disability Access Officers in all locations	Q2
National Office for Clinical Audit	Irish Audit of Surgical Mortality (IASM) Collate report of initial 12 months information pertaining to surgical deaths, submitted voluntarily by Surgeons and Anaesthetists for peer review	Q4
	Irish National Orthopaedic Registry (INOR) Full implementation of INOR with collation of register data from Arthroplasty Nurses, Surgeons and Patients in relation to joint replacement	Q4
	National Intensive Care Unit Audit (ICU) ⌐ Full implementation and collation of ICU Audit data from initial 10 sites identified in 2011	Q3
	⌐ Commence Phase 2 implementation to collate ICU data from remaining ICUs	Q4
Quality and Patient Safety Audit	Deliver on an agreed programme of internal independent Quality and Patient Safety Audits (QPSA)	Q4
	Support the implementation of the *National Standards for Safer Better Healthcare* by providing independent assurance on the self assessment process	Q3
	Commence a cycle of re-audit and audit of QPSA report recommendations, to promote a culture of accountability and best practice	Q4
	Increase service user involvement, employing best practice processes to incorporate patient / client input into QPSA	Q4
	Report regularly on QPSA contribution to the quality improvement processes concerning quality and patient safety	Q4
Risk and Incident Management	Continue to implement the HSE Risk Management Policy, the updated incident management policy and guidelines	Q1-Q4
	Provide Incident Management Support to HSE Areas ⌐ Continue to roll out the Integrated Incident Management System (IIMS) module of the QPS to the point of incident occurrence at hospital and primary care sites, including the capability to facilitate mandatory incident reporting to external agencies, and capability to support and quality assure incident management work	Q1-Q3
	⌐ Quality assure HSE Area risk and incident management	Q1-Q4
	⌐ Share learning across the system from the incident management process	Q1-Q4
Quality Measurement, Health Intelligence and Learning	Continue to develop a suite of internationally recognised quality and patient safety indicators, as agreed at the National Quality and Patient Safety Indicator Steering Committee and in collaboration with the care groups / programmes, for formal reporting in 2014 NSP	Q1-Q4
	Develop indicators in regard to the number of agencies who have established Quality and Safety Committees, and also Board and Executive Management Teams that have standing agenda items regarding quality and safety, including review of indicators outlined in the NSP, incidents and risks	Q1-Q4
	Support the testing and piloting of nursing and midwifery indicators in regard to measures for patient falls and pressure ulcers	Q1-Q4
	Progress the incorporation of QPS indicators within the national performance management dashboard (CompStat)	Q2-Q4
	Conduct the Patient Safety Culture Survey in acute hospitals and agree roll out to other health service areas	Q1-Q4
	Develop a quality profile to inform and assist QPS in engagement with service providers	Q1-Q4
	Capture and provide information and evidence to support decision making through further development of Health Atlas as the Health Intelligence Ireland system. This development will include additional modules to the NQAIS (National Quality Assurance Information System)	Q4
	Provide specific advice, support, and facilitation to clinical programmes, care groups leads, and service delivery units using evidence based expertise including bio-statistical analysis	Q4
	Expert review of clinical evidence, most prominently in relation to the E112 (Treatment Abroad) Scheme on a national basis and extension / provision of knowledge resources via internet / intranet	Q4

Priority Area	Action 2013	End Q
	Work with the DoH and the Health Technology Assessment (HTA) function of HIQA to support robust HTA, relevant to the clinical requirements of the HSE	Q4
	Engage with and sustain post doctoral and doctoral placements with the Health Intelligence Team to support analyses and collaborative research	Q4
Healthcare Associated Infections	Improve hand hygiene by healthcare staff and the general public ⌐ Continue to roll out hand hygiene lead auditor training in hospitals and long term care facilities	Q2 and Q4
	⌐ Improve staff awareness on importance of hand hygiene in conjunction with World Health Organisation (WHO) Hand Hygiene Day on 5th May 2013	Q2
	⌐ Roll out hand hygiene e-learning module for staff nationally	Q1
	⌐ Develop a hand hygiene e-learning tool for community and general practice	Q2
	⌐ Roll out the hand and respiratory hygiene modules of e-Bug to all schools	Q3
	Prevent medical device related infections (such as IV lines and urinary catheters) Determine the percentage of inpatient departments in acute hospitals that are using care bundles for medical devices (where appropriate peripheral line, urinary catheter and central venous catheters) and have a process in place to action results (see Patient Safety Initiatives)	Q3
National Organ Donation and Transplantation Office	Living Kidney Donor Programme Expansion Beaumont Hospital will perform 50 live donor transplants in 2013 as part of an expansion of the Live Donor Transplantation Programme aiming to achieve up to 100 live donor transplants annually by 2015 (additional funding €3.5m and 30 WTEs)	Q1-Q4
	Maintain / increase number of solid organ transplants, to a minimum of 200 renal transplants (deceased and living), 20 lung transplants, 15 heart transplants and 54 liver transplants in 2013	Q4
Paediatrics	Support the implementation of Improving Services for General Paediatric Surgery policy and standards of care	Q4
	Continue to provide support for the development of a quality paediatric critical care service with the model of 'one service across two sites'. This includes the development of a national paediatric retrieval service, audit and improved access	Q4

Developing a Quality and Patient Safety Indicator Suite

In 2013 we will consolidate our efforts to develop a suite of internationally recognised quality and patient safety indicators, as agreed at the National Quality and Patient Safety Indicator Steering Committee, and in collaboration with care groups / programmes.

Following their development and a period of piloting / testing, it is anticipated that they will be formally reported in 2014. Quality indicators will include measuring areas such as:

- Patient experience
- Medication management
- Patient observation
- Failure to rescue (FTR) – (e.g. deep vein thrombosis / pulmonary embolism, pneumonia / sepsis / shock or cardiac arrest, acute renal failure, gastrointestinal haemorrhage / acute ulcer, iatrogenic pneumothorax)
- HCAI indicators – including hospital acquired Staph. Aureus Rates, number and percentage of people who develop catheter related blood stream infections, hospital acquired Clostridium Difficile rates, surgical site infection rates
- Post-operative complications (e.g. haemorrhage or haematoma / pulmonary embolism or deep vein thrombosis / sepsis / respiratory failure / wound dehiscence)
- Patient falls
- Pressure ulcers.

Indicators are also being developed regarding the number of agencies who have established Quality and Safety Committees, and also Board and Executive Management Teams that have standing agenda items regarding quality and safety, including review of indicators outlined in the NSP, incidents and risks.

Scorecard 2013 (NB: PIs with QPS governance for reporting only shown here to avoid duplication in the NSP and therefore do not represent the totality of the whole organisation's commitment to quality which is demonstrated through the various national care group scorecards)

Quality and Patient Safety Directorate				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Quality and Patient Safety Audit Service (QPSAS) No. of QPSAS audits commenced as specified in annual QPSAS strategic plan	24	Quality, Access and Activity	HCAI Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	< 0.060
No. of QPSAS audits completed within the timelines agreed in approved QPSAS audit plans	20		Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5
% of QPSAS audits incorporating structured service user involvement	50%		Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	83.7
Complaints % of complaints investigated within legislative time frame	75%		Alcohol Hand Rub consumption (litres per 1,000 bed days used)	25
			% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	90%
			Healthcare Associated Infection: Antibiotic Consumption Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	23

Supporting Service Reform

HEALTH AND WELLBEING

Introduction

The *Programme for Government* set out its vision with regard to the health and wellbeing of the population of Ireland, which is a population protected from public health threats, living in a healthier and more sustainable environment with increased social and economic productivity and greater social inclusion.

In response, a public health policy *Your Health is Your Wealth: A Policy Framework for a Healthier Ireland: 2012-2020* is being developed by the DoH, following extensive internal and external public consultation. The policy aims to improve the health of the population and reduce health inequalities by addressing the causes of preventable illnesses. It also aims to create an environment where every sector of society can play its part.

In addition, it is also widely recognised that promoting, protecting, and improving health and reducing health inequalities are economically more prudent than treating acute illness in hospital and the more costly long term chronic diseases. Many diseases and premature deaths are preventable and are strongly related to lifestyle health determinants such as smoking, alcohol consumption and drug consumption, physical inactivity, and obesity. The Government is seeking to prioritise action on reducing overweight / obesity and its ill-health burden.

Many factors besides lifestyle choices also influence health, such as sanitation, access to healthcare, educational attainment, level of income and the environment. There is also a clear relationship between socio-economic status and health. We must ensure that we focus on minimising the gap in socio-economic variations and ensuring that disadvantaged groups get the help and support they need to ensure that everyone in society has an equal chance to achieve his or her health potential.

We also need to support a healthier environment for people to live and work in by enforcing legislation and the promotion of activities to assess, correct, control, and prevent those factors in the environment which can potentially adversely affect the health of the population. With reduced resources we need to prioritise service provision. Additional funding of €.7m has been allocated in 2013 to maximise the number of public water supplies being fluoridated.

Immunisation is well recognised as one of the most cost effective public health interventions in reducing deaths and illness from vaccine preventable diseases. In recent years there have been considerable enhancements to the universal childhood and schools immunisation programmes and together with a number of successful catch up campaigns, these have resulted in significant decreases in morbidity and mortality. We must ensure high vaccine uptakes of all universal and targeted HSE immunisation programmes to maximise their benefit to the health of the population.

It is essential that the health service, government, local government, the voluntary sector, communities and individuals work together to ensure the Irish population experiences the best of health. Under the health reform programme, the Minister announced wide sweeping structural and organisational changes in the delivery of health and personal social services. This includes establishing a Health and Wellbeing Directorate, with strong and accountable leadership. This Directorate will also work with the DoH in establishing a Health and Wellbeing Agency in 2015.

2013 Key Priorities

- Consider the soon to be published *Your Health is your Wealth: A Policy Framework for a Healthier Ireland 2012-2020* and develop implementation plan.

Health Promotion

- Develop a workforce plan to reflect new organisational structures to deliver on priorities.
- Progress implementation of *Health Promotion Strategic Framework* through the key settings i.e. schools, community and health service.
- Progress the implementation of the *HSE Health Inequalities Framework*.
- Continue to address obesity priorities including implementation of Physical Activity Plan.

- Continue to deliver on priority areas including nutrition, alcohol misuse, tobacco, mental health promotion and sexual health through the key settings and with population groups.

Crisis Pregnancy

- Progress the work of the Crisis Pregnancy Programme.
- Implement the National Sexual Health Strategy as it relates to crisis pregnancy prevention and supports, in conjunction with other sectors and in line with other strategic priorities.

Child Health

- Support the area of Child Health, including immunisation and target screening programmes.
- Develop and implement new child health model by Child Health Task Force.
- Implement quality improvement plans for poorly performing areas in relation to child health screening uptake.

Health Protection

- Prevent, control, and manage infectious diseases, especially tuberculosis (TB), sexually transmitted diseases, and vaccine preventable diseases.
- Develop a National Immunisation Registry for all immunisations.
- Plan for introduction of new vaccines in accordance with national policy.
- Continue the Measles, Mumps and Rubella (MMR) and Pertussis Campaigns.
- Develop and implement a plan to reduce sexually transmitted illnesses and improve sexual health.

Environmental Health

- Enforce legislation and promote activities to assess, correct, control, and prevent those factors in the environment which can potentially adversely affect the health of the population.
- Reconfigure environmental health services nationally to ensure equity of service delivery.
- Implement a national Environmental Health Information System for all service users throughout the country.
- Target activities in tobacco control enforcement on areas of least compliance.
- Implement the service contract with the Food Safety Authority of Ireland (FSAI).
- Complete preparatory work, compliance building and training for the introduction of sunbed legislation nationally to reduce risk of exposure for children.
- Develop guidance and training materials as part of the SHIPSAN project to deliver on the requirements of the *International Health Regulations*.
- Agree Memorandum of Understanding with Customs Service, Environmental Protection Agency, Irish Medicines Board and the proposed Child and Family Support Agency. The delivery of the early year's inspection service is co-dependent with the Child and Family Support Agency, when established.
- Implement the revised Cosmetic Control Regulations.
- Undertake information awareness on tattooing / skin piercing guidelines.

Emergency Management

- Plan, prepare and make a co-ordinated response to major emergencies across all HSE Directorates and with other response agencies.
- Implement new procedures across the HSE in planning for large crowd events and agree new interagency procedures.
- Develop HSE procedures for response to chemical, biological, radiological and nuclear events and agree inter-operability with other response agencies.
- Oversee the development of HSE plans for severe weather conditions.
- Co-ordinate HSE Emergency Management activities with other agencies and Government Departments.

Tobacco Control

- Implement the recommendations of the *HSE Tobacco Control Framework* and the Government's strategy *Towards a Tobacco Free Society: Report of the Tobacco Free Policy Review Group* and enforce the *Public Health (Tobacco) Act* and other tobacco control legislation.

- Support the DoH in policy development and implementation.
- Deliver accredited brief intervention training for smoking cessation to frontline healthcare staff.
- Maintain social marketing QUIT campaign.
- Continue roll out of the tobacco free campus policy.
- Deliver a national model for smoking cessation services.

2013 Actions

Priority Area	Action 2013	End Q
Health and Wellbeing Policy Framework	Consider the soon to be published *Your Health is your Wealth: A Policy Framework for a Healthier Ireland 2012-2020* and develop implementation plan	Q2 Future Health Action 9
Health Promotion Strategic Framework	**Health Promotion Cross Setting Strategy and Policy Development**	
	⌐ Complete the programmatic review of health promotion programmes, including obesity programmes	Q4
	⌐ Develop a workforce plan to reflect new organisational structures to deliver on priorities	Q4
	Breastfeeding	
	⌐ Expand community breastfeeding support	Q4
	⌐ Implement baby friendly hospital initiative	Q4
	⌐ Implement Infant Feeding Policy in all maternity hospitals	Q3
	Prevent Overweight and Obesity	
	⌐ Implement a physical activity action plan	Q2-Q4
	⌐ Promote and advocate healthy weight management throughout the lifecycle	Q1-Q4
	⌐ Develop a national system for surveillance and screening of children, according to *Best Health for Children*	Q2-Q4
	⌐ Develop Adult Hospital Weight Management Treatment Services (one per HSE area) and National Paediatric Hospital Service with the full multidisciplinary team in each centre to ensure the maximum throughput of patients with severe obesity	Ongoing
	⌐ Develop and implement nutritional standards for health system	Q1-Q2
	⌐ Undertake social marketing programmes for nutrition and exercise in partnership with Special Action Group on Obesity (SAGO)	Q1-Q4
	Alcohol	
	⌐ Develop and implement action plan based on relevant recommendations of the *National Substance Misuse Strategy* especially in area of social marketing campaigns	Q2-Q4
	⌐ Review emergency department brief intervention project and community mobilisation projects on alcohol	Q3
	Positive Mental Health Support mental health promotion priorities in partnership with mental health structures in line with *A Vision for Change*	Q4
	Health Promoting Community Setting	
	⌐ Develop and implement a model for health promoting communities	Q4
	⌐ Develop community participation, community health needs assessment, and health equity audit within all services	Q4
	⌐ Support participating cities to establish new Irish Healthy Cities network	Q4
	Health Promoting Health Service Setting	
	⌐ Develop and deliver to healthcare staff a national model for brief intervention training (smoking, alcohol, diet, mental health) in partnership with other stakeholders	Q4
	⌐ Continue to offer support to primary care community health needs assessment	Ongoing
	Health Promoting Education Setting	
	⌐ Implement nationally agreed model for health promoting schools in 10% of primary and post primary	Q4
	⌐ Develop health promoting tools and resources to support the development of the health promoting education setting	Q3
Women's Health, Men's Health	Put in place best models of care for shared care of women in pregnancy	Q2
	Progress the implementation of the *National Men's Health Policy*	Q4

Priority Area	Action 2013	End Q
Crisis Pregnancy	Fulfil all statutory requirements relating to crisis pregnancy prevention and crisis pregnancy support and implement the *CPP Strategy 2012 -2016* in line with legislative requirements	Q4
	Implement the National Sexual Health Strategy, when published, as it relates to CPP and supports, in conjunction with other sectors and in line with other strategic priorities	Q4
	Develop a plan to ensure co-ordination of sexual health and promotion with other sexual health education and promotion activities in order to add value to work in this area	Q4
	Maintain and develop information and education campaigns relating to prevention and supports during and after crisis pregnancy (Think Contraception, Positive Options and Abortion Aftercare)	Q4
Health Inequalities	Review impact and outcomes of the *Health Inequalities Framework 2010-2012* and report on same	Q4
	Set out tasks to address health inequalities as part of HIQA healthcare standards	Q4
	Develop a gender mainstreaming policy for HSE / healthcare system based on published framework and offer related training for staff in service planning	Q2
National Immunisation, Infectious Diseases and Child Health	National Immunisation	
	⌐ Develop a national immunisation registry for all immunisations	Q4
	⌐ Deliver a National Immunisation Programme, with vaccine uptake rates in accordance with international targets	Q4
	⌐ Extend measles elimination plan, with MMR catch-up programme	Q4
	⌐ Extend the implementation of a national standardised school based immunisation programme	Q4
	Health Protection	
	⌐ Increase influenza vaccination uptake rates in General Medical Services (GMS) and doctor only card holders aged 65 years and older and healthcare workers	Q4
	⌐ Develop and implement TB Action Plan which reflects the World Health Organisation (WHO) and European Centre for Disease Prevention and Control consolidated action plans to combat TB	Q3
	⌐ Implement national directly observed treatment (DOT) guidance in all HSE Regions	Q4
	⌐ Reduce the impact of vaccine preventable diseases	Q4
	⌐ Develop and implement a plan to reduce sexually transmitted illnesses and improve sexual health	Q3
	⌐ Address the issue of increase in antimicrobial resistant (AMR) Gonococcal disease	Q2
	⌐ Plan for implementation of the public health recommendations of the 2012 National Hepatitis C Strategy	Q2
	Child Health	
	⌐ Reach agreement on revised child health model programme through the Child Health Task Force and develop implementation plan	Q1
	⌐ Review *Best Health for Children* guidelines and develop implementation plan including review of training needs	Q4
	⌐ Develop and support linkages / co-dependencies with Child and Family Support Agency	Q4
	⌐ Progressively implement governance structure for all non-cancer childhood national screening programmes	Q2
	⌐ Develop a child injury network and develop a child injury prevention strategy	Q3
	⌐ Review and update Child Health Information Service Project (CHISP) documents and child health website for parents / practitioners	Q3
	⌐ Complete planning and implementation of Phase 2 of IT system for National Newborn Screening Programme (NNBSP)	Q3
	⌐ Roll out training on new WHO / Ireland growth charts	Q1
Emergency Management	Implement new planning procedures across the HSE for large crowd events and develop new interagency procedures for same with the Department of Environment and An Garda Síochána	Q2
	Co-ordinate a review and develop HSE plans for severe weather across all directorates	Q2
	Support the adoption and role out of the HSE standard template Major Emergency Plan for all hospitals	Q2-Q4
	Co-ordinate HSE Emergency Management activities with other government departments and agencies at the Government Task Force on behalf of all Directorates	Q1-Q4
	Co-ordinate the development of hospital, ambulance service, public health and other services procedures for chemical, biological, radiological and nuclear (CBRN) events and agree inter-operability with other agencies	Q1-Q4
	Reconstruct the HSE Crisis Management Teams at local and regional levels to provide for a membership of all directorates ensuring a co-ordinated health service response	Dependent on timing of health reform

Priority Area	Action 2013	End Q
Environmental Health	Reconfigure environmental health services nationally to ensure equity of service delivery	Q2-Q3
	Implement National Environmental Health Information system for all service users throughout the country, providing evidence base for health protection decisions	Q3
	Target activities of tobacco control enforcement on areas of least compliance (complaints, under age sales to minors, and smoke free exempted areas)	Q1-Q4
	Implement the service contract with the FSAI	Q1-Q4
	Complete preparatory work, compliance building and training for the introduction of sunbed legislation nationally to reduce risk of exposure to children	Pending legislation
	Agree Memorandums of Understanding / Service Level Agreements with Customs Service, Environmental Protection Agency, Irish Medicines Board and Child and Family Support Agency	Q3
	Participate in European SHIPSAN ACT project to develop agreed international guidance and training materials	Q4
	Implement revised cosmetic control regulations	Q3
	Information awareness raising on tattooing / skin piercing guidelines	Q3
	Consider role in alcohol enforcement strategy which is dependent on identification of statutory role for Environmental Health and an agreement with the DoH as to what priority will be assigned to this activity. This is an additional activity for 2013 and may impact on the delivery of other activities	Q1-Q4
	Define service involvement in human bio-monitoring proposal	Q1
	Manage budget for fluoridation of the public water supply to maximise the number of public supplies being fluoridated (additional funding €.7m)	Q1-Q4
Tobacco Control	Tobacco Control Framework	
	⌐ Roll out standardised national model for smoking cessation service	Q1-Q4
	⌐ Provide efficient smoking cessation support via National Smokers' QUITline	Q1-Q4
	⌐ Deliver accredited training in brief intervention for smoking cessation to 1,350 frontline healthcare workers: - DML 300 - DNE 400 - South 250 - West 400	Q1-Q4
	⌐ Extend national roll out of tobacco free campus policy: - DML – all hospitals, all newly opened primary care sites and 35% of existing sites, all administration sites - DNE – all hospitals, all newly opened primary care sites and 35% of existing sites, all administration sites - South – all hospitals, all newly opened primary care site and 35% of existing sites, all administration sites - West – all hospitals, all newly opened primary care sites and 35% of existing sites, all administration sites	Q1-Q4
	⌐ Launch national policy to protect staff from second-hand smoke exposure while working in domestic settings	Q2
	⌐ Develop and implement a national policy to protect children in care from tobacco exposure	Q4
	⌐ Maintain social marketing QUIT campaign	Q1-Q4
	⌐ Undertake tobacco control enforcement action in areas of least compliance (complaints, underage sales, and smoke free exempted areas)	Q1-Q4
	⌐ Continue to monitor and evaluate the effectiveness of tobacco control measures	Q1-Q4
	⌐ Advocate to 3rd level institutions / medical colleges for the introduction of brief intervention training / cessation training in all graduate and post graduate education	Q4
	HSE National Tobacco Control Office Implement recommendations of *Towards a Tobacco Free Society Report* and the *Tobacco Control Framework*	Q1-Q4
	Support the development of and implement the DoH's Tobacco Policy Review Group recommendations (when finalised)	Q1-Q4
	Maintain tobacco legislation enforcement	Q1-Q4

Scorecard 2013

Health and Wellbeing Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Immunisations and Vaccines % children aged 12 months who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine Haemophilus influenzae type b (Hib_3) Polio ($Polio_3$) hepatitis B ($HepB_3$) (6 in 1)	95%	Quality, Access and Activity	% of children reaching 10 months within the reporting period who have had their child development health screening on time before reaching 10 months of age	95%
			Tobacco Control % hospital campuses with tobacco-free policy	100%
% children at 12 months of age who have received 2 doses of the Pneumococcal Conjugate vaccine (PCV2)	95%		No. and % of smokers on cessation programme who were quit at one month	New PI
% children at 12 months of age who have received 2 doses of the Meningococcal group C vaccine ($MenC_2$)	95%		No. of smokers who received intensive cessation support from a cessation counsellor	9,000
% children aged 24 months who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine, Haemophilus influenzae type b (Hib_3), Polio ($Polio_3$), hepatitis B ($HepB_3$) (6 in 1)	95%		No. of frontline healthcare staff trained in brief intervention smoking cessation	1,350
			No. of sales to minors test purchases carried out	320
% children aged 24 months who have received 3 doses Meningococcal C ($MenC_3$) vaccine	95%		Food Safety % of Category 1, 2 and 3 food businesses receiving minimum inspection frequency as per FSAI Guidance Note Number 1	100%
% children aged 24 months who have received 1 dose Haemophilus influenzae type B (Hib) vaccine	95%		Cosmetic Product Safety No. of scheduled chemical samples taken	540
% children aged 24 months who have received 3 doses Pneumococcal Conjugate (PCV_3) vaccine	95%		International Health Regulations All designated ports and airports to receive an inspection to audit compliance with the IHR 2005	8
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	95%		Health Inequalities No. of PCTs who have completed, at a minimum, Step 1 of a Community Health Needs Assessment	21
% children aged 4-5 years who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)	95%		No. of hospitals who have completed, at a minimum, Stage 1 of the 6 stage Health Equity Audit	6
% children aged 4-5 years who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine	95%		Finance Variance against Budget: Income and Expenditure	≤ 0%
% children aged 11-14 years who have received 1 dose Tetanus, low dose Diphtheria, Accelular Pertussis (Tdap) vaccine	95%		Variance against Budget: Income Collection	≤ 0%
No. and % of first year girls who have received third dose of HPV vaccine by August 2013	80%		Variance against Budget: Pay	≤ 0%
No. and % of sixth year girls who have received third dose of HPV vaccine by August 2013	80%		Variance against Budget: Non Pay	≤ 0%
Child Health / Developmental Screening % of newborns who have had newborn bloodspot screening (NBS)	100%		Variance against Budget: Revenue and Capital Vote	≤ 0%
% newborn babies visited by a PHN within 48 hours of hospital discharge	95%		Human Resources Absenteeism rates	3.5%
% newborn babies visited by a PHN within 72 hours of hospital discharge	100%		Variance from approved WTE ceiling	≤ 0%

SOCIAL INCLUSION

Introduction

Social Inclusion Services in the HSE have a remit for a range of issues and vulnerable groups, including addiction, alcohol, homelessness, intercultural health (including asylum seekers, refugees, migrants), Irish Travellers and Roma, LGBT (Lesbian, Gay, Bisexual and Transgender) and HIV / AIDS, together with such elements as community development, gender based violence, and RAPID / CLÁR initiatives.

Social inclusion is synonymous with tackling poverty and social exclusion. Poverty and social exclusion have a direct impact on the health and wellbeing of the population. The overarching aim of social inclusion in a health context is to improve access to mainstream and targeted health services for people from disadvantaged groups, reduce inequalities in health and enhance the participation and involvement of socially excluded groups and communities in the planning, design, delivery, monitoring and evaluation of health services.

This is achieved by providing specific targeted services for people who may experience social exclusion, supporting enhanced responsiveness of mainstream services, and facilitating partnership and inter-sectoral working wherever possible.

Social inclusion actions in the HSE are underpinned by a sociodeterminant approach to health. Social inclusion services are unique within the HSE in that, while some services are provided directly, most are delivered through funding to non-governmental organisations within the community and voluntary sector. The cross cutting nature of social inclusion demands collaboration across a range of statutory agencies, as well as close co-operation with an extensive range of agencies in the community and voluntary sector.

The pressures associated with the current climate exert a disproportionate effect on vulnerable groups. The impact of the recession has led to continuously increasing demand for social inclusion services. This poses significant challenges for supporting an integrated approach to meeting the complex health and support needs of service users of this cohort.

The national Social Inclusion Governance Group ensures appropriate arrangements are in place to co-ordinate, support and monitor best practice in developing and implementing all aspects of the social inclusion agenda.

The intra and interagency approach of social inclusion means it is well placed to continue effectively addressing a range of priority actions within proposed new structures in 2013.

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
651	646	115	114	- 1.0%

2013 Key Priorities

- Support addiction services through progressing implementation of the *National Drugs Strategy 2009-2016* actions on early intervention, treatment and rehabilitation.
- Implement recommendations of HSE *National Hepatitis C Strategy* in line with specified time frame and within existing resource constraints.
- Continue to implement *The Way Home – A Strategy to Address Adult Homelessness in Ireland* in conjunction with other key partners.

- Continue to implement identified outstanding recommendations of the *HSE National Intercultural Health Strategy 2007- 2012.*
- Address Traveller health issues in the context of the *All-Ireland Traveller Health Study*, with particular attention to priority areas of mental health, suicide, men's health, addiction / alcohol, domestic violence, cardiovascular health and diabetes.

2013 Actions

Priority Area	Action 2013	End Q
Addiction Services	Implement the *National Drugs Strategy 2009-2016*	
	Implement recommendations from HSE *Opioid Treatment Protocol*: - Produce six monthly updates on HSE led actions	Q1 and Q3
	- Produce a quarterly analysis report on Opioid Substitution Therapy from the HSE's national waiting list and report on exits from the Central Treatment list, highlighting type of throughput	Q1-Q4
	- Expand the national waiting list to include treatment waiting times for substances misuse interventions	Q3
	- Continue to implement quality standards (Quality in Addiction and Drug Services, QuADS) or its equivalent in both statutory and voluntary-managed addiction services	Q1-Q4
	- Maintain and ensure that the national drug and alcohol service directory includes in-depth up to date information on treatment and rehabilitation services for staff and service users	Q1-Q4
	National Overdose Prevention Strategy - Progress the development of an implementation plan for the *National Overdose Prevention Strategy* to include: - Development and implementation of a demonstration project using Naloxone as a pharmacy supervised product	Q2-Q4
	Implement *Report of the Working Group on Residential Treatment and Rehabilitation 2007* and *HSE National Drugs Rehabilitation Framework 2010* in partnership / via the National Drugs Rehabilitation Implementation Committee	Q2
	Prioritise and implement HSE actions in the Report of the Steering Group on a *National Substance Misuse Strategy* - Develop a national screening and brief intervention protocol for alcohol and substance misuse for tier 1 services / tier 2 interventions	Q3
	- Progress development of an implementation plan with specific delivery targets for the roll out of the national screening and brief intervention protocol	Q3
	- Produce a screening and brief intervention training manual	Q4
	- Launch an alcohol public education / awareness campaign	Q3-Q4
	National Addiction Training Programme Develop an annual training plan (which targets emerging trends and best practice in addiction) including:	Q2
	- A national training substance misuse policy	Q3
	- Specific training modules based on Irish Drugs and National Occupational Standards (DANOS) competencies	Q1-Q4
	Needle Exchange Programmes - Provide training on safe injecting practices for steroids and image enhancing drugs to 50 outreach workers nationwide via the HSE and to pharmacists	Q3
	- Train 15 trainers on overdose prevention who would then cascade overdose and prevention management to their regional team - Target group members of the National Liaison Pharmacist Office, Addiction Services and HSE outreach workers	Q2
	- Target expansion of 130 pharmacies to sign SLA for needle exchange for NEX subject to local needs requirement and pharmacy interest in supporting the service	Q1-Q4
	- Pilot the Needle Exchange Online (NEO) system (an online data collection program) in two pharmacies for 1-2 months and undertake a review of its implementation	Q2
	Clinical Governance - Review addiction clinical governance structures nationally	Q2-Q4

Priority Area	Action 2013	End Q
	Drug Treatment Centre Board (DTCB) ⌐ Integrate the DTCB into the HSE Addiction Services and maximise its inputs	Q1-Q4
National Hepatitis C Strategy	Implement recommendations of HSE *National Hepatitis C Strategy* 2011-2014 in line with specified time frame and within existing resource constraints ⌐ Develop a targeted plan to support and address implementation of specific recommendations relating to surveillance, prevention and treatment in partnership with DoH and all stakeholders	Q1
Homelessness	Implement *The Way Home – A Strategy to Address Adult Homelessness in Ireland* in conjunction with other key partners: ⌐ In relation to homeless people, ensure that a care and case management approach is implemented and working effectively across the homeless services sector with a particular focus on improving the health outcomes of homeless persons	Q1-Q4
	⌐ Ensure that effective discharge policies / protocols for homeless persons are in place in each hospital network which are in line with the newly revised National Integrated Care Guidance document: *A Practical Guide to Discharge and Transfer from Hospital*	Q4
	⌐ Support the establishment of homeless action teams (HATs) across the country in partnership with other key statutory and voluntary providers which support and link with mainstream primary care teams (PCTs) / mental health teams and addiction services	Q1-Q4
	⌐ Review the Service Level Agreement template to ensure a stronger focus on addressing the health needs of homeless persons, including the development of targets, outcomes, quality standards, greater monitoring and evaluation	Q1-Q4
	⌐ Develop best practice and quality standards for homeless services (all funded agencies / service providers) with particular reference and collaboration to existing quality standard frameworks (e.g. *Putting People First – A Good Practice Handbook for Homeless Services*, HSE Quality Standards in Alcohol and Drug Services etc.)	Q2-Q4
	⌐ Support the establishment of a national co-ordinator post within the homeless sector to develop multi-agency best practice in addressing homelessness amongst persons with convictions for sexual offences	Q4
Intercultural Health	Implement recommendations of *HSE National Intercultural Health Strategy* within existing resource constraints	Q1-Q4
	Access to Services ⌐ Conduct a detailed mapping exercise to confirm extent of service provision for ethnic minority groups across the four HSE regions	Q2
	Interpreting and Translation ⌐ Continue development, expansion and application of a national database to support staff in accessing and developing appropriate translated health related material.	Ongoing
	⌐ Conduct exercise to determine nature and costs of interpreting service provision in acute and community settings	Q3
	Ethnic Identifier ⌐ Continue to extend the roll out of the ethnic identifier on an incremental basis to capture key health information of minority ethnic groups in each HSE region	Ongoing
	⌐ Develop basic online training package to support staff in use of an ethnic identifier	Q4
	⌐ Provide outcome data pertaining to ethnic identity from datasets in a range of services, including addiction, homelessness and other identified settings	Quarterly
	Refugee Resettlement ⌐ Continue to implement health related element of the Refugee Resettlement Programme led by the Office of Integration (Department of Justice and Equality) in line with Government commitments	Ongoing
	Female Genital Mutilation (FGM) ⌐ Develop action plan in respect of progressing health related elements of FGM, with specific reference to awareness raising among communities, staff information and support, together with data collection	Q1
	⌐ Reprint and circulate updated FGM resource pack for health professionals to relevant staff in maternity and associated settings	Q2
Traveller Health	⌐ Develop a detailed health action plan to progress delivery of recommendations of the *All-Ireland Traveller Health Study* (AITHS), with particular reference to those priority areas identified such as mental health, suicide, men's health, addiction / alcohol, domestic violence, diabetes and cardiovascular health	Ongoing
	⌐ Design and deliver a structured education programme for the prevention of type 2 diabetes in the Traveller community	Q2

Priority Area	Action 2013	End Q
Roma	Progress identified agreed actions towards enhancing health status of Roma, building on findings of seminars and reports in 2012, together with requirements of the national Roma integration strategy	Ongoing
LGBT Health	Continue to progress strategic actions in the area of LGBT health	Q1-Q4
HIV / AIDS	Work in partnership with HSE health promotion services towards supporting the European joint action on quality improvement in HIV prevention	Q4
Enhancing Access to Services and Community Development	Progress efforts to facilitate engagement of members of socially excluded groups in PCTs and Networks within the context of the Service User Framework	Ongoing
Child Protection in respect of Social Inclusion Services	Preparation for the *Children First Guidelines* being put on a legislative footing ⌐ Develop inter-sectoral working protocols with primary care, mental health, children and family services and social inclusion to enhance quality and experience of services for children and young people	Q2
	⌐ Develop a social inclusion specific Children First and Hidden Harm Implementation Guide which will include the development of a pilot training module and roll out of training in at least one HSE Addiction Service Area	Q2-Q3
	⌐ Commence implementation of *Children First Guidelines* / Hidden Harm across the social inclusion care group sector	Ongoing
Improving Quality of Information	Review the strategic information requirements needed for effective planning, management and monitoring of social inclusion services, and develop a strategic information framework and associated workplan in partnership with DoH and sectoral colleagues to ensure efficient collection and application of agreed data	Q2
	Build a robust information base to facilitate evidence informed planning around health needs and outcomes of service users from diverse ethnic and cultural groups	Ongoing

Scorecard 2013

Social Inclusion Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Methadone Treatment No. of clients in methadone treatment (outside prisons)	8,650	Quality, Access and Activity	No. of pharmacy needle exchange packs provided	1,500 Q1 1,650 Q2 1,800 Q3 1,950 Q4
No. of clients in methadone treatment (prisons)	500			
Substance Misuse No. of substance misusers (over 18 years) for whom treatment has commenced following assessment	New PI		Average no. of needle / syringe packs per person	90
No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	1,260 100%		No. and % of needle / syringe packs returned	600 Q1 (40%) 660 Q2 (40%) 720 Q3 (40%) 780 Q4 (40%)
No. of substance misusers (under 18 years) for whom treatment has commenced following assessment	New PI			
No. and % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	105 100%		Traveller Health Screening No. of clients to receive national health awareness raising / screening programmes (breast check, cervical smear screening, men's health screening, blood pressure testing) delivered through Traveller Health Units / Primary Care Projects	2,580
Homeless Services No. and % of individual service users admitted to statutory and voluntary managed residential homeless services who have medical cards	1,847 > 75%			
No. and % of service users admitted to homeless emergency accommodation hostels / facilities whose needs have been formally assessed within one week	1,839 75%		Finance Variance against Budget: Income and Expenditure	≤ 0%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities who have a written care plan in place within two weeks	1,845 75%		Variance against Budget: Income Collection	≤ 0%

Social Inclusion Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Needle Exchange No. of pharmacies recruited to provide Needle Exchange Programme	130		Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
No. of unique individuals attending pharmacy needle exchange	200 Q1 250 Q2 300 Q3 400 Q4		Variance against Budget: Revenue and Capital Vote	≤ 0%
			Human Resources Absenteeism rates	3.5%
			Variance from approved WTE ceiling	≤ 0%

PRIMARY CARE

Introduction

Over the last number of years we have been working to realise our vision for primary care services whereby the health of the population is managed, as far as possible, within a primary care setting, with the population very rarely requiring admission to a hospital, those with additional or complex needs having care plans developed with their local Primary Care Team (PCT) who co-ordinate all care required with specialist services in the community and, for hospital attendance, through integrated care pathways. The PCT is the central point for service delivery which actively engages to address the medical and social needs of its defined population in conjunction with a wider range of Health and Social Care Network (HSCN) services.

International evidence shows that the cost-effectiveness of any national healthcare system is strongly correlated with the strength and position of primary care within that system. The enactment during 2012 of the *Health (Provision of General Practitioner Services) Act 2012* now allows for open entry to the General Medical Services (GMS) for suitably qualified and vocationally trained GPs and eliminates restrictions on GPs wishing to treat public patients.

This vision will be further advanced in 2013 guided by new policy direction for primary care as part of the wider health reform agenda. The *Programme for Government* (2011) commits to reforming the current public health system by introducing Universal Health Insurance (UHI) with equal access to care for all. As part of this, the Government is committed to introducing, on a phased basis, GP care without fees i.e. universal primary care, following the enactment of essential legislation. Its first phase will deliver free GP care to people with prescribed illnesses.

Other priorities for Government to address will be the creation of a Primary Care Fund, the development of a GP contract which reflects the new model of care and ensures sufficient capital allocations for primary care centres, to be prioritised in areas of greatest need.

In 2013 there are plans to invest €20m in primary care services to support the recruitment of prioritised frontline PCT posts and to further develop community intervention teams. The failure to complete key team members has reduced the effectiveness of primary care services to-date. Additionally, a number of cost pressures are being funded from demographic funding including implementation of the national diabetes integrated care package and further developing audiology services.

Central to success of the reform programme is the establishment of a new Primary Care Directorate with clear leadership and responsibility for the implementation of primary care reform, centrally and locally. Work will continue with the DoH and all stakeholders during the year to deliver on these fundamental changes in primary care. We will link with the DoH on the implications of *Future Health* for primary care service.

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
9,231	9,166	372	400	7.6%

2013 Key Priorities

- Continue to develop and consolidate Primary Care Teams and Health and Social Care Networks.
- Continue the roll out of the National Diabetes Integrated Care Package.
- Define and develop guidelines / protocols between primary care in the context of emerging structures.

- Manage multidisciplinary complex care (including appropriate access to e.g. mental health, older people, disability, addiction services and vulnerable service users).
- Develop ICT electronic referral systems within and from primary care to acute sector.
- Deliver preventative, self-care and health promotion programmes.
- Roll out of Universal Newborn Hearing Screening.
- Improve oral health services by implementing strategic reviews on Primary Care Dental Services and completing independent reviews on secondary and tertiary oral health services.
- Develop high quality services, within current resources, for the most vulnerable care groups and reduce urgent dental general anaesthesia waiting lists for adults with intellectual disabilities.
- Reconfigure primary care HSE dental services to maximise efficiency and enable adherence of HIQA infection control and health and safety standards.

2013 Actions

Priority Area	Action 2013	End Q
Primary Care Teams and Health and Social Care Networks	Developing and Supporting PCTs and HSCNs - Deliver primary care services through 484 PCTs. The 2012 Primary Care Funding of €20m will be carried forward to 2013 to support the recruitment of prioritised frontline primary care team posts	Q4 Future Health Action 28
	- Implement (on agreement) governance model for PCTs and HSCNs in accordance with agreed structures	Q4
	- Enhance service integration through the development of HSCNs, this being enabled through agreed governance model and reconfiguration of existing resources	Q4
	- Define and develop guidelines / protocols between primary care and children and family services, disability, mental health, social inclusion and older people services in the context of emerging structures. These guidelines will be developed in collaboration with stakeholders from other care groups	Q2 (define) and Q4 (develop)
	- Continue to provide access to psychotherapy and counselling for patients eligible under the GMS, in collaboration with mental health services	Ongoing
	- Conclude and evaluate the PCT pilot intra team electronic referral projects (5 pilots in total)	Q2
	ICT Infrastructure - Progress with ICT the development of the functional specification of a Primary Care Patient Management System - Progress Phase II of National Electronic GP Referral Pilot Project to develop a fully integrated electronic referral between primary care and secondary care outpatient services of seven pilot site hospitals (Cork and Kerry acute hospitals and Tallaght hospital). (This project is under the governance of the national clinical primary care programme and closely links with the work of the outpatient performance improvement programme. The necessary ICT integration work will adopt the mandatory protocols of the outpatient performance improvement programme and will assist hospitals in delivering these through automation of processes)	Q4
Enhance Primary Care Services	Community Intervention Teams (CIT) - Roll out of additional CITs within primary care settings (additional €1.475m in 2013)	Q4
	Cancer Control - Promulgate use of standardised electronic referral processes developed for common tumours - Partnership with Irish College of General Practitioners (ICGP) to implement integrated cancer care - Develop e-learning programmes for GPs in prostate disease and lung cancer, in collaboration with the ICGP and specialist teams - Obtain university accreditation for the community nurse training programme for cancer care and expand its delivery in association with specialist services - Contribute to the work of the HSE Prevention of Chronic Disease Programme - Develop training courses for PCT professionals, utilising opportunities for remote learning where feasible - Update GP referral guidelines for breast, lung and prostate cancers as required - Interface with specialist services and GPs to deliver appropriate follow up cancer care of common cancers in the primary care setting	Q1-Q4 Future Health Action 9
	Falls Prevention - Deliver falls prevention programmes through PCTs in line with national model	Q4
	Public Health Nursing Review - Establish and progress review of public health nursing within primary care	Q4

Priority Area	Action 2013	End Q
GP Training	Conclude transfer of the GP Training Scheme to the ICGP as contracted service providers	Q1
GP Out of Hours Review	Implement recommendations from *National Review of GP Out of Hours Services*	Q1-Q4
Accommodation	Sufficient and appropriate accommodation available to enable successful functioning of PCTs ⌐ Open 18 additional primary care centres	Q4 Future Health Action 29
Audiology Services	Progress implementation of recommendations from *National Review of Audiology Services* (Additional funding €1.9m and 5 WTEs in 2013)	Q4
Oral Health	Complete independent review of oral and maxillofacial surgery services and independent review of orthodontic services	Q3
	Commence and implement phase 2 of the independent *Strategic Review of the Delivery and Management of HSE Dental Services*	Q4
	Develop high quality services, within current resources, for the most vulnerable care groups and thereby reduce urgent dental general anaesthesia waiting lists for adults with intellectual disabilities	Q4
	Continue implementation of phase 1 HIQA infection control standards for dental services	Q4
	Reconfigure primary care HSE dental salaried services	Q4
	Realign complex paediatric dental general anaesthetic services to regional centres	Q4
	Orthodontics ⌐ Await recommendations from the independent review of orthodontic services to address waiting times for assessment and treatment and prioritised urgent surgical intervention cases	Q4
National Clinical Care Programmes – Primary Care Actions		
Clinical Care Programmes	⌐ Establish Primary Care Clinical Care Programme under the clinical care programme structure to provide governance for development of primary care elements of clinical care programmes ⌐ Priority will be given to progressing the primary care delivery element of the following chronic disease clinical care programmes in 2013: Diabetes, Asthma / COPD, Stroke and Heart Failure	Q1 Q4 Future Health Action 27
Acute Medicine	⌐ Develop a system to accept direct access referrals from GPs to AMU and work towards electronic communication between GPs and AMUs	Q3
Cardiovascular (Diabetes)	⌐ Implement the National Integrated Care Package for Diabetes, with the appointment of 17 integrated care diabetes nurse specialists nationally (one per ISA) (Additional funding of €1.8m and 17 WTEs in 2013) ⌐ Develop ICT prototype to facilitate delivery of national clinical model ⌐ Agree with relevant stakeholders developing a standardised model of care to allow a targeted screening programme for women with gestational diabetes (proposed initiative with obstetrics, primary care and the national diabetes programme)	Q4 Future Health Action 27 & 28
Cardiovascular (Heart Failure)	Community heart failure diagnosis and cardiovascular prevention through a piloted service to be run in conjunction with the diabetic and primary care services ⌐ Expand (working within available resources) on the observation of the Screening to Prevent Heart Failure (STOP-HF) results to focus cardiovascular (CV) prevention strategies on high risk patients defined by brain natriuretic peptide (BNP) in order to reduce de novo and recurrent CV hospitalisations for heart failure and other CV diagnoses and to enhance the new diagnosis of heart failure in the community	Q4
Cardiovascular (Stroke)	⌐ Review (working within available resources) the current four early supported discharge programmes with a view to maximising the service to a wider population base ⌐ Adopt agreed community-based model of care	Q4
	⌐ Implement and evaluate an integrated hospital and primary care project in two sites to test the feasibility of implementing opportunistic screening for atrial fibrillation in primary care	Q4
Chronic Diseases and Prevention of Chronic Diseases	⌐ Develop core data sets for chronic diseases which can be used on ICT systems	Q4 Future Health Action 9
	⌐ Co-ordinate national programmes of education for all chronic disease programmes	Q4 Future Health Action 9
	⌐ Roll out national modified brief intervention training for smoking cessation to 5% of HSE clinical primary care team members	Q4
	⌐ Formulate a primary care based programme of risk factor reduction for chronic disease	Q4 Future Health Action 9
	⌐ 100% of new Primary Care Centres will be smoke free by year end 2013	Q4

Priority Area	Action 2013	End Q
	⌐ Develop a chronic disease prevention and management patient support and education programme	Q4 Future Health Action 9
Critical Care Programme	⌐ Engage with primary care and chronic disease prevention to develop model for first line responders for primary care	Q4
Diagnostics (Radiology)	⌐ Engage with primary care programmes to adapt national referral guidelines for GP use by integrating iRefer into decision support tools and electronic ordering systems for GPs ⌐ Develop strategy to roll out access to iRefer through GP ICT systems ⌐ Scope extension of National Integrated Management Imaging System (NIMIS) / Picture Archiving and Communication System (PACS) to primary care centres	Q4
Emergency Medicine	⌐ Select GP representatives for networks of ED sites and / or individual ED sites ⌐ Devise a template for discharge communication ⌐ Establish a template GP referral form	Q4
Epilepsy	⌐ Develop a communication plan with GPs regarding the Epilepsy Programme ⌐ Develop a model of care for epilepsy in primary care	Q4
Neurology	Work with the ICGP to increase neurology placements within the GP training programme	Q4
	Develop standard operating procedures for specific neurology conditions for use in primary care	Q4
	Develop a communication plan between neurology services and GPs	Q4
	Review and upgrade Neurolink	Q4
Obstetrics and Gynaecology	⌐ Develop national medication formulary for obstetrics and gynaecology ⌐ Develop GP electronic solution for shared antenatal care between GPs and obstetrics services	Q4
Older People	⌐ Develop and agree a framework to address the issue of polypharmacy in older people ⌐ Develop a model of care document that complements the acute model of care in relation to the management of the frail elderly pathway in primary care	Q4
Orthopaedics	⌐ Develop an agreed dataset for orthopaedics ⌐ Develop the MSK (musculo-skeletal) pathway in collaboration with the Rheumatology programme	Q4
Outpatient Antimicrobial Therapy (OPAT)	Develop a communication plan for GPs regarding OPAT	Q4
Paediatrics	Develop and agree paediatric algorithms for use in primary care	Q4
Rehabilitation Medicine	Develop a set of standards of care for specialist community rehabilitation services	Q4
Respiratory (Asthma)	Disseminate and facilitate implementation of guidelines - *Asthma Control in General Practice*	Q4
Respiratory (Chronic Obstructive Pulmonary Disorder (COPD))	Disseminate and facilitate the implementation of COPD guidelines in primary care	Q4
	Develop a model to support delivery of spirometry in primary care	Q4
	Facilitate access to pulmonary rehabilitation in local health areas as per NSP2012 target (100% by end 2014) Target 20 sites by end 2013 (62.5%)	Q4
Rheumatology	Develop model(s) of integrated care for patients with rheumatological diseases	Q4

Scorecard 2013

Primary Care Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Primary Care No. of PCTs implementing National Integrated Care Package for Diabetes	51		No. of patients receiving active treatment during reporting period	13,600
No. of Health and Social Care Networks in development	126		GP Out of Hours No. of contacts with GP out of hours	975,609
% of Operational Areas with community representation for PCT and Network Development	100%			

Primary Care Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Orthodontics No. of patients on the assessment waiting list during reporting period	New PI 2013	Quality, Access and Activity	Physiotherapy Referral No. of patients for whom a primary care physiotherapy referral was received in the reporting month	172,387
Waiting time from referral to assessment during reporting period: i). No. of patients waiting 1-6 months ii). No. of patients waiting 7-12 months iii). No. of patients waiting 13-24 months iv). No. of patients waiting over 2 years	New PI 2013		No. of primary care physiotherapy patients seen for a first time assessment	139,102
			No. of primary care physiotherapy face to face contacts / visits / appointments that took place	720,026
No. of patients on the treatment waiting list – grade 4 – during reporting period	New PI 2013		Occupational Therapy No. of clients who received a direct service in the reporting month	12,254
Waiting time from assessment to commencement of treatment during reporting period (Grade 4): i). No. of patients waiting 1-6 months ii). No. of patients waiting 7-12 months iii). No. of patients waiting 13-24 months iv). No. of patients waiting 2-3 years v). No. of patients waiting over 4 years	New PI 2013		No. of clients for whom a primary care occupational therapy referral was received in the reporting month	70,752
			Finance Variance against Budget: Income and Expenditure	≤ 0%
No. of patients on the treatment waiting list – grade 5 – during reporting period	New PI 2013		Variance against Budget: Income Collection	≤ 0%
Waiting time from assessment to commencement of treatment during reporting period (Grade 5): i). No. of patients waiting 1-6 months ii). No. of patients waiting 7-12 months iii). No. of patients waiting 13-24 months iv). No. of patients waiting 2-3 years v). No. of patients waiting over 4 years	New PI 2013		Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
			Variance against Budget: Revenue and Capital Vote	≤ 0%
			Human Resources Absenteeism rates	3.5%
			Variance from approved WTE ceiling	≤ 0%

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

Dublin Mid-Leinster

- Kilnamanagh / Tymon - Primary Care Centre, lease agreement
- Longford, Co. Longford - Primary Care Centre, lease agreement
- Newbridge, Co. Kildare - Primary Care Centre, lease agreement
- Dun Laoghaire, Co. Dublin - Primary Care Centre, lease agreement
- Clane, Co. Kildare - Primary Care Centre, lease agreement
- Baggot Street, Dublin - Primary Care Centre, lease agreement
- Shankill, Co. Dublin - Primary Care Centre, lease agreement
- Athlone, Co. Westmeath - Primary Care Centre, lease agreement

Dublin North East

- Ashbourne, Co. Meath - Primary Care Centre, lease agreement
- Blanchardstown, Grove Court, Dublin - Primary Care Centre, lease agreement

South

- Schull, Co. Cork - Primary Care Centre, lease agreement
- Carrigtwohill, Co. Cork - Primary Care Centre, lease agreement

West

- Athenry, Co. Galway - Primary Care Centre, lease agreement
- Manorhamilton, Co. Leitrim - Primary Care Centre
- Swinford, Co. Mayo - Primary Care Centre, lease agreement
- Castlegar – Ballinafoile, Co. Galway - Primary Care Centre, lease agreement
- Loughrea, Co. Galway - Primary Care Centre
- Market, Garryowen, Pennywell, Limerick - Primary Care Centre, lease agreement

COMMUNITY (DEMAND-LED) SCHEMES

Introduction

Primary Care Schemes form the infrastructure through which the Irish health system delivers a significant proportion of primary care to the general public. In 2012, services were provided to over 3.4m people in their community through 6,500 primary care contractors such as doctors, pharmacists, dentists and opticians, with a full year forecast expenditure of €2,697m (at November, 2012). This includes schemes / arrangements such as:

- General Medical Services (GMS) – Medical Card Scheme
- Drug Payment Scheme
- Long Term Illness Scheme
- Dental Treatment Service Scheme
- High-Tech Drugs Arrangement
- Primary Childhood Immunisation Scheme
- GP Visit Cards
- Community Ophthalmic Scheme
- Health (Amendment) Act 1996
- Methadone Treatment Service, and
- Immunisation for certain GMS eligible persons.
- European Economic Area (EEA)

The Financial Challenge 2013

Delivery of health services under the Primary Care Schemes occurs in the context of an ever challenging macro-economic environment, which places growing demand on our services at a time of limited funding. The Schemes budget for 2012 was €2,518m and this placed a significant financial challenge on Schemes in light of the expenditure incurred during the year.

The preliminary Schemes budget for 2013 is €2,562m. This preliminary budget assumes the following:

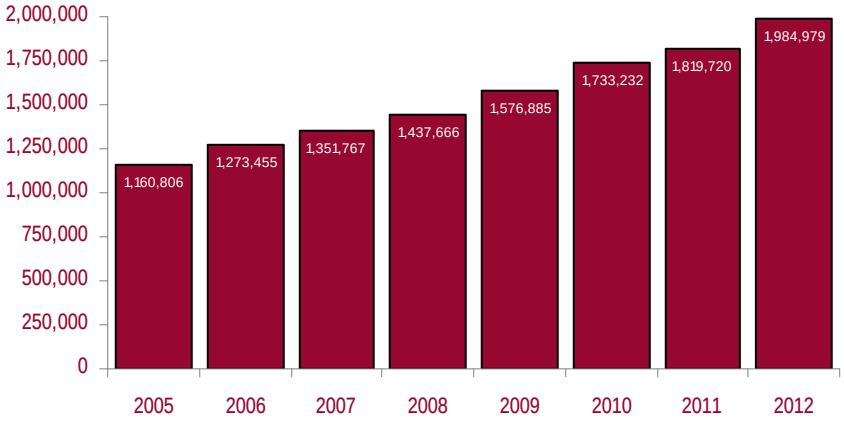
- A range of challenging cost saving initiatives totalling €383m, some of which are dependent upon changes in policy / legislation, to be fully delivered in 2013.
- Additional funding of €177m allocated for Schemes growth in 2013.
- Funding of €15m is provided to extend free GP care for people with certain conditions.
- Demand continues in line with recent expenditure trends (volume / cost mix).

The rate of unemployment has risen from 4.6% in 2007 to 14.8% (October, 2012). Over 1.8 million individuals or nearly 40% of the population are now eligible for the range of health services covered by medical cards. This is a 50% increase since 2005 and is the highest number of people ever recorded in receipt of a medical card.

The Primary Care Schemes are demand-led and the number of card-holders is a significant cost driver. The number of persons eligible for a medical card has increased from 1,694,063 at 1 January 2012 to 1,853,877 at 1 January 2013. This represents growth of +159,814 and exceeds the NSP2012 target by + 54,814 persons. This growth results in an increasing pressure on Scheme costs. For example, the number of items reimbursed on the Medical Card Scheme has grown by over 3 million items compared to the same period in the previous year. In addition, the cost per item trend is increasing.

Based on projections, provision has been made for growth of up to 100,000 medical cards and up to an additional 130,000 GP visit cards. However, policy changes will reduce eligibility for approximately 40,000 people giving an anticipated net growth in 2013 of 60,000 medical cards.

No. of persons covered by Medical Card / GP Visit Card



Resources

Budget Allocation		
2012 €m	2013 €m	% change
2,518	2,562	1.7%

Key Priorities 2013

- Continue to reimburse approximately 6,500 primary care contractors across 12 primary care schemes for the services they provide to eligible persons.
- Participate in, and contribute to, the implementation of Reference Pricing and the development of a new GP contract to meet emerging service requirements (led by DoH).
- Advance the process of transforming primary care services provided by GPs by working with them to ensure their service arrangements support health service provision reconfiguration.
- In collaboration with DoH, deliver a range of challenging cost saving initiatives totalling €383m, most of which are dependent upon changes in policy / legislation.
- Progress a number of key strategic actions with the objective of continuously enhancing schemes during 2013.
- Harness community pharmacy expertise to build capacity in primary care and support optimal medicines usage in the community.

2013 Actions

Priority Area	Action 2013	End Q
Reimbursement of primary care contractors	Provide a wide range of primary care services to the general public across 12 community health schemes through 6,500 primary care contractors	Q1-Q4
Supporting DoH to progress key initiatives	Reference Pricing / Generic Substitution - Support the DoH to progress this key initiative following the enactment of the requisite legislation	Q1-Q4
Primary Care Reimbursement Services	National Client Index - Continue development of the National Client Index to support delivery of a wide range of potential benefits across the health system, such as the National Integrated Patient Management System (IPMS) and the National Integrated Medical Imaging System (NIMIS)	Q1-Q4
	Centralisation of Primary Care Schemes - Continue to implement Medical Card Centralisation Project in line with guidance on implementation of budget 2013:	Q1-Q4

Priority Area	Action 2013	End Q
	- Produce revised and updated national guidelines - Enhance online application process in line with revised national guidelines - Enhance customer service experience	
	Dental Review ⌐ Implement recommendations of Dental Treatment Services Scheme (DTSS) review pertaining to PCRS	Q1-Q4
	Dental Inspectorate ⌐ Continue development of the Dental Inspectorate, including audit of standard operating procedures, DTSS Contractors and HSE primary care dental services (salaried services)	Q4
Free GP Care	Extend free GP care for people with certain conditions (provision of additional €15m)	Q1-Q4 Future Health Action 26
Other Initiatives	National Cancer Control Programme ⌐ Continue to develop and implement the reimbursement of oncology drugs project	Q1-Q4
	Acute Hospitals and Clinical Care Programme Collaborate with the Acute Hospitals and Clinical Care Programme through the utilisation of existing PCRS business expertise and IT infrastructure to support the following key actions: ⌐ Medicine Management Programme: Support the Medicines Management programme by continuing to develop and implement access by GPs to online analysis of prescribing by utilising existing business expertise and IT infrastructure of PCRS ⌐ Continue to develop and implement the centralised reimbursement of Outpatient Parenteral Antimicrobial Therapy (OPAT) service and continue to develop and implement the centralised reimbursement of Hepatitis C drugs ⌐ Hi-Tech Drugs Scheme: Continue to develop and implement reimbursement of the Hi-Tech Drugs Scheme (HTDS) project, commencing initially with rheumatology	Q1-Q4

Scorecard 2013

Community (Demand-Led) Schemes Scorecard

Performance Indicator / Activity	Target 2013		Performance Indicator / Activity	Target 2013
% of properly completed medical / GP visit card applications processed within the 15 day turnaround	90%	Quality, Access and Activity	DTSS ▪ No. of treatments (above the line) ▪ No. of treatments (below the line)	 1,127,410 54,357
Medical Cards No. of persons covered by medical Cards	1,921,245			
(incl. no persons covered by discretionary medical cards)	55,328		▪ No. of patients who have received treatment (above the line) ▪ No. of patients who have received treatment (below the line)	519,707 56,323
GP Visit Cards No. of persons covered by GP visit cards	265,257			
(incl. no. persons covered by discretionary GP visit cards)	15,836		Community Ophthalmic Scheme ▪ No. of treatments ▪ i). Adult ▪ ii). Children	 798,393 730,649 67,744
Long Term Illness ▪ No. of claims ▪ No. of items	 923,794 3,020,807			
Drug Payment Scheme ▪ No. of claims ▪ No. of items	 2,834,189 8,871,012		Finance Variance against Budget: Income and Expenditure	 ≤ 0%
			Variance against Budget: Income Collection	≤ 0%
GMS ▪ No. of prescriptions ▪ No. of items ▪ No. of claims – special items of service ▪ No. of claims – special type consultations	 20,864,890 65,307,106 883,796 1,217,992		Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
			Variance against Budget: Revenue and Capital Vote	≤ 0%
			Human Resources Absenteeism rates	 3.5%
Hi-Tech No. of claims	 461,668		Variance from approved WTE ceiling	≤ 0%

PRE-HOSPITAL EMERGENCY AND RETRIEVAL CARE

Introduction

A significant reform programme has been underway in recent years to totally reconfigure the way we manage and deliver pre-hospital care services. This is in line with the recommendations of the DoH's strategic framework *Future Health* to ensure a clinically driven, nationally co-ordinated system, supported by improved technology, which will also encompass the National Aeromedical Co-Ordination Centre.

As part of this process, major restructuring of the Control Centres is underway which is expected to deliver a single national Control Centre across two sites by Quarter four, 2013. In July 2012, the National Ambulance Service (NAS) commenced a new more cost effective model of service delivery known as the Intermediate Care Service (ICS). Intermediate Care assists in 'bridging the gap' between secondary and primary care, by complementing existing primary care services, facilitating early discharge from hospital for patients and helping to avoid unnecessary admissions to hospital.

The main objective of the ICS for the NAS is to support the needs of patients who require stretchers or clinical supervision during transfers in Ireland by way of enhanced planning / bed management, discharge policies, ensuring a safe transfer for patients when moving to step down facilities in the community (e.g. patient discharges to nursing homes occurring in a timely manner which will free up acute beds) or for critical patients moving to hospital care. The potential contribution of the ICS to bed management in hospitals will also support the work of the SDU.

With ICS looking after patients already within the healthcare system, emergency ambulances can then focus on services delivered by the paramedics and advanced paramedics in Pre-Hospital Emergency Care. This will be achieved by supporting improvements in response times for transporting vehicles which are benchmarked against the national Key Performance Indicators (KPI). The national roll out of the ICS will take several years to complete. Our vision for the future is that NAS will deliver services by two different but complementary divisions respectively, ICS and Pre-Hospital Emergency Care which will enable a more focused approach to the needs of our patients.

In 2013 we will progress this vision by prioritising any increases in Intermediate Care Services to support the needs of the Clinical Care Programmes and small hospitals framework, once published. The proposal to invest €12.2m in ambulance services in 2013 includes funding of the National Ambulance Service Control Centre Reconfiguration Project, the Aeromedical Service, implementation of Neonatal / Paediatric Retrieval Services (detailed further in the acute and clinical care programme section) and further development of the intermediate care service and adult retrieval services.

Resources

National WTE Numbers	
End Dec. 2012 Ceiling	End Dec. 2012 Projection
1,527	1,550

2013 Key Priorities

- Continue implementation of the NAS Control Centre Reconfiguration Project from nine to two sites and associated ICT integrated enabling solutions to transition communications to digital voice and data on a national basis.

- Develop clinical outcome indicators to support the enhancement of patient safety and quality improvement. Implementation of a national Mobile Data and electronic Patient Care Record (ePCR) combined technology solution as part of NAS Control Centre Reconfiguration Project will be the key enabler to measure NAS clinical outcome and response time performance.
- Reconfigure NAS to deliver separate Pre-Hospital Emergency Care and Intermediate Care Services (ICS) to support the small hospitals framework and Clinical Care Programmes nationally in appropriate response to changing models of service.
- Continue the roll out of national Appropriate Hospital Access Protocols to standardise patient transfer to EDs / other areas in support of small hospitals framework and Clinical Care Programmes.
- Evaluate the national pilot Emergency Aeromedical Service.
- Support the continuing professional competence of paramedics and advanced paramedics.

2013 Actions

Priority Area	Action 2013	End Q
Reconfigure the National Ambulance Service to deliver separate Pre-Hospital Emergency Care and Intermediate Care Services to respond to changing models of service	Implementation of NAS Control Centre Reconfiguration Project and associated ICT enabling Projects: Operationalise Control Centre Reconfiguration from nine to two sites nationally (funding of €4.44m in 2013 (half-year) and 55 WTEs)	Q4 Future Health Action 33
	Continue to develop suite of key performance indicators with HIQA on Pre-Hospital Emergency Care which will support clinical outcome KPIs, improving access and performance	Q2
	Identify alternative options for care pathways for low acuity (Omega) 999 calls	Q4
	Enhance quality and patient safety capacity to support clinical governance of Pre-Hospital Emergency Care - Finalise appointment of fulltime Medical Director	Q1
	In line with needs of the Small Hospitals Framework, continue the development of Intermediate Care Services, supporting the NAS elements of the Transport Medicine Programme for Adult Retrieval and releasing existing emergency resources to enhance the Emergency Care Services (€4.95m funding in 2013 and 106 WTEs)	Q4 Future Health Action 28
	Continuation of pilot Emergency Aeromedical Service and NACC (funding of €.8m and 2.3 WTEs in 2013): - Implement new ICT technologies to support the work of the National Ambulance Control Centre (NACC) as per HIQA Meadhbh McGivern Report Recommendation G7/8 - Review pilot project to be carried out at 9 months	Q1 Future Health Action 28 Q2
	Prepare the National Ambulance Service to support changes to acute hospital services: Increase paramedic and advanced paramedic educational capacity to support associated workforce planning requirements, operational requirements and roll out of Pre-Hospital Emergency Care Council (PHECC) Competency Assurance: - Paramedic training: 203,697 hours - Advanced Paramedic training: 139,620 hours - Intermediate Care Operative training: 14,820 hours - Call Taker and Dispatcher training: 46,800 hours - Competency and assurance training: 60,500 hours *(Hours are calculated on a per student basis)*	Q4
	Deliver cost savings of €2m following from engagement with Unions (through the auspices of the Labour Relations Commission (LRC) in 2012) to implement new rosters, intermediate care service provision and elimination of restrictive and cost inefficient work practices	Q4

Scorecard 2013

Ambulance Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Emergency Response Times % of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 85%)	> 70%	Quality, Access and Activity	Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 85%)	> 68%		Variance against Budget: Revenue and Capital Vote	≤ 0%
Finance Variance against Budget: Income and Expenditure	≤ 0%		Human Resources Absenteeism rates	3.5%
Variance against Budget: Income Collection	≤ 0%		Variance from approved WTE ceiling	≤ 0%

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

National

- Reconfiguration of National Ambulance Command and Control to a nationally integrated system working over two sites and relocation of National Ambulance Service College

ACUTE HOSPITALS INCLUDING CLINICAL PROGRAMMES

Introduction

Future Health – A Strategic Framework for the Reform of the Health Service 2012-2015 forms the strategic basis for the work of the HSE in the immediate to near future. Its four pillars of reform coupled with targeted actions set out the strategic objectives that the HSE will be working toward in 2013. The HSE will also utilise the HIQA *Standards for Safer Better Healthcare* in conjunction with key reports such as the Tallaght Hospital Investigation Report (HIQA 2012) as a key enabler to achieving the required changes. Fundamental to the reform agenda is the need to reorganise our hospital resources to ensure that patients can access appropriate treatment in the right setting, receive the best possible clinical outcomes and provide sustainability for hospital services into the future. The HSE anticipates that the report on hospital trusts and the small hospitals framework will provide the necessary and appropriate strategic guidance to build our modern acute hospital infrastructure and networks. This, coupled with reforms and service improvements in the area of primary and community care, will result in an enhanced customer service experience for patients and a greater flexibility in the provision and configuration of services at a regional level.

The HSE continues its commitment to delivering the optimal care pathway for different clinical needs enabled by implementation of clinical programmes of care - generic models of care and service delivery solutions that assist local management to deliver improvements in the delivery, quality and patient safety of their services. The scope of the programmes covers the whole of the patient journey from self management and prevention through to primary, secondary and tertiary care. These programmes provide a national, strategic, and co-ordinated approach to a wide range of clinical services and include the standardisation of access to, and delivery of, high quality, safe, and efficient hospital services nationally as well as the development of better linkages with primary care services.

The HSE will work hand in hand with the DoH, to drive performance improvement on access to acute hospital services – particularly to improve waiting times for emergency or unscheduled care and elective or scheduled care. The strengthening of its performance management approach through the development of a new CompStat system and the continued development of its base of quality indicators in 2013 will provide the platform for future governance and accountability structures. These necessary developments will facilitate *Future Health* objectives of purchaser / provider split and performance contracts in the future.

Additional funding of €3.35m is being allocated towards demographic pressures for renal services in 2013. Also, €12.2m is being invested in ambulance services which includes funding of the National Ambulance Service Control Centre Reconfiguration Project, Aeromedical Services, implementation of Neonatal / Paediatric Retrieval Services, intermediate care services and adult retrieval services (see Pre-Hospital Emergency and Retrieval Care section also).

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
47,524	47,190	3,978	4,117	3.5%

2013 Key Priorities

- Establish hospital groups and associated governance and management arrangements, pending primary legislation to give full effect to establishment of public hospitals as independent not-for-profit trusts.

- Implement the small hospitals framework when published which will ensure that patients receive high quality care in the most appropriate setting resulting in best possible outcomes.
- Implement new methods of resourcing in hospital in order to drive further efficiencies. This will include working towards implementation of the 'money follows the patient' system of funding provided on a per patient basis. Hospital budgets in the areas of oncology and metabolic drugs will be increased to reflect anticipated growth. Some hospital budgets will be increased where they have been independently assessed as requiring additional bed capacity. There will be a strong focus on working with hospitals to ensure their effective management resulting in the introduction of earned increasing autonomy during the year.
- Improve access to our services by reducing waiting times for emergency or unscheduled care and elective or scheduled care in public hospitals. This includes improved access to outpatient and diagnostic services. Specific targets include:
  - No adult will wait more than 8 months for an elective procedure (either inpatient or day case).
  - No child will wait more than 20 weeks for an elective procedure (either inpatient or day case).
  - No person will wait longer than 52 weeks for an OPD appointment.
  - No person will wait more than four weeks for an urgent colonoscopy and no person will wait more than 13 weeks following a referral for routine colonoscopy or OGD.
  - 95% of all attendees at Emergency Departments will be discharged or admitted within 6 hours of registration.
  - Our expected activity for 2013 is 600,887 inpatient and 830,165 day cases.
- Continue our commitment to delivering the optimal care pathway for different clinical needs enabled by implementation of clinical programmes of care.
- Continue to collaborate with the National Paediatric Hospital Development Board on the process of planning and development of the National Paediatric Hospital.
- Continue the development of, and deployment of, the hospital clinical and non-clinical workforce in line with our reform agenda.
- Continue to implement all elements of the *Public Service Agreement* to ensure maximum value for money and cost reduction opportunities within services.
- Ensure complete alignment between hospital and pre-hospital, primary and community services at both a strategy and operational level.
- Continue to develop the Leadership and Innovation Centre for Nursing and Midwifery.

2013 Actions

Priority Area	Action 2013	End Q
Improving hospital governance and accountability while driving efficiencies and better outcomes		
Hospital Groups and Re-organisation of Smaller Hospitals	Establish remaining hospital groups and associated governance and management arrangements Undertake a public and key stakeholder communication and consultation process nationally on the framework, and locally on the re-organisation process that will be implemented in the nine sites	Q1 Future Health Action 30
Resource Allocation	Work towards implementation of the 'money follows the patient' system of funding and establish hospital group budgets and appropriate financial management systems	Q1-Q4 Future Health Action 22
Improving Access	Implement programmes aimed at reducing waiting times for emergency or unscheduled care and elective or scheduled care in hospitals	Q1-Q4 Future Health Action 30
National Clinical Care Programmes Future Health Action 30 throughout clinical programmes		
Acute coronary Syndrome (ACS)	Optimal Reperfusion Service (OPS) protocol in operation in all 4 HSE regions	Q1
	An additional two Primary Percutaneous Coronary Intervention (PPCI) centres functioning as per programme definition and collecting data to measure care and improvement	Q2
	Increase PPCI to 70% for eligible STEMIs	Q4
Acute Medicine	Implement Acute Medicine pathways in all receiving hospitals (33)	Q4
	Implement National Early Warning Score (NEWS) in all relevant sites	Q4

Priority Area	Action 2013	End Q
Anaesthesia	Design a model of care together with an implementation plan and national steering committee for a standardised pre-admission programme	Q3
	Progress the implementation of TPOT with associated monitoring function	Q1-Q4
Asthma	Continue delivery of the Asthma Education Programme in primary and secondary care	Q1-Q4
Blood Transfusion	Deliver reduction in red cell usage of 10% over 2011 baseline over three years 2012-2014	Q4
	Deliver reduction in platelet usage of 1.5% over 2012 baseline	Q3
Chronic Obstructive Pulmonary Disease (COPD)	Access to structured pulmonary rehabilitation programmes (working within available resources) in 25 acute hospital services and 20 local health areas	Q1
	Structured COPD Outreach Programme operational in 15 acute hospitals (working within available resources)	Q1
Critical Care	Launch the national model of care for Critical Care	Q1
	Develop and implement a model for maintenance / expansion of critical care capacity	Q1-Q4
	Develop a strategy and educational framework for registered nurses in critical care	Q2
Cystic Fibrosis	Develop a national model of care for Cystic Fibrosis	Q1-Q4
Dermatology	Maximise new patient attendances and wait list targets	Q1-Q4
Diabetes	⌐ Implement the National Integrated Care Package for Diabetes with the appointment of 17 integrated care diabetes nurse specialists nationally (one per ISA) (see primary care section) (additional funding of €1.8m and 17 WTEs in 2013) ⌐ Develop ICT prototype to facilitate delivery of national clinical model	Q4
	Continue to implement the National Diabetic Retinopathy Screening Programme to 30% of eligible population in 2013 (see National Cancer Control Programme section) - €1.1m additional funding 2013 for screening and €1.8m additional funding for treatment ⌐ Provide treatment to support diabetic retinopathy screening sites (6 identified sites)	Q2
	Implement the National Footcare Programme ⌐ Ongoing training of Practice Nurses nationally in low risk foot management ⌐ Ongoing implementation of the national footcare model in all 16 sites ⌐ Appoint outstanding Podiatrists	Q2
	Develop national guidelines for diabetes in pregnancy, ensure dissemination and training	Q3
Emergency Medicine	Establish Emergency Care networks in all regions	Ongoing
	Increase patient access to Advanced Nurse Practitioner care	Q4
	Develop Clinical Decision Units in major EDs to reduce inpatient bed demand and improve the quality and experience of patient care	Q2
	Ensure the audio-visual separation of children in EDs	Q3
	Design solutions to ensure ED compliance with recommendations of HIQA Tallaght report (such as unscheduled returns, patients leaving before completion of treatment, ambulance patient handover protocol)	Q3
Epilepsy	Two remaining (out of six) regional Epilepsy Centres operational	Q4
	Epilepsy Monitoring Units operational in Beaumont Hospital and Cork University Hospital	Q2
	Implement Electronic Patient Record in six regional centres	Q4
Heart Failure	Aim to have programme implemented in a further 5 sites (17 in total)	Q4
Medicines Management Programme	Continue to develop and implement proposals to influence prescriber behaviour with GPs having access to online analysis of their individual prescribing	Q1-Q4
Neurology	Maximise new patient attendances and wait list targets	Q1-Q4
Older People	Establishment of Acute Hospitals Specialist Geriatric Services to include: ⌐ frail older person's pathway in ED / Acute Medicine Unit (AMU) in all sites ⌐ specialist geriatric teams ⌐ specialist geriatric wards ⌐ specialist geriatric rehabilitation services ⌐ specialist geriatric outreach service	Q1
Orthopaedics	Introduce a procurement process for prosthetics	Q1
	Develop musculo-skeletal interface pathway with primary care in collaboration with the Rheumatology Programme	Q2

Priority Area	Action 2013	End Q
	Extend Irish Hip Fracture Database to all 16 orthopaedic sites	Q4
Outpatient Antimicrobial Therapy OPAT	Implement national OPAT standards, protocols, guidelines and standard operating procedures in all sites as the service rolls out to that site	Q4
Pathology	Design and roll out pathology handbook to support standardisation of laboratory practices	Q2
Productive Ward Initiative	Commence implementation in the nine phase 2 sites with the focus on patient status at a glance, developing key metrics and organisation of wards	Q1-Q3
Prevention of Chronic Disease	Support all healthcare agencies going smoke free on their campuses by 2015	Ongoing
Radiology	Develop framework for collecting and reporting on performance indicators to measure demand for and access to radiology to assist in planning and resourcing efficiencies	Q2
	Support radiology departments to meet turnaround times for emergency or unscheduled care in line with AMP / EMP and other programmes	Q1-Q4
Rehabilitation Medicine	Commence development of region managed clinical rehabilitation networks, supporting local rehabilitation teams guided by associated national guidelines, protocols, pathways and bundles	Q4
	Develop a set of standards of care for specialist inpatient rehabilitation	Q3
	Develop a set of standards of care for specialist community rehabilitation services	Q3
Renal *(Additional funding of €3.35m has been allocated in 2013)*	Following award of National Peritoneal Dialysis Tender, undertake a rationalisation / standardisation of financial administration across regions	Q2
	Complete national cycle of enhanced procurement processes of haemodialysis equipment and consumables to ensure access to the most modern equipment in the remaining two of the nine networks of renal units	Q2
Rheumatology	Maximise new patient attendances and wait list targets	Q1-Q4
	Develop and implement national clinical guidelines and pathways	Q4
	In conjunction with PCRS, implement and develop reimbursement of the Hi-Tech Drugs Scheme project which is commencing initially with rheumatology, by utilising business expertise and IT infrastructure of PCRS	Q1
Stroke	Implement rapid access to specialist TIA (transient ischemic attack) services in selected hospitals	Q4
	Review the four current Early Supported Discharge Programmes with a view to maximising the service to a wider population base (included in primary care section also)	Q2
	Implement and evaluate an integrated hospital and primary care project in two sites to test the feasibility of implementing opportunistic screening for Atrial Fibrillation in primary care	Q4
Surgery	Agree acute surgery model of care	Q1
	Reduce overall bed usage for surgical admissions based on 2011 baseline	Q4
	Establish Acute Surgical Assessment Units in more than 10 hospitals	Q4
	All hospitals recording 'in-hospital' surgical mortalities	Q4
Transport Medicine	Neonatal Retrieval: Implement Phase 2 of the National Neonatal Retrieval Service, extending the service from seven days daytime to 24/7	Q3
	Paediatric Retrieval: Establish Phase 1 of the National Paediatric Retrieval Service on a Monday to Friday daytime basis (Additional funding of €2m and 7 WTEs in 2013)	Q3
	Adult Retrieval: Commence implementation of Adult Retrieval Service	Q1-Q4
Women and Children	Obstetrics and Gynaecology Further develop, disseminate and implement national clinical guidelines	Ongoing
	Establish local quality improvement projects in each maternity unit	Q2-Q4
	Develop and implement new models of maternity care	Q3
	Conduct a second audit of the Early Pregnancy Assessment services	Q3
	Develop tools to support primary care teams in managing obstetrics and gynaecology	Q3
	Paediatrics and Neonatology Commence the development of a national model of care and associated guidelines for the provision of paediatric and neonatology services with an initial focus on sub-specialty tertiary services	Q4
	Implement recommendations from the Paediatric / Neonatology Site Visit report	Q1-Q4

Priority Area	Action 2013	End Q
	Roll out of insulin pump therapy for children under five years with type 1 diabetes in a number of regional centres	Q1-Q4
Other National Priorities		
National Paediatric Hospital	Continue to collaborate with the National Paediatric Hospital Development Board on the process of planning and development of the National Paediatric Hospital	Ongoing
	Continue to progress joint working and collaboration across the three children's hospitals that will be in line with the model of care for the National Paediatric Hospital and the National Model of Care for Paediatrics as set out by the Paediatric Clinical Programme	Q4
Tallaght Hospital Investigation Report	Continue to progress implementation of the HIQA Tallaght Report	Ongoing Future Health Action 47
European Working Time Directive (EWTD) for Non-Consultant Hospital Doctors (NCHDs)	Implement EWTD in respect of interns	Q1
	Implement revised rosters for Senior House Officers (SHOs), Registrars and Specialist Registrars that maximise EWTD compliance	Q1
	Issue guidance to each agency regarding site-specific measures to reduce hours, and the standards each agency should meet in terms of hours worked and rostering practices in place	Q1

Scorecard 2013

Acute Care (including Clinical Programmes) Scorecard

Performance Indicator	Target 2013		Performance Indicator	Target 2013
Day of Procedure Admission % of elective inpatients who had principal procedure conducted on day of admission	75%	Quality, Access and Activity	ALOS Medical patient average length of stay	5.8
			Surgical patient average length of stay	4.5% reduction
% of elective surgical inpatients who had principal procedure conducted on day of admission	85%		ALOS for all inpatient discharges and deaths	5.6
Re-Admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%		ALOS for all inpatient discharges and deaths excluding LOS over 30 days	4.5
% of surgical re-admissions to the same hospital within 30 days of discharge	< 3%		Colonoscopy / Gastrointestinal Service No. of people waiting more than four weeks for an urgent colonoscopy	0
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%		No. of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	0
			Delayed Discharges Reduction in bed days lost through delayed discharges	10% reduction
Stroke Care % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	9%		Activity Expected no. of inpatient discharges	600,887
			Expected no. of day case discharges	830,165
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	50%		Expected no. of emergency presentations	*1,207,099
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%		Expected no. of emergency admissions	380,090
			Expected no. of births	71,096
Emergency Care Waiting Time % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%		Finance Variance against Budget: Income and Expenditure	≤ 0%
			Variance against Budget: Income Collection	≤ 0%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	100%		Variance against Budget: Pay	≤ 0%

Acute Care (including Clinical Programmes) Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Acute Medicine Programme % of all new medical patients attending the acute medical assessment unit (AMAU) who spend less than 6 hours from ED registration to AMAU departure (TMAT)	95%		Variance against Budget: Non Pay	≤ 0%
			Variance against Budget: Revenue and Capital Vote	≤ 0%
Elective Waiting Time No. of adults waiting more than 8 months for an elective procedure	0		Human Resources Absenteeism rates	3.5%
No. of children waiting more than 20 weeks for an elective procedure	0		Variance from approved WTE ceiling	≤ 0%
Outpatients No. of people waiting longer than 52 weeks for OPD appointment	0			

*This figure is an amendment to that shown in NSP2013

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

Dublin Mid-Leinster

- Coombe Women's Hospital - emergency theatre and delivery suite upgrade
- National Maternity Hospital, Dublin - repair works to roof and relocation of the neo-natal intensive care unit
- St. James's Hospital - provision of a new Haemophilia / Hepatology Centre

Dublin North East

- Mater Misericordiae University Hospital, Dublin - final phase of the re-development of Mater Adult Hospital on existing site
- Connolly Hospital, Blanchardstown, Dublin - provision of an MRI scanner and associated building works
- Beaumont Hospital, Dublin - epilepsy monitoring beds
- Temple Street Hospital, Dublin - interim works including an ECG room, admissions unit and cochlear implant / audiology facility
- Temple Street Hospital, Dublin - upgrade and refurbishment of 6/7 North Frederick Street to free up additional clinical space in the hospital

South

- Cork University Hospital - upgrade and refurbishment of existing cardiac theatres to create new trauma and one emergency theatre
- Cork University Hospital - refurbishment of an existing ward area to provide a surgical assessment unit
- Cork University Hospital - provision of an MRI and CT
- Cork University Hospital - development of final phase of the acute medical assessment unit
- Waterford Regional Hospital - ED extension including neonatal unit
- Mallow General Hospital, Co. Cork - day procedures unit – endoscopy suite
- South Infirmary / Victoria University Hospital, Cork - relocation of ophthalmology out-patients department to SIVUH. Provision of a modular facility
- Mercy University Hospital, Cork - upgrade of the electrical supply and distribution system
- Mercy University Hospital, Cork - extension to the existing radiology department to house one replacement CT scanner and one additional CT scanner

West

- Mayo General Hospital - refurbishment and upgrade of existing renal unit

Mid Western Hospitals Group

- Mid Western Regional Hospital, Limerick - new critical care block, to provide 12 ICU, 16 HDU and 16 CCU beds
- Mid Western Regional Hospital, Limerick- completion of ED (shell space construction)
- Mid Western Regional Hospital, Nenagh – theatre upgrade (phase 1)

NATIONAL CANCER CONTROL PROGRAMME

Introduction

Since the National Cancer Control Programme (NCCP) was established in late 2007, we have been steadily implementing cancer policy as outlined in A *Strategy for Cancer Control in Ireland, 2006* using a programmatic approach to the management of hospital and community based cancer services across geographical locations and traditional institutional boundaries. The goals of the programmatic approach to cancer services are to improve cancer prevention, detection and treatment in order to increase survival rates. This is being achieved through the development of a comprehensive national service, based on evidence and best practice. The majority of cancer care and service delivery (surgical, medical, and radiation oncology) is now delivered through designated cancer centres and four cancer control networks.

In recent years significant resources have been invested and reorganisation taken place to ensure that cancer patients are treated in centres with full multidisciplinary specialist teams, adequate case volumes and with close monitoring of performance targets to ensure prompt access and high quality of care. Projections from the National Cancer Registry of Ireland indicate a 46% increase in new cancers between 2010 and 2020 (21% from 2010-2015). These projections have been substantiated to date and the NCCP will work with cancer centres and the new hospital groups to assess and treat these patients in a timely manner.

The key priorities for the NCCP in 2013 are to deliver on the following objectives:

- Formally launch and roll out the two new national screening programmes (colorectal and diabetic retinopathy) in line with Ministerial priorities.
- Address the service pressures in medical oncology and chemotherapy services through, inter alia, the establishment of a national oncology drugs budget.
- Support volume growth in demand for radiation oncology facilities and implement national haematology and medical oncology programmes.
- Develop a national surgical oncology programme and support gynaecological oncology services in Dublin Mid Leinster.
- Continue the transfer of major cancer surgeries into designated cancer centres.
- Ensure that, in an environment of consolidation and fiscal constraint, adequate resources are made available to diagnose and treat cancer patients in a timely manner.
- Define and monitor national standards for cancer care.

The National Screening Programme continues to deliver two population-based screening programmes, BreastCheck and CervicalCheck. The implementation process for two new programmes, the national colorectal screening programme and the national diabetic retinopathy screening programme began in late 2012. In 2013 there will be a significant focus on developing these new programmes. The National Colorectal Screening Programme when fully implemented will offer free screening to men and women aged 55-74 years every two years. The programme will begin with 60-69 year olds and planning will continue to incorporate the full eligible population. The National Diabetic Retinopathy Screening Programme will be offered to people with diagnosed diabetes aged 12 years and over. The programme will be introduced on a phased basis in 2013 to ensure all aspects are highly quality assured. Screened patients requiring treatment will be referred to the National Clinical Programme for Diabetes who will manage the treatment pathway.

There have been major developments in the field of oncology drugs. The new cancer drugs are increasingly more sophisticated and targeted, and this, coupled with the growth in incidence and prevalence, will result in an increase in the numbers of patients on active treatment. Addressing this growth in expenditure is an increasing challenge for those hospitals delivering medical oncology treatments. There has been a 15% increase in expenditure on existing oncology drugs between 2011 and 2012, and this level of increase can be expected to continue into 2013. In addition, new drugs approved by the NCCP Technology Review Committee will require funding.

The NCCP in conjunction with PCRS intends to establish a centralised oncology drug budget which will link to the newly implemented national registration system. This approach encompasses budget planning, evidence based protocols, and quality and safety considerations, as well as allowing for audit and improved financial management. A €17m additional provision has been made in 2013 for the increased costs of cancer drugs.

The centralisation of cancer surgery has resulted in additional and sustained demands on the designated cancer centres to continue the ongoing care of patients referred in from other hospitals. This has placed additional financial and capacity demands upon already constrained services. Growth in the incidence of cancer and participation in screening programmes will further increase the demand for services.

The Minister has approved plans to progress the expansion of radiotherapy facilities in Cork and Galway under the HSE capital programme. Options for the expansion of capacity in Dublin are still being considered. The work of the National Radiation Oncology Planning and Implementation Committee will continue to oversee the consistency of approach in providing high quality care and determine where specialist services, such as stereotactic radiosurgery, will be located. This Committee will also continue to develop and implement national clinical guidelines for radiation oncology.

The 2013 community oncology work programme includes building on its existing partnership with the Irish College of General Practitioners (ICGP), increasing the proportion of electronic referrals and delivering a community nurse training programme for medical oncology patients.

Resources

National WTE Numbers	
End Dec. 2012 Ceiling	End Dec. 2012 Projection
1,196	1,188

2013 Key Priorities

- Continue to deliver two population-based screening programmes BreastCheck and CervicalCheck and roll out two new programmes:
  - a national colorectal screening programme
  - a national diabetic retinopathy screening programme.
- Continue to develop the eight cancer centres (and Letterkenny) to deliver rapid access diagnostic clinics and cancer surgical services, within multidisciplinary diagnostic and therapeutic environments, inclusive of medical and radiation oncology services.
  - Continue the transfer of major cancer surgeries into designated cancer centres. This includes the transfer of rectal, prostate and upper GI surgeries.
  - Support cancer genetic services in Cork and Dublin to identify extreme risk populations and implement preventative and diagnostic strategies.
  - Develop a national surgical oncology programme and support gynaecological oncology services in Dublin Mid Leinster.
  - Establish a national register and monitoring service of Trophoblastic disease in CUH.
- Implement a national medical oncology programme comprising multidisciplinary human resources, evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery, technology review processes for oncology drugs, and related molecular tests and the introduction of a nationally funded oncology drug budget.
- Expand and renew radiotherapy facilities and equipment to accommodate growth in demand and the introduction of new technologies including the expansion of national brachytherapy services.
- Evaluate options for the development of a National Cancer Information System.

- Quality Care in the Community: Support care of cancer patients in the community with the development of education systems for GPs and nursing staff.
- Continue to progress the work of national expert Tumour Groups comprising expert leads in relevant clinical disciplines to develop and promulgate national clinical practice guidelines. Collaborate with all stakeholders to ensure public, patient, and professional policies, safety, and standards are nationally developed and maintained across the scope of cancer services.
- Continue to develop professional staff knowledge, through education and research and collaboration with relevant colleges and educational bodies. Develop primary care skills in prevention, diagnosis, care, and follow up to facilitate safe, high quality care in the community.

2013 Actions

Priority Area	Action 2013	End Q
National Cancer Screening Services	BreastCheck	
	- Continue to provide breast screening to women aged 50-64	Ongoing
	- Plan for the extension of screening to 65-69 year old age range	Ongoing Future Health Action 11
	CervicalCheck	
	- Continue to provide cervical screening and colposcopy services to women aged 25-60 years on a three or five year basis (dependent on age)	Ongoing
	Colorectal Screening	
	- Continue the implementation process for the national colorectal screening programme (funding 2013 €4.3m)	Ongoing Future Health Action 12
	- Commence the Masters training programme for Clinical Nurse Specialists (CNS)	Q2
	Diabetic Retinopathy Screening Programme	
	- Continue the implementation process for the national diabetic retinopathy screening programme (€1.1m additional funding for screening and €1.8m additional funding for treatment)	Ongoing
	- Collaborate with the National Clinical Programmes for Diabetes who will manage the treatment pathway for screened patients	Ongoing
	All Screening Programmes	
	- Continue the recruitment process for all outstanding posts unfilled from 2011 / 2012 National Service Plans	Ongoing
	- Continue to develop initiatives to promote participation of marginalised groups in all screening programmes	Ongoing
Development of Eight Cancer Centres (and Letterkenny)	Prostate Cancer Surgery	
	In collaboration with the RDO, complete transfer of prostate cancer surgery into six centres:	
	- South: Transfer prostate surgery from the Mercy University Hospital into CUH	Q4
	- DML: Transfer prostate cancer surgery from Adelaide and Meath, incorporating National Children's Hospital, Tallaght (AMNCH) into St. Vincent's and St. James' Hospitals	Q4
	Rectal Cancer Surgery	
	In collaboration with the relevant RDO / CEO, complete transfer of rectal cancer surgery into eight cancer centres and continue to monitor implementation and impacts on other surgical services in the centres:	
	- South: Transfer rectal cancer surgery into CUH	Q4
	- West: Transfer rectal surgery from Sligo General Hospital and Mayo General Hospital into Galway University Hospital	Q4
	- DML: Transfer rectal surgery from AMNCH into St. James' Hospital	Q1
	Pancreatic Surgery	
	- Complete establishment of pancreatic satellite unit in CUH linking into St. Vincent's National Centre	Q2
	Upper GI	
	- Implement the national upper gastrointestinal (GI) Service in the national centre (St. James' Hospital and three satellite centres)	Q2
	Cancer Genetics	Q3
	- Support expanded access to cancer genetic services in Cork and Dublin	

Priority Area	Action 2013	End Q
	Other Cancers ⌐ Analyse scope of cancer head and neck services	Q4
	⌐ Develop a national surgical oncology programme and support gynaecological oncology services in Dublin Mid Leinster	Q3
	⌐ Complete transfer of cancer surgery in line with the cancer strategy, as appropriate, for specific complex cancers including urological cancers, head and neck cancers and sarcomas	Q4
	⌐ Establish a national register and monitoring service of Trophoblastic disease in CUH	Q2
	Diagnostic Services ⌐ Develop a plan for the distribution of cancer molecular diagnostic services in Ireland	Q3
	Rapid Access Lung and Prostate Clinics ⌐ Monitor activity and KPIs across rapid access clinics	Ongoing
National Medical Oncology Programme	Review medical oncology services from a quality assurance (QA) and safety perspective	Q3
	Assist in the development of mechanisms for the management of the cancer budget within the PCRS	Q2
	Recommend projected drug budget to PCRS / Integrated Services Directorate (ISD)	Q4
	Continue to assess new cancer drugs and related predictive laboratory tests through the Health Technology Review Committee and present to HSE Management Team / DoH for approval and funding	Ongoing
	Develop national protocols for drug usage, and standardise practice nationally	Ongoing
Radiation Oncology Services	Continue to increase capacity at St. James' Hospital and Beaumont Hospital (St. Luke's Radiation Oncology Network) as required until fully functional (Phase 1). This includes recruitment of all outstanding approved posts, specifically physicists and radiation therapists	Ongoing
	Progress the radiation oncology programme with the development of facilities as set out in the National Plan for Radiation Oncology (NPRO) within a single clinical framework	Q2
	Continue the development of the National Radiation Oncology Network by: ⌐ Implementing national clinical guidelines and standards ⌐ Implementing the national performance management and monitoring system established to drive quality and service improvement ⌐ Expanding the national programmes for prostate brachytherapy	Q3
	Continue to establish performance management and monitoring systems to drive service quality and service improvement	Ongoing
National Cancer Information System (NCIS)	Scope the options for the longer term development of an integrated national cancer information system which will enable audit, evaluation, programme monitoring and programme planning for the purposes of cancer control and will satisfy the requirements for cancer registration	Q4
	Evaluate national / regional IT connectivity across all medical oncology units with a longer term view to support electronic prescribing	Q4
	Disseminate information on standards of care, treatment protocols, cancer management guidelines, and cancer outcomes to health professionals, patients, and the public via website	Ongoing
	Assess feasibility of the electronic transfer of pathology reports to the NCRI and National Cancer Screening Service (NCSS) databases	Q4
Quality Care in the Community	Promulgate use of standardised electronic referral processes developed for common tumours	Ongoing
	Work in partnership with ICGP to implement integrated cancer care	
	Enhance smoking cessation training for all healthcare professionals including e-learning in partnership with primary care specialists	Ongoing
	Develop e-learning programmes for GPs in prostate disease and lung cancer, in collaboration with the ICGP and specialist teams	Q3
	Obtain university accreditation for the community nurse training programme for cancer care and expand its delivery in association with specialist services	Q4
	Contribute to the work of the HSE Prevention of Chronic Disease Programme	Ongoing
	Deliver training courses for PCTs, utilising opportunities for remote learning where feasible	Ongoing
	Update GP referral guidelines for breast, lung and prostate cancers as required	Ongoing
	Interface with specialist services and GPs to deliver appropriate follow up cancer care of common cancers in the primary care setting	Ongoing
Quality and Safety: National	Direct and facilitate the cohesive national specialist clinical networks established for the purpose of clinical audit, sharing of good practice and problem solving for breast, lung, prostate, upper gastrointestinal (GI), brain and	Ongoing

Priority Area	Action 2013	End Q
Expert Tumour Groups	rectal cancers	
	Drive and guide the five national expert tumour groups established for breast, lung, prostate, gastrointestinal and gynaecological cancers in the development of national evidence based clinical practice guidelines	Ongoing
	Continue to define appropriate parameters to devise and monitor quality domains across cancer services	Ongoing
	Continue to assist in the development of a National Radiology Quality Assurance Programme, led by the Faculty of Radiologists, including development of diagnostic radiology guidelines	Ongoing
	Continue to assist in the development of a National Histopathology Quality Assurance Programme, led by the Faculty of Pathology, including the development of QA benchmarks and implementation of a framework for national histopathological reporting	Ongoing
	Review the role of the NCCP and plan for embedding ongoing National Histopathology Quality Assurance Programme in new health service governance structures	Ongoing
	Define strategies for QA for prognostic and predictive cancer tests including molecular testing	Q3
Education and Research	Engage with professional training / educational bodies regarding training, educational needs, and workforce planning for cancer staff	Ongoing
	Promote the goals and objectives of the NCCP through educational sessions in primary care and also through collaboration with consultant staff nationally including conference presentations	Ongoing
	Participate in the Ireland – Northern Ireland – National Cancer Institute Cancer Consortium, to identify opportunities for shared learning, particularly in the areas of cancer prevention, cancer nursing and survivorship	Ongoing

Scorecard 2013

National Cancer Control Programme Scorecard				
Performance Indicator / Activity	Target 2013		Performance Indicator / Activity	Target 2013
Symptomatic Breast Cancer Services No. of urgent attendances	13,900	Quality, Access and Activity	Rectal Cancers No. of centres providing services for rectal cancers	8
No. of non urgent attendances	25,200			
No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals *(No. and % offered an appointment that falls within 2 weeks)*	13,200 95%		Radiotherapy No. of patients who completed radical radiotherapy treatment in the preceding quarter (palliative care patients not included)	To be deter-mined
No. and % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals *(No. and % offered an appointment that falls within 12 weeks)*	23,940 95%		No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	To be deter-mined
Breast Cancer Screening No. of women who attend for breast screening	140,000		Finance Variance against Budget: Income and Expenditure	≤ 0%
Lung Cancers No. of attendances at rapid access lung clinic	2,700		Variance against Budget: Income Collection	≤ 0%
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre	2,565 95%		Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
Prostate Cancers No. of centres providing surgical services for prostate cancers	7		Variance against Budget: Revenue and Capital Vote	≤ 0%
No. of attendances at rapid access prostate clinics	2,970		Human Resources Absenteeism rates	3.5%
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	2,600 90%		Variance from approved WTE ceiling	≤ 0%

PALLIATIVE CARE

Introduction

Palliative care is an approach that improves the quality of life of patients and their families who are facing the challenges associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment, and treatment of pain and other physical, psychosocial, and spiritual problems. In the last twenty years, the scope of palliative care has broadened to providing palliative care at an earlier stage in the disease trajectory. The emphasis on the early provision of palliative care concurrently with disease modifying treatment has been shown to ease the transition towards an eventual sole focus on palliation and to offer improved quality and efficiency of care in the earlier stages of chronic disease management. Historically, palliative care has been associated with those suffering from cancer, but future provision must also ensure equity of access for those with other chronic diseases such as dementia, cardiovascular and respiratory disease.

The strategic direction for palliative care services is provided by a number of national documents including:

- *Report of the National Advisory Committee on Palliative Care* (2001, DoH)
- *Palliative Care for Children with Life-limiting Conditions* (2009, DoH)
- *Palliative Care Services – Five Year Medium Term Development Framework* (2009, HSE)
- *Palliative Care for All – Integrating Palliative care into Disease Management Frameworks* (2009, HSE and IHF).

Our vision for the future is that palliative care will be a gradual and natural increasing component of care from diagnosis to death. We will ensure that patients with a life-limiting condition, and their families, can easily access a level of high quality palliative care service that is appropriate to their needs, regardless of age, care setting, or diagnosis. Under the Health Reform Programme we will continue the drive to achieving access to high quality healthcare services. In particular, the development and implementation of the best practice model of palliative care will apply a set of service principles across identified clinical streams and patient flow continuums in order to enable people get the right care, at the right time, by the right team and in the right place.

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
615	611	73	72	- 1.6%

2013 Key Priorities

- Improve resource utilisation of palliative care services including systematic assessment of need, and streamline processes of access and referral to specialist palliative care services.
- Support the delivery, and improve the quality of, generalist and specialist palliative care services in line with our strategic policy direction.
- Improve the integration and governance of services in generalist and specialist palliative care settings.
- Strengthen the quality, efficiency, and effectiveness of existing service provision through the development and collection of evidence based performance measures that support the quality improvement cycle.
- Progress the development of paediatric palliative care services.

2013 Actions

Priority Area	Action 2013	End Q
Improving resource utilisation of palliative care services	Support the implementation of a model for the systematic assessment of palliative care need, and processes of access and referral to specialist palliative care services	Q4
	Develop a palliative care prospective funding model for submission to the Universal Health Insurance implementation group	Q4 Future Health Action 41
	Work in collaboration with the IHF to conduct an assessment of the End of Life Audit Tool and develop an implementation plan as appropriate	Q4
Improving the delivery and quality of Generalist and Specialist Palliative Care provision	Work in partnership with the Irish Hospice Foundation to implement the recommendations within the *Palliative Care for All* report through: ⌐ Supporting existing and new demonstration projects focused on providing best practice models of palliative care for people with non-malignant disease ⌐ Undertaking a review of the 2011/12 demonstration projects and integrating the learning into the clinical care programmes that focus on chronic disease management	Ongoing Future Health Action 27
	Work in partnership with the Emergency Medicine Programme to support a demonstration project focused on developing a best practice model of palliative care in the ED setting	Q4
	Develop and implement evidence based guidelines / clinical pathways for generalist and specialist palliative care practitioners in order to improve quality of care, access to, and resource utilisation within services	Q1-Q4
	Develop and implement a national system of care delivery that promotes advance care planning, where appropriate and desired. This will include the development and implementation of: ⌐ National guidelines to promote good practice in advance care planning ⌐ A national e-learning programme for the multidisciplinary team to provide training in engaging in end of life discussions and advance care planning ⌐ A national system for recording advance care plans ⌐ Initiatives to increase community awareness of planning options and capacity to discuss and plan for death and dying	Q4
	Implement the Palliative Care Competence Framework to support managers, teams and individuals to identify appropriate palliative care competences for use within their particular setting	Q1-Q4
	Continue to work with the Irish Hospice Foundation on the Design and Dignity Grants Scheme in order to progress projects designed to enhance the dignity of people who die in hospitals	Q1-Q4
Improving integration and governance of palliative care services	Finalise and support system wide utilisation of the governance tool Towards Excellence in Palliative Care - Self Assessment Tool	Q4
	Develop a strategic plan for effective, efficient and high quality utilisation of palliative care support beds based on the findings of the national review conducted in 2012	Q4
Develop Evidence based Performance Measures	Expand the collection of data on specialist palliative care activity to include: ⌐ Acute hospital services	Q2
	Scope the development of palliative care minimum datasets for use in: ⌐ Outpatient services ⌐ Primary care settings	Q4 Q4
Developing Paediatric Palliative Care	Work with the Irish Hospice Foundation to progress the implementation of the recommendations in *Palliative Care for Children with Life-Limiting Conditions in Ireland (2009)*: ⌐ Extend the provision of co-ordinated care to children with life-limiting conditions, and their families	Q1-Q4
	⌐ Design and implement a monitoring and evaluation process for the outreach programme for children with life-limiting conditions	Q3
	⌐ Provide a range of education and training programmes that will support staff to meet the needs of children with life-limiting conditions, and their families	Q1-Q4
	⌐ Complete a feasibility study on the establishment of a national database for the identification of children with life-limiting conditions	Q3
	⌐ Develop a strategic plan for a children's 'Hospice at Home' service model	Q3
Primary Care: Continue to progress the effective integration of	Progress the effective integration of primary care and palliative care services: ⌐ Map primary palliative care services and develop a national strategy on primary care provision	Q4
	⌐ Scope the feasibility of developing a structured system for palliative care prescribing in the community	Q4
	⌐ Continue to collaborate with the All-Ireland Institute of Hospice and Palliative Care, Education Centres in	Q4

Priority Area	Action 2013	End Q
primary care and palliative care services	Specialist Palliative Care Units, professional bodies and universities to develop and provide programmes that ensure primary care staff have the necessary training to improve the quality of palliative care	
	⌐ Continue to develop and implement evidence based guidelines and the tailored use of standardised and optimised clinical pathways for primary palliative care	Q4
	⌐ Implement the universal referral form for specialist palliative care in partnership with primary care	Q4

Scorecard 2013

Palliative Care Services Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Inpatient Units Waiting Times i) Specialist palliative care inpatient bed within 7 days	92%	Quality, Access and Activity	Day Care No. of patients in receipt of specialist palliative day care services	331
ii) Specialist palliative care inpatient bed within 1 month	98%		No. of new patients in receipt of specialist palliative day care services	848
No. of patients in receipt of treatment in specialist palliative care inpatient units	340		Community Hospitals No. of patients in receipt of care in designated palliative care support beds	149
No. of new patients seen or admitted to the specialist palliative care service (reported by age profile)	173		Finance Variance against Budget: Income and Expenditure	≤ 0%
No. of admissions to specialist palliative care inpatient units	2,892		Variance against Budget: Income Collection	≤ 0%
Community Home Care i) Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non Acute hospital)	82%		Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
ii) Specialist palliative care services in the community provided to patients in their place of residence within 1 month (Home, Nursing Home, Non Acute hospital)	99%		Variance against Budget: Revenue and Capital Vote	≤ 0%
			Human Resources Absenteeism rates	3.5%
No. of patients in receipt of specialist palliative care in the community	2,948		Variance from approved WTE ceiling	≤ 0%
No. of new patients seen or admitted to specialist palliative care services in the community (reported by age profile)	664			

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

West

Ballina, Co. Mayo - 2 bedded end of life care facility in Ballina District Hospital

MENTAL HEALTH SERVICES

Introduction

Mental health services include a broad range of primary and community services as well as specialised secondary care services for children and adolescents, adults, older persons, forensics, and suicide prevention initiatives. Services are provided by the HSE and voluntary sector partners in a number of different settings including the service user's own home, acute inpatient facilities, community mental health centres, day hospitals, day centres, and supported community residences.

Guiding the development of services is *A Vision for Change (2006)* – a progressive, evidence based and pragmatic policy document, which proposes a new model of service delivery designed around the service user, one that is recovery-orientated and community-based. *A Vision for Change* is strong on values - prioritising and promoting positive mental health, service user focused service delivery, recovery oriented services, social inclusion - and sets out a comprehensive change programme for our mental health services.

In 2012, under the *Programme for Government*, ring-fenced funding of €35m annually from within the health budget was set aside specifically to develop General Adult and Child and Adolescent Community Mental Health Teams as recommended in *A Vision for Change,* to implement the recommendations of the suicide prevention strategy *Reach Out*, and to provide access to counselling and psychotherapy in primary care. The allocation to the community mental health teams included support for the implementation of the national Mental Health Clinical Programmes when agreed.

The national Mental Health Clinical Programmes were developed with the primary aim of implementing *A Vision for Change* recommendations in a phased structured way within Community Mental Health Teams (CMHT). The programmes describe the critical developments that will ensure a modern, high quality national mental health service. The first phase of the programmes in first episode psychosis, early intervention in eating disorders and the management of self harm presentations to emergency departments sets out pathways of care based on the best available evidence and ensures shared linkages between primary and secondary care. In 2013, lead clinicians in each CMHT will receive training in the clinical area to ensure that the clinical pathways are implemented. This will ensure that services are provided in a systematic way while improving outcomes for service users.

In addition to the completion of the mental health investment programme of 2012, additional funding of €35m will be prioritised and utilised in 2013 to enhance Community Mental Health Team capacity in General Adult and Child and Adolescent Mental Health Services and to support the development of services for older people with a mental illness, those with an intellectual disability and mental illness and forensic services. Further investment will also be made in implementing the recommendations of the suicide prevention strategy *Reach Out.*

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
8,837	8,775	711	733	3.1%

2013 Key Priorities

- Promote positive mental health and implement the outstanding actions in *Reach Out – National Strategy for Action on Suicide Prevention*.
- Enhance the *capacity at primary care and acute hospitals* to respond to suicidal behaviour.
- Complete the strengthening of the General Adult Community Mental Health Team (CMHT) capacity commenced in 2012 and provide additional capacity in 2013.

- Enhance mental health services for children and adolescents in both community and inpatient environments to:
  - Complete the strengthening of the Child and Adolescent Community Mental Health Team (CAMHT) capacity commenced in 2012
  - Maintain and increase child and adolescent acute inpatient capacity.
- Continue to rationalise adult acute inpatient and continuing care bed provision in line with *A Vision for Change* recommendations.
- Develop the service user and carer partnership by ensuring service user representation on Area Mental Health Management Teams.
- Provide access to quality psychotherapy and counselling services for patients eligible under the general medical services within primary care, commenced in 2012.
- Progress the project plan to relocate Central Mental Hospital to St. Ita's, Portrane and progress associated national forensic infrastructure to include Forensic CAMHS Unit, Forensic Mental Health Intellectual Disability (MHID) Unit and provision of four Intensive Care Rehabilitation Units (ICRUs).
- Implement agreed clinical care programmes in mental health across primary and secondary care
  - Early intervention in first episode psychosis
  - Early intervention in eating disorders
  - Management of self harm presentations amongst service users to Emergency Departments.
- Develop phase two of the clinical care programmes in mental health across primary and secondary care to extend psychosis interventions to a wider relevant service user population, develop interventions for complex psychological conditions and develop a programme for depression.
- Improve the quality of mental health services in line with the requirements of the Mental Health Commission.
- Enhance specialist community mental health services for Older People with a Mental Illness, those with an Intellectual Disability and Mental Illness (MHID) and forensic mental health services.

2013 Actions

Priority Area	Action 2013	End Q
Promote positive mental health and implement *Reach Out – National Strategy for Action on Suicide Prevention*	*Reach Out– National Strategy for Action on Suicide Prevention* - Implement strategy and progress the developments set out in the Programme for Government	Ongoing
	- Establish an expert advisory group to support the work of the National Office for Suicide Prevention and to contribute to the strategy to follow *Reach Out*	Ongoing
	- Enhance response at primary care level to suicidal behaviour through the delivery of suicide intervention skills training to GPs and practice staff.	Ongoing
	- Transfer the learning from SCAN (suicide crisis assessment nurse) pilots to four other services nationally (2013 investment)	Ongoing
	- Continue to enhance funding to non-statutory partners delivering frontline services related to key action areas within *Reach Out*	Ongoing
	- Conduct a review of the NOSP funding programme and develop a funding strategy for the period 2013-2016	Q2
General Adult Community Mental Health Teams	- Complete the strengthening of the General Adult Community Mental Health Team (CMHT) capacity commenced in 2012	Q2
	- Provide additional capacity through further investment in General Adult Community Mental Health Teams in 2013	Q2
Enhance mental health services for children and adolescents in both the community and inpatient	Child and Adolescent Community Mental Health Teams - Complete the strengthening of the Child and Adolescent Community Mental Health Team (CAMHT) capacity commenced in 2012	Q2
	- Provide additional capacity through further investment in Child and Adolescent Community Mental Health Teams in 2013	Q2
	- Realign CAMHS catchment areas to reflect HSE Areas *(LRC Agreement 17th September 2012)*	Q2

Priority Area	Action 2013	End Q
environments	Child and Adolescent Acute Inpatient Capacity Implement measures to increase CAMHS acute inpatient capacity: ⌐ DML – 8 bed Interim CAMHS Unit fully operational at St Loman's in Palmerstown	Q1
	⌐ DML – Day Hospital in Cherry Orchard fully operational	Q2
	⌐ South – Bring CAMHS unit in Cork to 20 bed capacity	Q1
	⌐ DNE – Bring CAMHS Unit in Fairview to 12 bed capacity	Q1
	Full compliance with the access protocols for 16 and 17 year old to mental health services *(LRC Agreement 17th September)*	Q1
	Enhance Young People's Mental Health ⌐ In partnership with Headstrong, progress the six new Jigsaw sites in development through the allocation of available Innovation Funding	Q4
	⌐ Prepare for the implementation of *Children First* on a legislative basis	Q4
	⌐ The National Office for Suicide Prevention will work in partnership with other agencies to deliver mental health programmes targeted at building the resilience and well-being of young people in key settings e.g. schools, sports clubs supported by a social marketing campaign e.g Let Someone Know.	Q4
Continue to rationalise adult acute inpatient and continuing care bed provision in line with *A Vision for Change* recommendations and sustain acute inpatient bed numbers at *A Vision for Change* levels	Reduction of a minimum of 102 acute inpatient beds nationally to bring the ratio to 20:100,000 having regard to the incomplete provision of community mental health services. Sustain acute inpatient capacity at *A Vision for Change* recommended levels when reached South (currently 272) ⌐ Reduce to 237	Q4
	West (currently 271) ⌐ Reduce to 217	Q4
	DML (currently 284) ⌐ Reduce to 269	Q4
	DNE (currently 206) ⌐ Sustain at this level but reconfigure for population needs.	Ongoing
	Closure of old psychiatric hospitals to acute inpatient admissions ⌐ Continue to work with all stakeholders to plan for the closure of admissions to old psychiatric hospitals	Ongoing
	Transition of Continuing Care and High Dependency service users to *A Vision for Change* models of service ⌐ Develop plans for the phased discontinuation of low and medium support hostels provision including the provision of continuing clinical supports as required for those transitioning to new arrangements in the community as articulated in the *National Housing Strategy*	Q4
	⌐ Review high support hostel and continuing care bed capacity to provide for population needs in line with *A Vision for Change* recommended levels and plan to reconfigure over-capacity to provide crisis resources and for those with difficult to manage behaviours	Q4
Service User and Carer Partnership	Ensure service user representation on Area Mental Health Management Teams *(LRC Agreement 17th September 2012)*	Q4
	Fostering Innovation ⌐ Allocation of €2m recurring to Genio to accelerate innovative practice and service modernisation in mental health in line with *A Vision for Change*	Ongoing
Mental Health in Primary Care and Access to Psychotherapy Services	Continued participation of PCTs in Team Based Approaches to Mental Health in Primary Care Accredited Programme and roll out of programme to satellite sites	Ongoing
	Continue to provide access to psychotherapy and counselling for patients eligible under the general medical services. (The Counselling in Primary Care Initiative is delivered by the National Counselling Service and Mental Health Services)	Ongoing
National Forensic Mental Health Services	Replacement of Central Mental Hospital (CMH) ⌐ Progress the project plan to relocate CMH to St. Ita's, Portrane and progress associated national forensic infrastructure to include Forensic CAMHS Unit, Forensic Mental Health Intellectual Disability (MHID) Unit and provision of four intensive care rehabilitation units (ICRU)	Q4 into 2014
Mental Health – Clinical Care Programmes	Early Intervention in First Episode Psychosis ⌐ Agree and introduce clinical care pathway in primary care	Q3
	⌐ Develop and agree physical health guidelines for use in primary care	Q2
	⌐ Deliver an agreed training programme to named staff on each CMHT	Q2

Priority Area	Action 2013	End Q
	⌐ Agree and introduce clinical care pathway in each CMHT / CAMHS	Q3
	Early Intervention in Eating Disorders	
	⌐ Agree and introduce clinical care pathway in primary care	Q3
	⌐ Develop and agree physical healthcare guidelines for use in primary care	Q2
	⌐ Deliver an agreed training programme to named staff on each CMHT	Q2
	⌐ Commence clinical care pathway in each CMHT / CAMHS	Q3
	Management of self harm presentations amongst service users in Emergency Departments (EDs)	
	⌐ Deliver an agreed training programme to mental health staff working in EDs	Q2
	⌐ Train identified mental health staff as trainers to deliver an education programme on self harm to ED staff (minimum of 2 mental health staff per ED)	Q2
	⌐ Agree and introduce clinical care pathway in EDs	Q3
	Develop phase two of the clinical care programmes ⌐ Progress the introduction of phase two of the psychosis clinical programme ⌐ Develop phase two of the self harm programme to primary care ⌐ Develop a clinical programme for the management of depression ⌐ Develop a clinical programme for the management of complex psychological disorders ⌐ Develop a national referral and discharge template between primary care and secondary mental healthcare ⌐ Develop and introduce a national protocol for a single point of contact in each CMHT to facilitate shared care between primary and secondary care	Q4
Improve the quality of services in line with the requirements of the Mental Health Commission	Promote quality and patient safety through ⌐ Adherence to Mental Health Commission(MHC) Regulations for approved centres and the suite of rules and codes of practice of the MHC on various aspects of mental health service delivery	Ongoing
	⌐ Work with the Inspector of Mental Health Services during annual inspection and respond to Inspectors' Reports	Ongoing
Older People with a Mental Illness / Intellectual Disability and Mental Illness (MHID)	⌐ Enhance community mental health service provision for Older People with a Mental Illness	Q4
	⌐ Enhance community mental health service provision for those with an Intellectual Disability and Mental Illness	Q4
	⌐ Enhance provision of Forensic Mental Health Services.	Q4

Scorecard 2013

Mental Health Services Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Adult Inpatient Services No. of admissions to adult acute inpatient units	14,044	Quality, Access and Activity	No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	165
Median length of stay	11		No. of children / adolescents admitted to adult HSE mental health inpatient units i). < 16 years ii). < 17 years iii). < 18 years	< 50 0 15 35
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	76.5			
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	24.9			
Acute re-admissions as % of admissions	67%		No. and % of involuntary admissions of children and adolescents	16 5%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area	51.6		No. of child / adolescent referrals (including re-referred) received by mental health services	13,089
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	23.2		No. of child / adolescent referrals (including re-referred) accepted by mental health services	10,471
No. of adult involuntary admissions	1,624*		Total no. of new (including re-referred) child / adolescent referrals offered first appointment and seen	10,025

Mental Health Services Scorecard			
Performance Indicator	Target 2013	Performance Indicator	Target 2013
Rate of adult involuntary admissions per 100,000 population in mental health catchment area	8.8	No. and % of new / re-referred cases offered first appointment and seen i). < 3 months	70%
General Adult Community Mental Health Teams (CMHT) No. of General Adult CMHT	New PI	No. and % of cases closed / discharged by CAMHS service	8,377 80%
No. of referrals (including re-referred) received by General Adult CMHT	New PI	Total no. on waiting list for first appointment at end of each quarter (reduce no. waiting by > 5%)	1,778
No. of referrals (including re-referred) accepted by General Adult CMHT	New PI	No. and % on waiting list for first appointment at end of each quarter by wait time i). < 3 months	761 43%
No. of new (including re-referred) General Adult CMHT cases offered first appointment and seen or DNA by Wait Time (time period to be decided)	New PI	ii). 3-6 months	327 18%
No. of cases closed / discharged by General Adult CMHT	New PI	iii). 6-9 months	246 14%
Psychiatry of Old Age Community Mental Health Teams (CMHT) No. of Psychiatry of Old Age CMHT	New PI	iv). 9-12 months	443 25%
No. of referrals (including re-referred) received by Psychiatry of Old Age CMHT	New PI	v). > 12 months	0
No. of referrals (including re-referred) accepted by Psychiatry of Old Age CMHT	New PI	Finance Variance against Budget: Income and Expenditure	≤ 0%
No. of new (including re-referred) Old Age Psychiatry Team cases offered first appointment and seen or DNA by Wait Time (time period to be decided)	New PI	Variance against Budget: Income Collection	≤ 0%
		Variance against Budget: Pay	≤ 0%
No. of cases closed / discharged by Old Age Psychiatry CMHT	New PI	Variance against Budget: Non Pay	≤ 0%
Child and Adolescent No. of child and adolescent Community Mental Health Teams	58	Variance against Budget: Revenue and Capital Vote	≤ 0%
No. of child and adolescent Day Hospital Teams	2	Human Resources Absenteeism rates	3.5%
No. of Paediatric Liaison Teams	3	Variance from approved WTE ceiling	≤ 0%

* This figure is shown in NSP2013 as 1,642 due to a typographical error

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

Dublin Mid-Leinster

- St. Loman's Hospital, Mullingar, Co. Westmeath- replacement of St. Edna's ward to provide a 20 bed special behavioural unit and up to 24 replacement beds

Dublin North East

- Grangegorman, Dublin - replacement accommodation on existing site for all services, including accommodation for 54 residents
- Beaumont Hospital, Dublin - 44 bed psychiatric unit to allow relocation of acute psychiatric services from St. Ita's, Portrane and 9 beds for Mental Health and Intellectual Disability
- St. Ita's, Portrane, Dublin - residential accommodation for existing residents of St. Ita's in Carraige House and Maryfield (14 beds) and St. Joseph's (8 beds)

South

- St. John's Hospital, Enniscorthy, Co. Wexford -14 place residence (Havenview) to re-house residents from St. Senan's Hospital
- St. John's Hospital, Enniscorthy, Co. Wexford - 13 place high support house (Mill View) to re-house residents from St. Senan's Hospital
- Waterford Regional Hospital - upgrade acute mental health unit
- CNU, Wexford – (Mental Health / Older People) 50 bed CNU to accommodate residents of St. Senan's Hospital
- Kerry General Hospital, Tralee- high observation unit

West

- Gort Glas Day Centre, Ennis, Co. Clare - refurbishment
- Nazareth House, Churchill, Sligo- delivery of a centre for Child and Adolescent Mental Health Services (CAMHS)
- Unit 5B, Mental Health Acute Inpatient Unit, Limerick- completion of refurbishment works
- Community Mental Health Team (CMHT) base, Donegal - development of CMHT base in Donegal Town
- University Hospital Galway - replacement car parking - enabling works for adult mental health unit.

OLDER PEOPLE

Introduction

The majority of people in Ireland over 65 years are well and live healthy active lives, with the vast majority remaining independent into old age in their homes or in their own community, receiving support only as and when required. This includes community-based support services such as home help services, home care packages, respite care, day care, meals on wheels, health promotion initiatives / programmes, etc.

In line with trends in most western countries, people are living longer and healthier lives. This is a cause for celebration, as society can benefit greatly from older peoples' experiences and advice. However, the challenges of an ageing population, particularly for those aged 75 years and older, is increasingly more complex care needs, at a greater cost. The 2011 Census reports there are 535,393 persons over 65 years resident in the State and, of these, 230,565 are aged 75 years and older. These figures are expected to rise significantly in the years ahead. Our goal is to help people remain in their home environment rather than entering long term residential care, except in exceptional circumstances when their care needs become so great that those needs cannot be catered for in the community or primary care setting.

While it is the aim of the HSE to care for older people in their own homes for as long as possible, some older people will require long term residential care. The provision of adequate residential care beds for older people is a key challenge and will continue to be going into the future. The composition of units and number of long stay care beds have changed significantly in the last number of years, predominantly due to financial constraints, reduction in capital funding, introduction of HIQA standards, public service moratorium and legislative changes including the implementation of the *Nursing Homes Support Scheme Act 2009*. A target of no more than 4 – 4.5% of persons over 65 years of age in long stay care has been set by the HSE. However, this target can only be achieved through strong community and support services being in place to assist people living at home for as long as possible, and the achievability of this target is dependent on the expansion of community and support services.

At the end of July 2012, there were approx 25,500 long stay beds in the country. From a national perspective it would appear there is sufficient long stay bed stock to meet the needs of the growing elderly population for the next two years. However, as there is not an even geographical spread, there are areas currently that have an under supply of beds, particularly Dublin and other urban centres, and also areas where there is an over supply of beds so this national picture is distorted. Based on population projections, there will be a significant national deficit of long stay beds by 2016 based on the HSE's target of 4% of older persons in long stay care.

In order to meet increasing population need and deliver sustainable services within available resources, innovative models of care are required to further advance the development of equitable integrated care for older people across community-based services, intermediate care options and quality long term residential care services (supported by a robust and well funded scheme - presently the *NHSS*). The provision of intermediate care options and the provision of clear pathways of care for older persons accessing the healthcare systems will continue to be developed in 2013, with specific emphasis on the provision of transitional / intermediate type care to address the issue of unnecessary admissions to acute hospitals and the requirements for long stay care. This will build on work commenced in 2012 which saw an investment of €11m in these types of services. We will also work with primary care, clinical care programmes and hospitals to address recommendations from the *Strategy to Prevent Falls and Fractures in Ireland's Ageing Population.* Building on a variety of service reviews and audits undertaken in 2012, we will continue to work with all stakeholders to find a sustainable solution for the future, ensuring that older people's needs and preferences remain central to decision-making and are at the centre of policy and practice development.

Resources

National WTE Numbers		Budget Allocation			
End Dec. 2012 Ceiling	End Dec. 2012 Projection		2012 €m	2013 €m	% change
9,833	9,764	OP Services	403	392	- 2.6%
		NHSS	994	998	0.4%

2013 Key Priorities

- Provide quality long stay residential care for older persons who can no longer be maintained at home, with the assistance of an appropriate, equitable, and accessible funding scheme. This will include:

  Nursing Homes Support Scheme (NHSS) – A Fair Deal
  - Full utilisation of NHSS – A Fair Deal within the funding allocated under Subhead B12.
  - Centralise administration and financial management of the scheme in a central national office (CNO), including the National Placement List. It is likely that it will be necessary for budgetary purposes to put this placement list in line with NHSS legislation and offer new places as budget becomes available.
  - Participate in the substantive DoH review of the scheme.

  Public Residential Care Settings for Older People
  - Reconfigure public residential facilities.
  - Review short term bed requirements.
  - Monitor and quality assure public bed management systems.
  - Devise efficiency measures – review skill mix configuration / human resource deployment / viability measures.

- Provide comprehensive home and community supports such as home help, home care packages, Community Intervention Teams, day / respite care, etc. for older persons to live independently, in their own homes, for as long as possible. This will include:

  Home and Community Supports
  - Progress work of the Home Care - National Task Group for Home Helps and Home Care Packages (HCP):
    - Complete the *National Quality Guidelines for Home Care Support Services.*
    - Complete the *National Guidelines for the Standard Operation of the Home Help Service for Older People.*
    - Monitor home care package (HCP) procurement.

  Intermediate and Community Care
  - Liaise with National Clinical Programme for Older People (NCPOP) in the implementation of innovative models of care for people requiring intermediate and home care, to prevent inappropriate admissions to acute hospitals / long term residential care and address delayed discharges, etc. in a more timely way.
  - Liaise with the primary care service to ensure the identified needs of older people are met through PCTs, Primary Care Networks and Community Intervention Teams.

- Encourage and support older people to keep healthy, remain at home and stay out of hospital.
  - Implement (on a phased basis) recommendations from the *Strategy to Prevent Falls and Fractures in Ireland's Ageing Population*, with the primary care service and the Clinical Strategy and Programmes Directorate.
  - Complete procurement process for the Telecare project to support older people at home and commence implementation.
  - Work with DoH on the development and roll out of the Dementia Strategy.
  - Monitor implementation of four pilots of the HSE / Genio Dementia Project.

- Progress the Single Assessment Tool (SAT) for older people to ensure a robust equitable standardised care needs assessment nationally. Begin implementation of the SAT in 2013 addressing key areas such as funding, governance, ICT and procurement, resource utilisation groups / case mix, education and dissemination, and early adopter sites for implementation.

2013 Actions

Priority Area	Action 2013	End Q
Quality Long Stay Residential Care	**Nursing Homes Support Scheme – A Fair Deal**	
	⌐ Support 22,761 clients under NHSS in 2013	Q4
	⌐ Rationalise the number of Nursing Home Support Offices processing applications under the scheme	Q4
	⌐ Participate in the substantive DoH review of the scheme	Q2 Future Health Action 38
	Public Residential Care Settings for Older People	Q1
	⌐ Provide an agreed level of public long stay residential beds for 2013 based on outcome of viability review	
	Efficiency - Skill Mix and Rostering	
	⌐ Continue to review and reduce the ratio of nursing to non-nursing direct care in public long stay units to gain further efficiencies in staff costs, aligned to patient dependency and national quality and safety key performance indicators in line with best practice	Ongoing
	⌐ Explore and examine alternative cost effective models of skill mix and rostering used in private sector and outside state with a view to reducing 2012 cost of care and increasing efficiencies in line with best practice	Ongoing
	Reconfiguration of Hospital and Public Residential Facilities	
	⌐ In light of 2012 Viability Review, develop a plan for future provision of public long stay facilities in each region for 2014 - 2015	Q4
	⌐ Review and determine short term bed requirements for rehabilitation (< 12months) / respite, short stay, step up / step down and assessment beds	Q1
	⌐ Identify, within public bed stock, number of beds that can be converted to meet short term bed requirement	Q1
	⌐ Examine and review alternative models of long stay care with a view to finding alternative and more efficient solutions for the shortage of long stay beds which will occur over the next 4 years based on population projections and identified need	Q4
	Standardise Residential Services Charges for Older Persons	
	⌐ Optimise income collection for long stay residential care	Q1
Comprehensive Home and Community Supports	**Home Care**	Q1-Q4 Future Health Action 34
	⌐ Implement the *National Quality Guidelines for Home Care Support Services* on phased basis to include VFM and service delivery	
	Home Help Service	
	⌐ Implement the *National Home Help Guidelines* on a phased basis to ensure effective and efficient delivery of service	Q4
	Home Care Packages	
	⌐ Repeat tender process for HCPs in 2013	Q1-Q2
	Provision of equitable ancillary care / aids and appliance services to all older persons	
	⌐ Complete work of National Ancillary Group to put in place standardised processes around the delivery of these services to both the community sector and the residential sector within available resources	Q2
Keep Older People Healthy and Out of Hospital	Work with DoH in implementing *National Positive Ageing Strategy* recommendations	Q1-Q4
	Work with DoH on development and roll out of Dementia Strategy	Q1-Q4
	Support the HSE / Genio Dementia Project to outline community based supports and implement	Q4
	Implement (on a phased basis) recommendations from the Strategy to Prevent Falls and Fractures in Ireland's Ageing Population, with the primary care service and the Clinical Strategy and Programmes Directorate. *(Agreement between Clinical Indemnity Scheme and HSE Services for Older People to each supply 0.5WTE to work on implementing Falls Strategy in 2013)*	Q4
	Telecare Project	
	⌐ Initiate a procurement process for the Telecare project to support older people at home and implement	Q2
	⌐ Begin to implement the Telecare project to support older people at home	Q4
	Elder Abuse - Protection of Older People – *Protecting Our Future*	
	⌐ Provide a timely / appropriate response to allegations of elder abuse in line with agreed performance measures	Q1-Q4
	⌐ Review all referrals of abuse at least six monthly	Q1-Q4

Priority Area	Action 2013	End Q
Standardised Assessment in Community and Acute Settings	Single Assessment Tool (SAT) ⌐ Establish governance structures for SAT and prepare and develop ICT procurement	Q1-Q3 Future Health Action 35
	⌐ Agree and roll out Early Adopter Sites, an Education and Development Programme and Case-Mix / Resource Utilisation Groups	Q2-Q4

Scorecard 2013

Services for Older People Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Home Care Packages Total no. of persons in receipt of a HCP	10,870	Quality, Access and Activity	No. of long stay residents in public and voluntary nursing homes admitted before 27 Oct 2009 (saver cases)	2,200
i). No. and % direct provision	3,308 30.4%		Public Beds No. of NHSS Beds in Public Long Stay Units	Subject to viability plan
ii). No. and % indirect provision	7,562 69.5%		No. of Short Stay Beds in Public Long Stay Units	Subject to viability plan
iii). No. and % cash grants	955 8.7%		Average length of Stay for NHSS clients in Public, Private and Saver Long Stay Units	New PI
iv). No. and % respite	41 0.4%		% of population over 65 years in NHSS / Saver Beds (based on 2011 Census figures)	New PI
v). No. and % multiple types	818 7.6%			
No. of HCPs provided	5,300		Elder Abuse No. of new referrals by region	2,640
No. of new HCP clients, annually	4,800			
Home Help Hours No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	10.3m		No. and % of new referrals broken down by abuse type: i). Physical	---
No. of people in receipt of home help hours (excluding provision of hours from HCPs)	50,002		ii). Psychological	---
			iii). Financial	---
Day Care No. of day care places for older people	21,460		iv). Neglect	---
			No. of active cases	---
NHSS No. of people being funded under NHSS in long term residential care at end of reporting month	22,761		% of referrals receiving first response from senior case workers within four weeks	100%
No. and proportion of those who qualify for ancillary state support who chose to avail of it	Demand-led		Finance Variance against Budget: Income and Expenditure	≤ 0%
% of complete applications processed within four weeks	100%		Variance against Budget: Income Collection	≤ 0%
Subvention and Contract Beds No. in receipt of subvention	700		Variance against Budget: Pay	≤ 0%
			Variance against Budget: Non Pay	≤ 0%
No. in receipt of enhanced subvention	380		Variance against Budget: Revenue and Capital Vote	≤ 0%
No. of people in long term residential care who are in contract beds	1,250		Human Resources Absenteeism rates	3.5%
			Variance from approved WTE ceiling	≤ 0%

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

Dublin Mid-Leinster

- Baltinglass Community Hospital, Co. Wicklow - upgrade and refurbishment

Dublin North East

- Cuan Ros Community Nursing Unit (CNU), Dublin - refurbishment
- Lusk CNU, Co. Dublin- refurbishment
- St. Oliver Plunkett Hospital, Dundalk – refurbishment (phase 1)
- St. Joseph's CNU, Trim, Co. Meath - refurbishment (phase 1 and 2)
- St. Oliver Plunkett Hospital, Dundalk - refurbishment (phase 1)

South

- CNU, Kenmare, Co. Kerry - Kenmare Community Hospital replacement
- CNU, Wexford – (Older People / Mental Health) 50 bed CNU to relocate and accommodate current residents from Ely Hospital, Wexford and facilitate current residents of St. Senan's Hospital

West

- Borrisokane, Tipperary - a day hospital / day centre for the elderly on existing (convent) site (funding source not yet confirmed)

DISABILITY SERVICES

Introduction

The publication, in July 2012, of the *Report of the Value for Money and Policy Review of the Disability Services Programme* (VFM) provides the framework within which significant change will be implemented in Disability Services. This includes changes to the governance, funding and focus of provision, positively impacting on the way in which people with disabilities are supported to live the lives of their choice. This requires significant realignment and reconfiguration of existing resources with a decreasing budget and staff complement.

The report emphasises:

- Migration from an approach which is predominantly organised around group-based service delivery towards a model of person-centred, individually chosen supports, and
- Implementation of a more effective method of assessing need, allocating resources and monitoring resource use.

It points the way towards the achievement of optimal effectiveness and efficiency within the existing substantial resources expended on health and personal services for people with a disability. In respect of children with disabilities, a key priority for 2013 is the continued roll out of the 0-18s Programme which envisages the establishment of integrated, geographically based Early Intervention and School-Age Teams. This and the other policy programmes currently being implemented will help to achieve many of the aims of the report. The HSE will manage and direct the migration towards a person-centred model of services and supports, through demonstration projects initiated by service providers as proof of concept, which will run in parallel with current services. Their suitability for wider application will then be evaluated.

The report lays the foundation for a system of individualised budgeting whereby a monetary value is placed on the supports required by the individual and they have more control over how that resource is allocated. This must be underpinned by a fair, transparent and standardised assessment of need. In order to address the recognised need for an assessment tool that can align to an allocation of resources, the HSE has been collaborating with the National Disability Authority (NDA) and the DoH in identifying an appropriate tool. The development and implementation of the assessment tool and resource allocation model are a priority as they provide the necessary infrastructure to support other key recommendations.

The *VFM and Policy Review* provides the vision and parameters within which the HSE will take action to implement agreed policy. Strengthening the management of the Service Agreement process with funded agencies and the collection of verifiable data, linked to activity and service delivery outputs, will be priority actions for implementation. An early examination will commence of the VFM findings in regard to rosters, skills mix, the unit cost base and average costs across the HSE-funded agencies in the sector.

It is recognised that the VFM recommendations will be implemented over a period of years during which we can expect there to be continued pressure on available resources. The allocation for disability services will be reduced by 1.2% in 2013, its share of the estimate reduction.

In addition, the HSE also recognises that during the course of 2012, 642 young people leaving school and rehabilitative training courses, and those requiring emergency placements, were accommodated within existing resources. We can expect similar, additional demand in 2013 which must be taken into account when planning services. €4m additional funding in 2013 is being targeted to school leavers.

The outcome of current discussions preceding the creation of the Child and Family Support Agency will have significant implications for disability services. Interagency protocols and service pathways must be developed to ensure that children with disabilities receive support in a seamless manner. In particular, the impact of the potential movement of personnel currently available to the users of disability services (and funded through disability services) to the new agency, thus putting increased pressure on disability services, must be monitored. The establishment of the Directorate structure within the HSE will also require the establishment of protocols and pathways to govern interaction between Directorates.

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
15,288	15,180	1,554	1,535	- 1.2%

2013 Key Priorities

- Implementation of the *Value for Money and Policy Review of Disability Services* is the overarching priority for 2013. We will develop an implementation plan for VFM, strengthen the National Disability function in order to put the plan into effect, and commence associated actions, including an early examination of critical rostering, skill mix and costing variables across the sector. The following items will also be addressed:
  - Further develop a national assessment and resource allocation model.
  - Improve efficiency in the delivery of services.
  - Develop a commissioning and procurement framework.
  - Reconfigure the following areas in accordance with agreed policies:
    - Services for children and young people
    - Residential services
    - Day services
    - Respite services
    - Neuro-rehabilitation services.
- Improve the quality of disability services, which will include:
  - Preparing for and implementing national HIQA standards for residential services for children and adults.
  - Implementing phase 2 of the audit of client protection.
  - Preparing for the *Children First Guidelines* being put on a legislative footing.
- Improve information systems for disability services, which will include:
  - Further developing the Service Agreement process as a source of data.
  - Under the auspices of the DoH, reviewing the strategic information requirements needed for the effective management of the Disability Services Programme, having regard to existing information sources and datasets.
  - Further review of and developing the PI set especially in respect of the incorporation of outcome-based PIs.

2013 Actions

Priority Area	Action 2013	End Q
Implementation of the Value for Money and Policy Review of Disability Services	Strengthen the National Disability Function in order to implement the VFM Report - This will be addressed within the new Directorate structure following the appointment of the National Director of Social Care	Ongoing
	Further develop a national assessment and resource allocation model, in conjunction with the NDA and the DoH - Identify an appropriate assessment tool to measure individual support levels	Q1 Future Health Action 36 & 39
	- Identify a method of matching support level to level of resource required	Q2
	- Develop a methodology for testing the new model	Q3
	- Commence testing of the new model of resource allocation	Q4
	Improve efficiency in the delivery of services - Strengthen capacity to manage the Service Arrangement process at national, regional and local levels with the appropriate knowledge and skills in the areas of procurement, financial accounting and service provision	Q1

Priority Area	Action 2013	End Q
	⌐ Support statutory and non-statutory providers to reconfigure their skill mix and rostering practices with a view to improving effectiveness and efficiency	Q1
	Develop a commissioning and procurement framework ⌐ Develop a market-shaping, commissioning and procurement framework	Q1
	⌐ Demonstrate the procurement process and evaluate it using personal assistance services	Q3
	⌐ Identify the potential for procurement of other disability services with particular emphasis on respite services	Q4
	Reconfigure the following areas in accordance with agreed policies: Services for children and young people ⌐ Develop a plan to position specialist services (such as those for complex ASD (autistic spectrum disorder), individualised seating, etc) in accordance with the 0-18s Programme while ensuring maintenance of specialist knowledge and its availability to children and young people according to their needs	Q2
	⌐ Finalise regional and area implementation plans for the reconfiguration of Children's Disability Teams	Q2
	⌐ Ensure that the processes under the *Disability Act 2005* are developed in such a way as to facilitate the implementation of the 0-18s Programme	Q1-Q4
	⌐ Develop inter-sectoral working protocols with primary care, mental health, child and family services and social inclusion to enhance quality and experience of service for children and young people	Q2
	Residential Services ⌐ Compile a database of the number of people currently resident in congregated settings	Q1
	⌐ Identify individuals who can move in 2013 from congregated settings without the necessity of additional resources	Q1
	Day Services (*New Directions* - National Implementation Group) ⌐ Develop a Quality Standards Framework for Day Services based on the *Standards for Safer Better Healthcare*	Q3
	⌐ Work with Genio to evaluate the development of services for school leavers with a view to enhancing this in 2013	Q1
	Respite Services ⌐ Develop procedures and governance arrangements to facilitate the implementation of the recommendations of the *Report of the Working Group on Respite / Residential Care with Host Families in Community Settings*	Q2
	⌐ Work with Genio to establish demonstration sites aimed at moving people from traditional models of respite care to alternative models such as Host Family Support	Q2
	Neuro-rehabilitation Services Map and develop ISA level rehabilitation networks	Q1
	Implement the model of care for rehabilitation services within the networks with focus on community rehabilitation teams	Q2-Q4
Improving the Quality of Services	Prepare for and implement standards for residential services for children and adults ⌐ Identify appropriate grades / positions in respect of 'Fit Person' and 'Person in Charge' and provide information and support in advance of implementation	Q1-Q4 Future Health Action 37
	⌐ Develop a process, ensuring that the welfare of service users is paramount, to address any closures enforced following HIQA inspections.	Q1-Q4
	Implement phase 2 of the audit of client protection ⌐ Complete phase 2 audit and compile action plan	Q4
	Prepare for the *Children First Guidelines* being put on a legislative footing ⌐ Finalise a disability specific Children First Implementation Guide to support organisations in implementation of *Children First* comprising: - A Child Protection and Welfare Policy, Procedures and Practices development tool kit - A compliance checklist	Subject to legislation being published: Q1-Q4
	⌐ Develop an information and training module in *Children First* requirements and use of the Guide delivered using the HSEland web site	Q1-Q4
	⌐ Collaborate with the Child and Family Support Agency on the roll out of Train-the-Trainers programme for revised Children First	Q1-Q4
	⌐ Develop a monitoring and reporting framework for organisation compliance with *Children First* using the service agreement process and Performance Reporting System	Q1

Priority Area	Action 2013	End Q
	⌐ Implement the monitoring and reporting framework for organisation compliance with *Children First*	Q4
Improvement of Information Systems	Further develop the Service Agreement process as a source of data In conjunction with service providers and in line with the recommendations of the VFM Report, improve the process as a source of data by: ⌐ Agreeing revised documentation	Q1
	⌐ Training staff on revised requirements	Q1-Q2
	⌐ Improving the compilation and maintenance of data	Q1-Q4
	Under the auspices of the DoH, review the strategic information requirements needed for the effective management of the Disability Services Programme, having regard to existing information sources and datasets ⌐ Review resources currently engaged in data collection with a view to rationalisation	Q1
	⌐ Based on a review of strategic information requirements, develop a strategic information framework and work plan which takes account of the following: - The requirements of the developing resource allocation model - The requirements of the *Disability Act 2005* - The information and case management requirements of service providers - The requirements of the service planning process	Q4
	⌐ Work with ICT Directorate to develop a proposal to provide an IT system that will support the work of Early Intervention and School-Age Teams and facilitate the progression of the 0-18s Programme	Q1
	Further review and develop the PI set especially in respect of incorporating outcome-based PIs ⌐ Develop an implementation plan in respect of the recommendations contained in section 8.3. of the VFM and Policy Review	Q4

Scorecard 2013

Disability Services Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
Day Services No. of work / work-like activity WTE places provided for persons with intellectual disability (ID) and / or autism	1,557	Quality, Access and Activity	No. of home support hours delivered to adults and children with physical and / or sensory disability	New subset
No. of persons with ID and / or autism benefiting from work / work-like activity services	3,123		No. of adults and children with an intellectual disability and / or autism in receipt of home support hours	New PI
No. of work / work-like activity WTE places provided for persons with physical and / or sensory disability	72		No. of home support hours delivered to adults and children with an intellectual disability and / or autism	New PI
No. of persons with physical and / or sensory disability benefiting from work / work-like activity services	144		Disability Act Compliance No. of requests for assessments received	3,501
No. of Rehabilitative Training places provided (all disabilities)	2,627		No. of assessments commenced as provided for in the regulations	3,294
No. of persons (all disabilities) benefiting from Rehabilitative Training (RT)	2,948		No. of assessments commenced within the timelines as provided for in the regulations	3,294
No. of persons with ID and / or autism benefiting from Other Day Services (excl. RT and work / work-like activities)	13,382		No. of assessments completed as provided for in the regulations	3,294
No. of persons with physical and / or sensory disability benefiting from Other Day Services (excl. RT and work / work-like activities)	2,793		No. of assessments completed within the timelines as provided for in the regulations	3,294
Residential Services No. of persons with ID and / or autism benefiting from residential services	8,172		No. of service statements completed	2,766
No. of persons with physical and / or sensory disability benefiting from residential services	847		No. of service statements completed within the timelines as provided for in the regulations	2,766
Respite Services No. of bed nights in residential centre based respite services used by persons with ID and / or autism	213,346		Services for Children and Young People % of Local Implementation Groups which have Local Implementation Plans for progressing disability services for children and young people	100%

Disability Services Scorecard				
Performance Indicator	Target 2013		Performance Indicator	Target 2013
No. of persons with ID and / or autism benefiting from residential centre based respite services	5,087		No. of established geographically based teams having current individualised plans for each child	New PI
No. of bed nights in residential centre based respite services used by persons with physical and / or sensory disability	32,917		% of established geographically based teams having current individualised plans for each child	New PI
No. of persons with physical and / or sensory disability benefiting from residential centre based respite services	2,571		Finance Variance against Budget: Income and Expenditure	≤ 0%
Personal Assistant (PA) / Home Support Hours Total no. of home support hours (incl. PA) delivered to adults and children with physical and / or sensory disability	1.68m		Variance against Budget: Income Collection	≤ 0%
			Variance against Budget: Pay	≤ 0%
Total no. of adults and children with physical and / or sensory disability benefiting from home support hours (incl. PA)	4,166		Variance against Budget: Non Pay	≤ 0%
No. of adults with a physical and / or sensory disability in receipt of PA hours	New subset		Variance against Budget: Revenue and Capital Vote	≤ 0%
No. of PA hours delivered to adults with a physical and / or sensory disability	New subset		Human Resources Absenteeism rates	3.5%
No. of adults and children with physical and / or sensory disability benefiting from home support hours	New subset		Variance from approved WTE ceiling	≤ 0%

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2013. (See also Appendix C)

South

- Cope Foundation Montenotte, Cork - open 8 bed residential specialist unit for adults with major challenging behaviour (funding not currently available to open this unit)

CHILDREN AND FAMILY SERVICES

Introduction

The *Programme for Government* undertook to fundamentally reform the delivery of child protection services by removing child welfare and protection from the HSE, creating a dedicated Child and Family Support Agency, reforming the model of service delivery and improving accountability to the Dáil.

In July 2012, the Minister for Children and Youth Affairs published the *Report of the Task Force on the Child and Family Support Agency,* clearly setting out the vision, governance and service model in the way forward for child and family services in Ireland. The report proposed the most significant shift in child welfare in the history of the State, with a single dedicated State agency overseen by a single dedicated government department, all focused on providing a single continuum of services committed to children's wellbeing and protection. At the heart of the new Agency will be a new Service Delivery Framework, which will differentiate between high and low risk child welfare and protection cases, such that lower risk family and child welfare concerns can be responded to by mobilising the community and voluntary sector as well as through direct provision.

Legislation to support the establishment of the Agency will be enacted in 2013. The foundations of this change agenda were laid in 2012 in regard to organisational and accountability arrangements. The year 2013 will see the process progressed under the existing HSE Child and Family Programme while preparing for the full move to the new Agency. This transitional process will occupy a considerable amount of management time and attention as well as attending to core business. Corporate support from the HSE in facilitating the transitions is also of critical importance. The Child and Family Support Agency and the National Educational Welfare Board will form part of the new Agency when established. Other services are likely to follow in due course in line with Government decisions following its consideration of the *Report of the Task Force on the Child and Family Support Agency.*

All policy and strategic priorities within this service plan are directed towards the disaggregation from the HSE and the merger of Children and Family Services with other services to form the new Agency. During 2012 a national management team, regional support and area management arrangements were put in place to support the Agency's functions. In 2013 organisational structure below Area Manager will be designed and implemented.

Meanwhile cost containment and budgets designed around core service priorities are key objectives for 2013.

Resources

National WTE Numbers		Budget Allocation		
End Dec. 2012 Ceiling	End Dec. 2012 Projection	2012 €m	2013 €m	% change
3,552	3,527	544	541	- 0.5%

2013 Key Priorities

- Prepare for the transition of responsibilities to the new Child and Family Support Agency.
- Deliver statutory services for the care and protection of children in keeping with the HIQA *Standards for the Protection and Welfare of Children* and anticipated legislation including the placing of *Children First, the National Guidelines for the Protection and Welfare of Children, 2011* on a statutory footing and adoption reform legislation.
- Work to ensure full implementation of Children First across relevant health services and prepare for any future statutory requirements relating to implementation.
- Promote quality and safe services underpinned by sound knowledge and information management.
- Cultural change and reforms necessary to provide a comprehensive range of service for children in care.

- Promote effective multidisciplinary shared practice and efficient community engagement.
- Develop a Workforce Development Strategy aimed at sustaining an efficient, professional and supported workforce within a culture of continuous learning.

2013 Actions

Priority Area	Action 2013	End Q
Prepare for the establishment of the Child and Family Support Agency	Progress transition arrangements with the Department of Children and Youth Affairs (DCYA)	Q1
	Design and implement management structures under Area Manager	Q2
	Completion of staff and resources census	Q1
	Agree protocols with Primary Care, Disability Services and Mental Health Services	Q1
Delivery of statutory services	Maintain progress to ensure that all children in need of care and protection are assessed in a timely fashion, have an allocated social worker and defined care plans, which are reviewed as per the regulations: - Review the use of Interim Care Orders	Q1
	- Increase use of supervision and other protective strategies to maintain children at home safely	Q2
	- Monitor adherence to the new HIQA *Standards for the Protection and Welfare of Children*	Q1
	- Prepare services for obligatory reporting of concerns under *Children First* when placed on a statutory footing	Q3
	- Prepare for adoption reform legislation	Q3
	- Assessment of impact of Children's Referendum on services, policy and practice	Q1
	- Reform of private foster care to ensure placement in accordance with need and value for the tax-payer	Q1
	- Reform of the residential sector with emphasis on individual need, occupancy and unit cost	Q3
	- Further development of Emergency Out of Hours Services in Limerick, Cork, Waterford and Galway	Q3
	- Reform of the NGO sector to ensure service delivery in line with top priorities and value for money	Q2
	- Integrate and develop child sexual abuse and treatment services in conjunction with primary care, acute hospitals and the NGO sector	Q1
Implement Children First	- Sustain implementation of *Children First* including advice and support to external organisations and quality assuring compliance with policies and procedures	Q4
Promote quality and safe services	Develop a Quality Assurance Strategy in conjunction with staff at all level	Q3
	Finalise migration of risk management from HSE Corporate to Children and Family Services	Q1
	Develop a Performance Management System	Q3
	Introduce new data metrics and associated IT	Q1
Cultural change and reforms necessary to provide a comprehensive range of high quality services for children	Provide time in care which is commensurate with the child's needs through the development and implementation of an integrated children services programme - Develop a Corporate Parenting Strategy for children and family services	Q3
	- Develop standardised polices and procedure manuals that are child centred and focused	Q3
	Ensure that there is up to date, timely, and accurate data on the number and circumstances of all children in the care system - Introduce a Management Information Framework including linking care activity with financial and human resources	Q2
	Complete the reform and modernisation of the special care service and associated therapeutic interventions - Establish a national therapeutic team for children in care and detention	Q3
	- Monitor implementation of the HSE aftercare policy	Q4
	- Conduct exit interviews with children leaving or changing care placements	Q2
	- Commence data collection regarding children from ethnic minority backgrounds	Q1
	Develop a National Service Delivery Model - Develop and implement eligibility thresholds for intake and initial assessment	Q3
	- Develop and implement Local Area Pathways	Q3

Priority Area	Action 2013	End Q
	⌐ Consistent implementation of Child Protection Notification System	Q3
Promote effective multidisciplinary shared practice and efficient community engagement	Implement a Change Management Plan for multi-agency working	Q3
	Take forward consistent family support arrangements as per the Family Support Action plan ⌐ Disseminate and implement a national and local commissioning strategy for community / voluntary sector	
	⌐ Develop a framework for involvement of children and young people in service planning and evaluation	
	⌐ Disseminate and implement the Supporting Parents Strategy	Q3
	Continue to support the Children's Services Committees and contribute to the departmental review of future initiatives in this area	Q4
	Promote Quality Assurance Systems in Early Years Inspectorate ⌐ Commence implementation of National Agreed Standards, operating policies / procedures with related business processes for the Early Years Inspectorate	Q1
	⌐ Continued phase implementation of the National Pre-School Standards	Q1
	⌐ Develop a regulatory registration system for Early Years services	Q4
	Implement the HSE Actions in the HSE *Policy on Domestic, Sexual and Gender-based Violence* and our actions under the Cosc *National Strategy* ⌐ Implement a National Training Pack on Domestic Violence and Sexual Violence and associated training	Q1
	⌐ Develop and audit standards for Domestic Violence and Sexual Violence Services	Q2
	⌐ Establish local and national frameworks for service user involvement in service planning, design, development, and evaluation	Q2
	⌐ Ensure robust data collection in relation to HSE-funded services for Domestic and Sexual Violence Services	Q2
	⌐ Review expenditure on service provision for Domestic and Sexual Violence Services	Q2
	⌐ Participate in the Sex Offender Risk Assessment Management (SORAM) national and local committees with the Probation Service and An Garda Síochána	Q4
Work Force Development	Develop a Children and Family Services Workforce Development Strategy incorporating a national structure and work programme that reflects national priorities and addresses continuous professional development needs for relevant staff	Q3
	Deliver the 2013 national training plan based on agreed national priority training areas	Q4
	Introduce the Continuous Professional Development Strategy	Q2
	Implement, on a phased basis, the revised National Child and Family Services Staff Supervision Policy (2012) and associated training for supervisors and supervisees	Q1
	Implement rotation of social workers across child care, child protection and welfare teams where appropriate	Q3
	Establish a probationary year of limited caseload, supervision and support for newly qualified social workers	Q2
	Enhance practice placement supports for social work students	Q3
	Deliver ongoing training throughout 2013 in relation to *Children First* including basic training to relevant staff, training the trainers, joint social work / Garda training and evaluation of the training process	Q4

Scorecard 2013

Children and Family Services Scorecard				
Performance Indicator / Activity	Target 2013		Performance Indicator / Activity	Target 2013
After Care No. of young adults aged 18 to 20 (inclusive) in receipt of an aftercare service on the last day of the reporting period	1,363	Quality, Access and Activity	iii). No. and % of children in residential general care with an allocated social worker	100%
No. of young adults aged 18 to 20 (inclusive) in receipt of an aftercare service who are in full time education on the last day of the reporting period	703		iv). No. and % of children in foster care general with an allocated social worker	100%
Child Protection – Child Abuse i). No. of referrals of child abuse	Demand-led		v). No. and % of children in foster care with relatives with an allocated social worker	100%

Children and Family Services Scorecard

Performance Indicator / Activity	Target 2013	Performance Indicator / Activity	Target 2013
ii). % of referrals of child abuse where preliminary enquiry(s) (National Intake Form) took place and were completed within 24 hours of receipt of the referral	74%	vi). No. and % of children in other care placements with an allocated social worker	100%
iii). % of referrals of child abuse which required an initial assessment following a preliminary enquiry	72%	Care Planning No. and % of children in care who currently have a written care plan as defined by *Child Care Regulations 1995*, at the end of the reporting period	100%
iv). % of these initial assessments completed within 21 days of receipt of the referral	25%		
v). % of initial assessments which led to the child being listed on the Child Protection Notification System (CPNS)	Demand-led	i). No. and % of children in residential special care with a written care plan	100%
Child Protection – Child Welfare i). No. of referrals of child welfare concerns	Demand-led	ii). No. and % of children in residential high support with a written care plan	100%
ii). % of referrals of child welfare concerns where preliminary enquiry(s) (National Intake Form) took place and were completed within 24 hours of receipt of the referral	60%	iii). No. and % of children in residential general care with a written care plan	100%
iii). % of referrals of child welfare concerns which required an initial assessment following a preliminary enquiry	55%	iv). No. and % of children in foster care general with a written care plan	100%
iv). % of these initial assessments completed within 21 days of receipt of the referral	30%	v). No. and % of children in foster care with relatives with a written care plan	100%
v). % of initial assessments which led to the child being listed on the Child Protection Notification System (CPNS)	Demand-led	vi). No. and % of children in other care placements with a written care plan	100%
Residential and Foster Care No. and % of children in care by care type on the last day of the reporting period	6,560	Foster Carer Total no. of foster carers	4,658
i). Residential Special Care	23	No. and % of foster carers approved by the foster care panel	88%
ii). Residential High Support	18	No. and % of relative foster carers where children have been placed for longer than 12 weeks whilst the foster carers are awaiting approval by the foster care panel, Part III of Regulations	90%
iii). Residential General Care (Note: Include special arrangements)	346		
iv). Foster care General (not including day fostering)	4,142	No. and % of approved foster carers with an allocated worker	90%
v). Foster care with relatives	1,888	Out of Hours No. of referrals made to the Emergency Out of Hours Place of Safety Service YTD at end of Q3 2012	518
vi). Other care placements	143		
Private Residential Care No. and % of children in private residential care: Special Care	6	No. of children placed with the Emergency Out of Hours Placement Service YTD at end of Q3 2012	427
		No. of nights accommodation supplied by the Emergency Out of Hours Placement Service YTD at end of Q3 2012	2,408
No. and % of children in private residential care: High Support	2	Early Years Services No. of notified early years services in operational areas at Q3	4,705
No. and % of children in private residential care: residential General	134	% of early years services which received an inspection	42.1%
No. and % of children in foster care private: Foster care General	215	No. and % of early years services that are fully compliant at Q3 YTD	21.7%
No. and % of children in other care placements in private care	14	No. of notified full day early years services at Q3	1,611
No. of children in single care residential placements	7	% of full day services which received an annual inspection at Q3 YTD	43.4%
No. of children in residential care age 12 or under	32	% of complaints investigated	100%
Children in Care in Education i). No. of children in care aged 6 to 16 inclusive	4,544	Finance Variance against Budget: Income and Expenditure	≤ 0%
ii). No. and % of children in care between 6 and 16 years, in full time education	4,399	Variance against Budget: Income Collection	≤ 0%
Allocated Social Workers No. and % of children in care who have an allocated social worker at the end of the reporting period:	100%	Variance against Budget: Pay	≤ 0%
		Variance against Budget: Non Pay	≤ 0%

Children and Family Services Scorecard				
Performance Indicator / Activity	Target 2013		Performance Indicator / Activity	Target 2013
i). No. and % of children in residential special care with an allocated social worker	100%		Variance against Budget: Revenue and Capital Vote	≤ 0%
ii). No. and % of children in residential high support with an allocated social worker	100%		Human Resources Absenteeism rates	3.5%
			Variance from approved WTE ceiling	≤ 0%

Supporting Financial and Structural Reform

CORPORATE SUPPORT SERVICES

Introduction

The health service is facing major challenges in 2013 and will require now more than ever, the essential support provided by corporate services to enable the HSE to fulfil all its functions as efficiently and cost effectively as possible. Corporate support services play a crucial role in the organisation with core support operations contributing to the efficient running of all areas of front line service and impacting on the quality of service delivered.

A number of key business actions need to be undertaken in 2013 in order to deliver on our legal commitments set out in the National Service Plan (NSP) 2013. These actions include how we are going to address delivering services at reduced costs within vote and employment ceiling and how we will continue to manage and improve on value for money (VFM).

Government's framework for health reform *Future Health, A Strategic Framework for Reform of the Health Service 2012 – 2015* aims at changing many aspects of the health service, including areas associated with back office functions such as financial reform. The financial reforms envisaged are designed to ensure that the financing system is based on incentives that promote fairness and efficiency, while also reducing costs, improving control and improving quality. In addition, health system structures will be changed in order to promote good governance, avoid duplication and ensure a strong regional focus in managing performance and delivering value for money.

The following sections detail key deliverables for our corporate support services in 2013 and are reflective of Government's programme for reform including key areas such as:

- Developing financial management systems
- Supporting the implementation of all ICT enabled health service and e-health initiatives
- Improving acute hospital and community health infrastructures
- Supporting succession requirements at senior management level, and
- Agreeing action plan for integrated workforce planning strategy.

Finance

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.

2013 Key Priorities

- Implement a single financial system.
- Enhance performance reporting.
- Re-organise Finance structures.
- Improve management and process for income collection.
- Develop resource allocation models and frameworks.
- Implement Shared Services and a National Accounts Payable system.
- Value for money – drive value and productivity.
- Enhance Finance functions.
- Continue to develop a risk management focus and culture throughout Finance.
- Support the implementation of the 2013 related *Future Health* actions.

2013 Actions

Priority Area	Action 2013	End Q
Financial Systems	Continue to work with the DoH to establish the most cost effective approach for the development and implementation of a single financial system that will meet the HSE's requirements, and to secure the required investment. This system will provide detailed financial management information to support decision making at local, regional and national level	Q1-Q4
	Work with the DoH to ensure the development and rollout of a comprehensive financial management system as a matter of priority	Q1-Q4 Future Health Action 21
Performance Reporting	Budget Management ⌐ Continue to enhance management information and support evidential based decision making	Q1-Q4
	Regional Performance Reporting ⌐ Continue to develop regional performance reporting in the context of the changing organisational structure	Q1-Q4
	Align Value for Money (VFM) with both the broader HSE cost management plans, resource use, service levels and outcomes data towards developing and driving productivity and value reporting	Q1-Q4
Finance Structure	Re-organise the finance structure to meet the evolving service management structure	Q1-Q4
Income Collection	Accelerate income collection and simplify the process of charging in collaboration with the DoH	Q1-Q4
	Develop phase 2 of national income reporting	Q1-Q4
	Implement phase 2 of national claims management system across hospital sector	Q1-Q4
Resource Allocation	Continue to develop patient level costing in line with Five Year Strategy - Vision for the development of patient costing in Ireland	Q1-Q4
	Further develop an output based payment system for orthopaedics	Q1-Q4
	Support the development of a prospective funding model for palliative care	Q4 Future Health Action 41
	Support the development of a Resource Allocation Framework	Q4 Future Health Action 36
Shared Services and National Accounts Payable System	Implement shared services on an incremental basis including the re-alignment of all transaction processing (Accounts Payable (AP) and Payroll) staff to the Financial Shared Services (FSS) structure	Q1-Q4
	Develop and implement a national accounts payable strategy for invoice processing and payments across the HSE following realignment of all AP staff to FSS structure	Q1-Q4
	National Payroll System ⌐ Develop and implement the national payroll solution (following the national payroll strategy submission in October 2012)	Q1-Q4
Value for Money	Align VFM with the broader HSE cost management plans, the resource use, service levels and outcomes data, towards developing and driving productivity and value reporting	Q1-Q4
Finance Function and other support systems	Provide financial expertise to non finance managers within resources available. Key areas to fill through an exemption from moratorium are in Fair Deal, Pensions, Primary Care Reimbursement Service (PCRS), Hospitals and Corporate Finance	Q1-Q4
	Capital payments ⌐ Carry out a review of the national capital payments system implemented in 2012	Q2
	Child Care ⌐ Support the extraction of the Child Care budget for 2013	Q1-Q4
	Fair Deal ⌐ Determine 2013 budgets for Fair Deal	Q1-Q4
	Disestablishment of HSE Vote ⌐ Work closely with the DoH on the preparatory work to return the Vote to the DoH for 2014	Q4 Future Health Action 18
	Development of Programme Based Budgeting ⌐ Work with the DoH and Department of Public Expenditure and Reform (DPER) to develop Programme Based Budgeting within the confines of existing financial systems	Q4
	Hospital reform and establishment of administrative hospital groups ⌐ Support the revised reporting arrangements required of the administrative hospital groups	Q4 Future Health Action 31

Priority Area	Action 2013	End Q
Risk Management	Continue to develop a risk management focus and culture throughout Finance function and define strategies to minimise identified financial risk	Q1-Q4
Assess Finance capacity to deliver on *Future Health*	An assessment on current and required capacity to deliver on actions within the *Strategic Framework for Reform of the Health Service (2012-2015)* will be carried out	Q1

Human Resources

The Human Resource (HR) Directorate is responsible for monitoring the employment control framework, monitoring and supporting the implementation of the *Public Service Agreement*, supporting the changes to the evolving structures / organisational design of the Health Services, effective work force planning, including succession management, implementing and deepening National HR Services in centralised recruitment, pensions management and personnel administration, and monitoring compliance with legislative responsibilities in; employment law, professional registers, and medical / education, training and research.

Maximising the role of staff to deliver the objectives in NSP2013 will require a strong focus this year. Against the backdrop of reduced budgets and staffing resources, the challenge is not only to maintain access, quality and safety of services but to continue to improve them.

Structural reform will be central to addressing current challenges with a key focus required on promoting good governance, avoidance of duplication and ensuring a strong focus on performance management and delivering value for money. The necessary reduction in the size of the health workforce must be accompanied by planning for the future needs of the service. It requires an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and up-skilling the workforce, providing for professional and career development and creating supportive and healthy workplaces. The threat to staff morale due to uncertainty, or a lack of clarity about the future, for organisations, and for individuals, must be minimised through effective communications, consultation and collaboration. Structural reform and the impact on the organisational design of Hospital Groups, Integrated Service Areas, Shared Services, and Corporate Functions and Resources will need to take account of effective workforce deployment and restructuring.

2013 Key Priorities

- Identify, address and manage the equivalence of almost a 4% reduction in the workforce in 2013, while adapting in ways that protect service levels to the maximum degree.
- Develop alternative exit strategies and implement to ensure reduction and cost savings / payroll savings targets can be met in 2013, with the minimum impact on service delivery.
- Further reduce the cost of labour, deliver cost reductions and payroll savings and manage the change agenda as set out in the *Public Service Reform* plan and *Future Health*.
- Introduce workforce measures to further reduce labour costs and monitor and control the use of more costly labour resources.
- Deliver cost effective and best value for money, while protecting front-line service delivery in the use of shared and combined services, coupled where necessary and the use of external sourcing and alternative resourcing to agency provision.
- Greater standardisation to facilitate the move to shared services.
- Remove duplication, achieve better efficiencies and allow for greater use of shared services within and across emerging structures through greater integration of the statutory and voluntary sectors.
- Ensure the reducing workforce is not offset by increased cost of alternative sourcing such as through overtime and agency. Alternative resourcing to agency provision is a key priority for 2013.
- Support the implementation of the framework for public health sector reform 2012 to 2015 as enunciated in *Future Health* from the HR and workforce perspectives.
- Ensure robust governance and management arrangements are in place to drive, manage and monitor implementation of the reform programme.

- Support leadership and management capacity through further development of both short-term and longer term succession requirements at senior management level and through the development of a series of leadership and learning sets in relation to governance, and quality and safety of health care delivery.

2013 Actions

Priority Area	Action 2013	End Q
Succession Management and Talent Development	Introduce and implement a succession management pilot programme in each region and specific areas as requested	Q1-Q4 Future Health Action 48
	- Provide coaching and mentoring support	
	- Review outputs to identify key development areas for senior managers	
	Develop plan for talent development	Q2
	Skill Programme - Implement re-structured, decentralised skill programme in line with VFM report	Q1
	Manpower planning - Develop and agree an action plan for implementing strategic goal (No. 2) of the *Integrated Workforce Planning Strategy*	Q1-Q2 Future Health Action 46
	- Work with other stakeholders to finalise an integrated approach to workforce planning in the HSE	Q1-Q2
Leadership Development	Implement Leadership and Management Development Strategy for senior managers incorporating design and delivery of bespoke development modules, incorporating medical and clinical managers	Q2-Q3 Future Health Action 47
	Employee Engagement - Implement the planned online employee engagement survey within the HSE	Q1
	- Agree actions and implement feedback facility	Q3
	Online development - Support the development and provision of online resources and solutions, which support learning and development activities across administrative and clinical staff within the greater health and social care Services	Q1-Q4
	- Support a blended learning approach for senior management development	Q2-Q4
	Health and Social Care Professionals (HSCP) - Work closely with the Higher Education Authority (HEA), the Higher Education Institutions (HEIs) and professional bodies in respect of course provision, student numbers, practice placement, fit for purpose for graduates and implications arising for the HSE	Q1
	- Support the maintenance and continuing development of knowledge and skills in the health and social care professions to maintain standards of competence, quality and safety (in accordance with the HIQA *Standards for Safer Better Healthcare*)	Q1-Q4
	- Continue to provide support to DoH in accordance with *Directive 2005/36/EC on the recognition of professional qualifications*, i.e. the validation of qualifications	Q1-Q4
	- Continue to proactively support the development of interdisciplinary working and integrated care through developing, encouraging and incentivising interdisciplinary education and development	Q1-Q4
	- Develop an implementation plan for the core principles on practice placement education for HSCPs in the HSE	Q1
	- Identify implications arising for the HSE as the registration of HSCPs progresses and work in liaison with relevant internal and external stakeholders	Q1-Q4
	- Provide a fully supported workplace mediation service for staff in the health and social care services	Q1-Q4
National Personnel Administration (NPA)	Rollout HR Electronic Document and Record Management System (EDRMS)	
	- HSE Dublin Mid-Leinster, Dublin North East, National Pensions Management (NPM) and National Recruitment Service (NRS)	Q2
	- HSE South and HSE West	Q3
	Pursue the transfer of responsibility of new employee set ups for former Midland Health Board (MHB) and North Eastern Health Board (NEHB) to NPA	Q4
	Continue to build service history records for all staff in former Eastern Regional Health Authority (ERHA)	Q4
	Extend service verification project nationally to all employees over 55 years of age	Q4

Priority Area	Action 2013	End Q
Pensions Management	Identify, calculate and pay retirees under the terms of the Lower Paid Workers Circular 19 and 20, 2005	Q3
	Meet pensions related responsibilities associated with:	
	⌐ Any targeted redundancy scheme	Q1
	⌐ The introduction of the *Public Service Pensions (Single Scheme and Other Provisions) Act 2012*	Q1
	Review and revise Leaving / Resignation Process and associated forms	Q1
	Continue structured and controlled processing of preserved pensions benefits cases for former North West Area	Q1
	Commence national roll out on a phased basis using an agreed standard national process	Q1
	Devise and implement a HSE national pension abatement process to ensure that pension abatement is applied where applicable in the case of rehired pensioners	Q1
	Finalise national plan to meet all compliance requirements as specified by Pensions Board (this will be a multi year plan)	Q2
	Address priority cases for retrospective review under Circular 8/2008 (best three in ten) in former North Western Health Board (NWHB) (approximately 1,000 cases require review)	Q1-Q4
HR Services	Complete ethics in public office	Q 1
	Gather all absences for HR Shared Services	Q1-Q4
	Implement travel pass scheme	Q1
	Implement cycle to work scheme	Q3
	Manage and process industrial relations cases	Q1-Q4
Staff Health Safety Welfare Department	Develop national guidelines, policies and procedures under health and safety	Q1-Q4
	Provide statutory and mandatory health and safety training for HSE employees on an ongoing basis as required under legislation	Q1-Q4
	Develop the health and safety training programme to meet HSE needs	Q1-Q4
	Provide competent health and safety advice and guidance to management and staff of the HSE	Q1-Q4
	Develop staff health, safety and welfare intranet site to provide information, guidance and advice to management and staff	Q1
National Recruitment Services	Implement an access data base system to ensure improved recruitment tracking facility	Q3
	Role out of Garda vetting process to existing employees	Q4
	Further use of innovative recruitment processes for high volume grades of staff	Q1
	Examine 'smart sourcing' of individual components of the recruitment process to drive efficiencies and improve and increase capacity	Q2
	Develop an appropriate online application system for all recruitment to the HSE	Q4
Voluntary Redundancy Scheme	Support the regions to implement the scheme, if and when agreed and manage reduced staffing levels while maintaining critical frontline services	Q4
Industrial Relations (IR)	Maintain a stable industrial relations climate in the health services utilising *Public Service Agreement* (PSA)	
	⌐ Continue to support the delivery of the objectives set out in the PSA Health Service Action Plan in six key areas where the operating model has to be fundamentally changed. Key areas are workforce planning, nursing, clinical, standardisation, allied health professionals, support grades / benchmarking	Q1-Q4 Future Health Action 45
	Address IR issues arising from realignment of services due to organisational changes to the structure of the HSE e.g. establishment of Hospital Groups	Q1-Q4
	Implement standardised annual leave arrangements for new entrants and new beneficiaries	Q1
	Support and co-ordinate implementation of Government decision on review of allowances including leading national discussions on allowances listed for further review and / or modification and allowances listed as a priority for elimination	Q1
National Joint Council	Ensure the interests of health service employers are represented at the National Joint Council, which continues to be the primary forum for the management of industrial relations in the health service	Q1-Q4
Employment Legislation	Develop policies and guidelines to support proper and consistent implementation of employment legislation and nationally negotiated agreements, including monitoring the implementation of the *Protection of Employees (Temporary Agency Work) Act 2012*	Q4

Priority Area	Action 2013	End Q
	Review Garda vetting policy once the *National Vetting Bureau (Children and Vulnerable Persons) Bill 2012* is enacted. This legislation provides for mandatory vetting of persons working with children or vulnerable adults and also provides for retrospective vetting	Q3
	Brief health service employers on developments in relation to reform of workplace relations structures arising from enactment of the *Workplace Relations (Law Reform) Bill 2012*	Q1-Q4
Third Party Representation	Continue to assist health service employers draw up submissions and provide representation at third party fora, including the Rights Commissioner Service, Labour Relations Commission, Labour Court, Equality Tribunal, Employment Appeals Tribunal and the Consultant Arbitration Process	Q1-Q4
	Continue to brief health service employers on important third party decisions and develop template for third party submissions for health service managers to ensure consistency and quality of submissions	Q1-Q4
HR Policy	Ensure a more standardised approach to HR policy in the HSE:	Q1-Q4
	⌐ Conversion of the sick pay scheme for officer grades to working hours as set out in DoH circular 10/71 (Section 9)	
	⌐ Implement circular on self-certified sick leave and apply agreed sick leave metrics	Q2
	⌐ Agree and implement revised policy on acting up in a higher capacity to ensure correct management and control of acting up arrangements and consistency across system	Q1
	⌐ Agree and implement a protocol on outsourcing in accordance with PSA and also in accordance with Department of Public Expenditure and Reform (DPER) guidelines	Q1
Employee Welfare and Wellbeing	Continue to advance the *Employee Wellbeing and Welfare Strategy*, taking measures to encourage maximum attendance at work and developing standard and consistent national approaches to staff safety, health and welfare	Q1-Q4
	Agree and implement a policy on protecting staff entering domestic settings from second hand smoke	Q1
Performance Management and Management Information	Support the implementation of the individual Performance Management process, the Performance Review Cycle in the new structures that will be established in the period 2013 and through to 2015	Ongoing
Professional Registration	Develop and implement policies that assure the HSE that relevant employees have appropriate statutory registration	Q1-Q4
Job specifications, qualifications standardisation and development	Support services in the development of job descriptions and the identification of appropriate qualifications that meet the principles contained in the Recruitment Licence issued under the *Public Service Management (Recruitment and Appointments) Act 2004*	Q1-Q4
	Maintain and update as required the National Qualifications Database in line with developments within the statutory regulated professions and service requirements	Q1-Q4
Recruitment Licence	Develop, disseminate and monitor resourcing policies to ensure effective resourcing in compliance with the Recruitment Licence issued under the *Public Service Management (Recruitment and Appointments) Act 2004*	Q1-Q4
Resourcing Policy	Develop resourcing policies that support the restructuring of the health sector through a sustainable and affordable workforce and which satisfies the conditions of the HSE's Recruitment Licenses	Q1-Q4

Estates and Capital

HSE Estates is responsible for maximising the value of HSE properties and facilities, to ensure that appropriate infrastructure is in place when and where required in order to enhance patient, client and staff wellbeing. It does this by managing the organisation's €10 billion capital infrastructure and annual capital plan. The Estates Directorate works closely with the other Directorates to ensure that the Capital Plan aligns with service needs and priorities. The aim of the Capital Plan is to improve patient care and outcomes, through provision of high quality, appropriate and efficient health buildings.

HSE Estates is also responsible for the central management of the HSE's Property Portfolio and is required to develop efficiencies and ensure better value for money with regard to purchases, disposals and the negotiation of leases. All property transactions, both disposals and purchase are as a direct response to service and client needs.

2013 Key Priorities

- Prudent Management of the Capital Budget.
- Continued management of the HSE's property portfolio.
- Progress the National Paediatric Hospital development.
- Progress the Central Mental Hospital development.
- Progress the National Programme for Radiation Oncology.
- Continue the roll out of Primary Care in line with the National Primary Care Strategy.
- Progress of the Mental Health Investment Programme in line with *A Vision for Change.*
- Reconfigure Acute Hospital Services.

2013 Actions

Priority Area	Action 2013	End Q
Capital Programme	Expenditure on 2013 Capital allocation to match profile	Q1-Q4
	Expenditure on 2013 Capital Plan to match NSP2013	Q1-Q4
National Paediatric Hospital	Work with the Development Board to progress the project in 2013	Ongoing
Mater Adult Hospital Development	Complete final phase which is programmed to facilitate construction of Metro works and will deliver the balance of accommodation (including two operating theatres)	Q2
Mid West Acute Hospital Development	Complete phase two, construction and fit out of the Emergency Department	Q4
Primary Care Roll out	14 new Primary Care Centres to become operational - Lease agreement – A further 12 will be delivered by the end of 2013 (33 delivered to date) - HSE own build – Manorhamilton and Loughrea Primary Care Centres to be delivered in 2013	Q1-Q4
Mental Health Services	Re-configuration of National Forensic Mental Health Service Facilities: - Detailed design work on project which includes a new National Forensic Hospital, a Forensic Child and Adolescent Mental Health Unit, a Forensic Mental Health Intellectual Disability Unit along with Intensive Care Rehabilitation Units (ICRU) planned for Cork, Mullingar, Galway and North Dublin	Q4
	Alignment of expenditure on mental health investment programme with sale of land and *A Vision for Change*	Q4
	Complete eight Mental Health Projects	Q4
Elderly Long Term Care	Complete Community Hospital, Kenmare	Q1
	Complete the upgrade and refurbishment of Baltinglass Community Hospital to fully comply with HIQA Guidelines	Q4
	Complete the refurbishment of three Community Nursing Units	Q2
Property	Support the development of the Regional Estate Management Plans in line with the National Estate Management Plan	Q3
	Continue to improve the central recording and tracking of Property Transaction Application Process	Q1
	Achieve greater utilisation of the HSE Property Database in routine estate management	Q4
	Enhance Property Database capabilities in dealing with Parliamentary Queries and Freedom of Information enquiries	Q2
	Fully tailor the output reporting capabilities of Property Database to HSE requirements	Q3
	Ensure ongoing process of continuous refinement of the database to achieve optimal data quality	Q4
	Co-ordinate HSE Finance Asset register and Property Registration Authority (PRA) health estate records with Property Database	Q2
National Ambulance Command and Control Centre	Complete the national Ambulance Command and Control Centre and Ambulance HQ at the Rivers Building, Tallaght. This project also includes a back-up support facility to be developed in the existing facility in Ballyshannon	Q2

Priority Area	Action 2013	End Q
National Rehabilitation Hospital	Tender and contract for phase one of this redevelopment which is the construction of a replacement 120 Bed Ward block (procurement of design team commenced in 2012)	Q4
Emergency Department (ED), Waterford Regional Hospital	Complete construction on expansion of the ED to provide additional resuscitation facilities and ancillary services with replacement Neo-Natal ICU Unit over ED	Q4
St Luke's Hospital Kilkenny ED and Medical Assessment Unit (MAU) and Day Unit Project	Ongoing construction for phase one of the redevelopment of St Luke's, to include a new ED, MAU and Day Services Unit (including Endoscopy) with planned completion in 2014	Q4
Roscommon General Hospital Endoscopy Unit	Equip and commission endoscopy suite for medical day procedures and an upgrade of the Hospital Sterile Services Department (HSSD)	Q4

Procurement

Procurement is responsible for the strategic sourcing, purchasing, storage and distribution of HSE products and services to optimise efficiencies and support the achievement of best value for money, cost reductions and security of supply in the delivery of patient care.

2013 Key Priorities

- Continue to support the Government Programme in relation to the reform of Public Sector Procurement
- Advance principles of Health Sector Procurement
- Effect delivery of service to 8,500 delivery locations managing 3,500 deliveries per day while continuing the phased transition of the logistics and inventory management structure to a National Distribution Operation
- Implement national, public health sector, regional and local contracting strategies to leverage economies of scale, maximise efficiencies and effectiveness and achieve best value for money
- Further develop customer relationship management and supplier relationship management
- Continue staff training and development
- Engage with our supply markets, small to medium size enterprises (SMEs) and collective industry representative organisations to further develop understanding of HSE requirements and processes and enhance competitiveness / improve value for money
- Continue to optimise the procurement resources to provide appropriate level of service and best value for money

2013 Actions

Priority Area	Action 2013	End Q
Implement Logistics and Inventory Management Strategic Plan	Implement National Distribution Centre (NDC) SAP System	Q4
	Implement automatic information data capture (AIDC) enhancement in conjunction with NDC system implementation	Q4
	Extend Point of Use Management to achieve additional stock and turnover reduction savings of €1m and release staff to front line services	Q3
	Proactively manage customer demand to achieve savings of €2m	Q4
	Secure price savings of €0.5m	Q3
	Develop prototype Procurement Data Warehouse for NDC	Q2

Priority Area	Action 2013	End Q
	Continue Consolidation of Stores and Inventory Reduction Programmes	Q2
	Implement new contracts awarded by Portfolio and Category Management	Q4
	Continue to implement Supply Channel Changes and eliminate non-value adding activities	Q4
	Increase Aids and Appliances recycling by €2m	Q4
Implementation of National Portfolio and Category Management Approach	Develop 4-year rolling Portfolio and Category Management activity Plan for the Public Health Sector in the context of the imminent changes in overall Public Sector Procurement	Q4
	Manage HSE purchasing portfolios and optimise competitive tendering for the supply of products and services including capital to contribute to a savings target of €40m across all agencies	Q4
	Provide procurement leadership, guidance and operational services in respect of NSP2013, service reconfiguration and corporate services requirements	Q4
	Develop Category Workbooks to support category analysis	Q4
	Further develop supplier relationship management	Q4
Implement Communications, Training and Customer Relationship Management and Business Support	Communications, Training, Customer Relationship Management (CTCRM) and Business Support ⌐ Continue the roll out of CRM across Procurement NDC Limerick and Galway and development of Customer Database	Q1-Q4
	⌐ Continue to roll out of a training and development programme for procurement staff	Q1-Q4
	⌐ Corporate management / governance of procurement related communications including the development of intranet and internet	Q1-Q4
	⌐ Support the development of strategic relationships with the supply base by assisting in the organisation of cross public sector supplier events with other public sector bodies on behalf of procurement	Q1-Q4
	Procurement Business Support ⌐ Lead out on a number of key projects to support the business of procurement some of which include, Development of Supply Catalogue, Management / Spend Analysis Reporting, Risk Management Administration, Centralisation of Procurement Budget, Development of Policies and Procedures and any other projects prioritised during 2013	Q1-Q4

Information and Communication Technology

The National Information and Communication Technology (ICT) Directorate has responsibility for the development and implementation of ICT strategy and for the delivery of value-adding ICT services, projects and support across the HSE.

The ICT directorate is a support function that works in partnership with all directorates within the HSE to ensure that the services and projects pursued are directly aligned with service needs.

2013 Key Priorities

- Maintain service levels.
- Support the implementation of all health service initiatives, in line with the Programme for Government that rely on ICT.
- Pursue all projects that can provide tangible cost savings.
- Improve communications, collaboration, consistency of data and access to systems by implementing the ICT Infrastructure and Operations Strategy and Integrated Services Framework.

2013 Actions

Priority Area	Action 2013	End Q
Patient / Client Services	Provide ICT support for DoH and Special Delivery Unit (SDU) projects	Q1-Q4
	Provide ICT support for National Clinical Programme initiatives	Q1-Q4
	Implement the National Patient Administration System (PAS) designated sites	Q1-Q4

Priority Area	Action 2013	End Q
	Implement the National Integrated Medical Imaging System (NIMIS) designated sites	Q1-Q4
	Expand the deployment of ICT within Primary Care e.g. expanded deployment of electronic referrals, additional infrastructure forPCTs, secure clinical email, Healthlink	Q1-Q4
	Support the completion of the business case, the development of the Specification of Requirements and the execution of the tendering process, working in conjunction with primary care	Q1-Q4
	Support the procurement for a single, national Standard Assessment Tool for Older People and commence planning for rollout in 2014	Q1-Q4 Future Health Action 35
	Commence deployment of the National Child Care Information System	Q2
	Implement the National Nephrology (Renal) System in designated sites	Q1-Q4
	Implement the National Electronic Blood Tracking System in designated sites (high blood usage)	Q1-Q4
	Implement the Track and Trace System for Reusable Invasive Medical Devices (RIMDs, including Endoscopes) in designated sites	Q1-Q4
	Implement the National ICU Clinical Audit Information System in designated sites (10 major sites)	Q1-Q4
	Commence deployment of the National Maternal and Newborn Clinical Management System	Q2
	Support the implementation of the National Colorectal Cancer Screening Programme by deployment of the Endoscopy Reporting System at designated screening hospitals	Q1-Q4
	Commence the deployment of the ICT solutions required to support the National Radiology QA Programme b	Q1-Q4
	Support the establishment of the Irish National Orthopaedic Register by procurement / deployment of appropriate ICT solution(s)	Q1-Q4
	Complete the procurement process for the National Medical Laboratory Information System (MedLIS)	Q4
	Implement the National Environmental Health System in 2013 designated sites	Q1-Q4
	Support the National Ambulance Service Control Centre Reconfiguration Project via procurement and deployment of the necessary digital communications systems, call management and dispatch systems	Q1-Q4
	Provide the necessary ICT support to the Diabetes Programme in the execution of procurement and prototyping for a Shared Care Record	Q1-Q4
Delivery of Corporate Systems	Implement the National Health Insurance Management System solution to all designated sites	Q1-Q4
	Implement a national Electronic Document and Record Management System (EDRMS) to record and manage all HSE Human Resource files electronically on all designates sites	Q1-Q4
	Support the implementation of the National Distribution Centre (NDC) by modifying the existing SAP Financials system in the Midlands so that the NDC can support the ordering and receipting of goods, input of requisitions and picking of orders providing financial management of deliveries to cost centres regardless of location	Q1-Q4
	Continue development of the national Corporate Information Facility (CIF) and roll out across all Corporate Directorates to meet business reporting requirements	Q1-Q4
	Support the Finance Directorate in the development of the business case for the National Finance and Procurement System and the procurement of the associated solution	Q1-Q4
Delivery of Infrastructure and Operations Initiatives	Servers and SAN ⌐ Reduce costs and improve service by implementing the virtualised server environment at the National Data Centre and designated sites regionally	Q1-Q4
	Telephony - Continue to leverage savings from existing legacy infrastructure by reducing operating costs. ⌐ Deploy network of enterprise level PABXs nationally and expand Internet Protocol (IP) telephony footprint ⌐ Leverage the National Health Network (NHN), least cost routing and revise maintenance contracts	Q1-Q4
	Mobile Communications ⌐ Continue to secure further savings on mobile communication service costs via enterprise wide management and deployment of services ⌐ Leverage public sector wide (central) contracts and tariffs to further reduce costs ⌐ Deploy software management platform as part of the new mobile telephony tender to improve visibility and assist in the management of costs	Q1-Q4
	Data Communications / National Health Network (NHN) ⌐ Pursue the implementation of a single communications network for the Irish Health Service by completing the deployment of NHN 1 and NHN2	Q1-Q4
	Data Communications / Local Area Networks and Wireless ⌐ Implement LAN and Wireless upgrades for existing health service sites provided requirements are aligned with the National Infrastructure and Operations Strategy	Q1-Q4

Priority Area	Action 2013	End Q
	⌐ Implement a consistent (.10) IP addressing scheme on all designated sites	
	Software Asset Management ⌐ Continue consolidation of software licensing ⌐ Bring all Citrix licenses up to a current version ⌐ Procure and implement software solution for management of software assets – for both servers and clients	Q1-Q4
	Messaging and Collaboration ⌐ Consolidate and deploy a single email solution ⌐ Deploy a single collaboration tool ⌐ Deploy a unified video-conferencing infrastructure to cover both Voice and Video	Q1-Q4
	Managed Print Services ⌐ Reduce costs and improve service by developing a framework for Managed Print Services	Q1-Q4
	Helpdesk Services ⌐ Continue the consolidation of Helpdesk Services nationally	Q1-Q4
Delivery of Applications Support and Maintenance Services	Implement National Vendor Management Programme	Q1-Q4
	Rollout the Applications Information Database and associated services	Q1-Q4
	Implement a review of all software applications	Q1-Q4
	Continue with ongoing support of existing applications and perform consolidation, VFM and other opportunities on that environment	Q1-Q4
	Implement "planning for support" service on new and existing ICT projects	Q1-Q4

Internal Audit

The Internal Audit Directorate is one of the key elements of the HSE's corporate governance framework. It is an independent and objective appraisal function established to provide assurance to both the CEO and the Board on the adequacy and degree of adherence to HSE's procedures and processes.

2013 Key Priorities

- Approval by both Audit Committee and Accounting Officer of HSE Internal Audit Annual Plan 2013.
- Conduct and complete a comprehensive programme of audits including exploring how HSE funded agencies can be incorporated in same.
- Track status of audit recommendations and reports to senior management for necessary action.
- Provide assistance in support of other directorates to improve controls.
- Conduct special investigations as and when required.

2013 Actions

Priority Area	Action 2013	End Q
Audit Plan	Audit Plan 2013 approved by Audit Committee and Accounting Officer	Q1
Audit Reports	Produce a substantial volume of completed audit reports covering a wide variety of audit topics and geographical spread throughout the HSE	Q1-Q4
Track Audit Recommendations	Submit quarterly reports to Management Team and Audit Committee on status of implementation of audit recommendations	Q1-Q4
Management Support to Improve Controls	Provide advice to senior management relating to controls and processes, including ICT security and assurance	Q1-Q4
Special Investigations	Conduct and complete any required special investigations	Q1-Q4

Communications

The structure and process of healthcare delivery is undergoing significant changes, in line with the *Programme for Government*. This in turn will see changes to the Communication's Directorate throughout 2013. This comes at a time when the Directorate is in the process of adapting to the proliferation of digital media channels and the associated challenges that this brings together with an ever reducing number of communications staff.

The priority for 2013 will be to continue to support service delivery while developing a new communications structure and processes to support the new HSE Directorate structures. This will involve a realignment of existing communications resources both nationally and regionally. It will also involve a revision of existing communications processes to ensure that information is managed in a co-ordinated manner thereby improving its accuracy, consistency and speed of delivery across as many and diverse channels as possible.

2013 Key Priorities

- Develop a new Communications Directorate structure to support the new service delivery model at national, regional and local level.
- Revise existing communications processes to support this new structure.
- Continue to improve the process of communication interoperability between the HSE and the DoH.
- Enhance our online / digital capacity, the quality, breath and ease of use of the information we provide, through the intranet, HSE.ie and other digital channels.
- Develop and encourage better feedback mechanisms with the public and our staff through our services and in our communications.

2013 Actions

Priority Area	Action 2013	End Q
Revise existing communications processes	**Public Communications** Develop new channels of communications by using appropriate locations within the HSE Estates portfolio	Q1-Q4
	Continue to enhance the Health A-Z patient information resource to support the work of the Clinical Programmes	Q3
	Develop and implement new ways to take on board feedback from the public	Q1-Q4
	Staff Communication Further improve and expand channels of communication in order to keep staff updated about organisational changes and health reforms	Q1-Q4
	Support the roll out of a Staff Engagement Programme by Human Resources	Q1-Q4
Enhance online / digital capacity	**Digital Communications** Continue to implement the HSE Digital Communications Strategy and the recommendations of the review of HSE online resources	Q1
	Continue to develop our capacity to develop user-friendly and relevant content	Q1-Q4
	Enhance access to, usability, content and relevance of digital communications for staff	Q1-Q4
Education / Training and Development	**Health Education Programmes** Deliver targeted, evidence based, cost effective, health education campaigns	Q1-Q4
	⌐ Develop greater cohesion across activities, key messages and priority areas to reflect the new Public Health Policy Framework, when published	Q1-Q4
	⌐ Continue to evaluate all campaigns to ensure value for money, best practice, continued learning and prioritisation of key activities	Q1-Q4
	⌐ Improve integration across the organisation for all campaigns to reflect the work of the clinical programmes and care groups	Q1-Q4
	⌐ Maximise the value in our own, and our partners communications channels, to support health education programmes within a reducing budget	Q1-Q4
	⌐ Develop opportunities across the organisation to enhance our research and evaluation capacity	Q2
	⌐ Develop active partnerships to maximise the impact of health programmes through our stakeholders	Q1-Q4

Priority Area	Action 2013	End Q
	Training and Development ⌐ Continue to develop protocols and best practice guidelines for all communication staff	Q2
	⌐ Continue to provide communications training and support for staff across the services	Q1-Q4
	⌐ Educate the system regarding new communications structures and processes, once in place	Q2-Q3
	⌐ Put in place a professional development programme for Communications Officers at both national and regional level	Q1
	⌐ Put in place an Intern Programme to support the work of the Communications Directorate	Q1
Press and Media	Provide high quality media relations support to all health services at a national and regional level	Q1-Q4
	Engage with media outlets at senior level to bring more objectivity to reportage on healthcare	Q1-Q4
	Greater engagement with local media in each HSE Area through 'Operation Home County'	Q1-Q4
Parliamentary Affairs	Improve the timeliness and quality of responses to all Parliamentary Questions (PQs) to 75%	Q1-Q4
	Integrate further the work of Parliamentary and Regulatory Affairs with Communications Resource Planning Group	Q1-Q4
	Integrate the work of Parliamentary Affairs Division (PAD) with that of DoH	Q1-Q4
	Improve the timeliness and quality of responses to all Freedom of Information (FOI) responses to achieve a 75% response rate within the statutory period	Q1-Q4
	Further integrate FOI and PAD at national level in context of ongoing reforms	Q1-Q4
	Develop a framework for an integrated ICT system for searching and tracking PQs, representations, FOI and data protection	Q1-Q4
Data Protection	Complete the detailed review of data protection in the HSE and implement all recommendations stated for 2012	Q2
	Implement a number of interim measures in order to ensure that all HSE staff are aware of their obligations under the Data Protection Act	Q2
Appeals	Optimise the numbers and grades dealing with appeals	Q2
	Examine existing protocols and revise if necessary	Q2
	Put in place a process to ensure appeals are dealt with as expeditiously as possible	Q2
	Optimise the numbers and grades dealing with appeals	Q2

Legal Services

The objective of Legal Services office is to ensure, through the provision of legal services, that the best interests of those to whom the HSE provides services, those who work for the HSE, and those who work with the HSE are protected and served in the most effective and efficient way possible. In this regard the Office provides legal advice in relation to certain matters of legal significance, it strategically manages certain cases, it oversees and audits legal services provided to the HSE and it liaises with Government Departments and other external stakeholders on legal matters. Demand for legal services has increased significantly in the last two years. It is believed that economic factors have significantly contributed to this increase.

2013 Key Priorities

- Ensure that the contract arrangement entered into by the HSE with certain legal service providers is working adequately to ensure increased efficiency and effectiveness in the provision of legal services to the HSE.
- Ensure more widespread use of alternative dispute resolution processes to facilitate better outcomes to dispute resolution.

2013 Actions

Priority Area	Action 2013	End Q
Effectiveness and efficiency review	Review the effectiveness and efficiency of the contractual arrangement with a cross section of its legal service providers to investigate areas where further improvements can be made	Q1
	Publish findings and implement recommendations of the Effectiveness and Efficiency Review	Q2-Q4
Alternative dispute resolution (ADR) protocol	Develop and implement a protocol on the use of ADR processes across the HSE to ensure a widespread and consistent approach in their application	Q3

Corporate Planning and Corporate Performance

The Corporate Planning and Corporate Performance (CPCP) Directorate is responsible for ensuring that the HSE complies with its legislative requirements in relation to planning, measuring and monitoring the organisation. This is underpinned by a robust planning and performance management framework. CPCP builds, monitors and reports on progress against the HSE's Corporate and annual National Service Plan (NSP). High quality planning, monitoring and measurement of services is a fundamental requirement of the HSE, ensuring effective governance and accountability within the health service and also allowing the HSE to evaluate its processes in order to learn, adapt, change and improve.

CPCP also works closely with the DoH in relation to health policy, health priorities and performance evaluation. Plans and performance metrics are developed across the HSE Directorates and agreed through a business process with the national care group and programme leads and Regional Directors of Operations (RDOs).

In 2013 CPCP will develop planning and performance monitoring and reporting at regional level, building on the control and performance management roles at regional levels. Clinical outcomes and quality will be a key focus for the further development of performance indicators. CompStat will continue to be developed to replace HealthStat as the operational reporting system and will be extended to incorporate all hospital and community services.

2013 Key Priorities

- Work with the DoH to support alignment of organisational priorities with those identified in the Programme for Government and identify future planning and performance needs under *Future Health – A Strategic Framework for Reform of the Health Service 2012 – 2015*.
- Work with the DoH to ensure best practice planning is evident in all areas.
- Finalise NSP2013 and Regional Service Plans
- Prepare NSP2014 within legislative timeframe.
- Prepare and develop the HSE Annual Report 2012.
- Oversee and monitor the implementation of NSP2013 and Regional Service Plans.
- Develop and report on the agreed suite of performance indicators for 2013 in conjunction with the services.
- Support services to put in place the necessary data collection and reporting systems for performance management of the organisation's priorities.
- Publish regular performance reports against NSP2013 to monitor performance in finance, HR and activity.
- Ensure CompStat meets the evolving needs of the organisation.
- Meet management information needs by maximising synergies across organisational units to reduce the potential for overlap / duplication at service, HSE and DoH level.

2013 Actions

Priority Area	Action 2013	End Q
Service and Business	Sign off Planning and Performance Management Framework for 2013	Q1
	Support service and business planning processes within resources available	Q1-Q4

Priority Area	Action 2013	End Q
Planning Processes		
National Service Plan	NSP2013 Finalise NSP2013 for approval by Minister for Health	Q1
	Ensure alignment of NSP2013 with Regional Service Plans	Q1
	NSP2014 Prepare and develop NSP2014 in collaboration with the DoH, national care group and programme leads and RDOs	Q4
Annual Report and Annual Financial Statements	Draft, publish and circulate Annual Report 2012, in collaboration with Finance Directorate and prepare Annual Financial Statements	Q1-Q2
Key Performance Indicator (KPI) process	Update KPI templates to reflect PIs and Measures in NSP2013	Q1
	Continue work with Care Groups and Operations to improve the data details and support transition to new governance under directorates	Q1-Q4
Performance Reporting	Work with all stakeholders to improve data quality in respect of relevance, timeliness and coverage	Q1-Q4
	Work with internal and external stakeholders to ensure the performance reporting requirements of the organisation and the DoH are met in 2013	Q1-Q4
	Further develop CompStat to encompass all hospitals, community services and emerging organisational needs	Q1-Q4
	Support monthly CompStat forums	Q1-Q4

Appendices

APPENDIX A – Financial Tables

NB: All financial information in tables has been rounded

Agency Forecast Outturn 2012

	Pay €m	Non Pay €m	Gross €m	Income €m	Net €m
Voluntary Providers					
Hospitals					
St. John's Hospital	21	7	27	-8	19
Mater Misericordiae Hospital	184	84	268	-52	216
Beaumont Hospital	222	96	317	-71	246
The Rotunda Hospital	52	14	66	-21	45
Children's University Hospital	73	27	100	-19	81
Cappagh National Orthopaedic	20	12	32	-7	25
The Adelaide and Meath	177	65	242	-60	182
Coombe Women's Hospital	52	13	65	-17	48
Our Lady's Hospital for Sick Children, Crumlin	112	40	152	-30	122
St. James' Hospital	252	143	395	-83	312
St. Vincent's University Hospital	167	75	242	-39	203
St. Michael's Hospital	25	9	34	-8	26
National Maternity Hospital	53	13	66	-20	46
Royal Victoria Eye and Ear	20	7	27	-6	21
Mercy University Hospital	65	23	88	-30	58
South Infirmary Hospital	47	21	69	-23	45
Hospital Total	1,541	649	2,190	-495	1,695
Community					
Clontarf Orthopaedic	9	3	12	-5	7
St. Vincent's Hospital	14	3	16	-2	14
Daughters of Charity	59	7	67	-9	58
St. Michael's House	73	13	87	-15	72
Central Remedial Clinic	15	3	18	-4	14
National Rehabilitation Hospital	23	8	31	-7	24
Dublin Dental School	6	2	8	-1	7
Leopardstown Park Hospital	13	3	16	-13	3
Sisters Of Charity	16	3	19	-3	16
The Royal Hospital Donnybrook	16	5	21	-10	11
The Drug Treatment Centre	6	2	8	-1	7
Our Lady's Hospice	30	7	37	-21	16
St John of God	89	22	111	-25	86
Cheeverstown House	22	3	25	-3	22
Kare	15	2	17	-2	15
Sunbeam House Services	18	3	21	-2	19
Peamount Hospital	23	5	28	-8	20
Stewarts Hospital	43	7	50	-7	43
The Children's Sunshine Home	4	1	5	-1	4
Community Total	495	102	597	-139	458
Total Voluntary	2,036	751	2,787	-634	2,153
Statutory Providers					
Hospitals					
Waterford Regional Hospital	110	57	166	-29	138
St. Luke's Kilkenny	56	15	71	-14	57
Wexford General Hospital	50	12	62	-12	49
St. Joseph's Hospital	45	12	57	-9	48
Cork University Hospital	244	93	337	-61	276
Kerry General Hospital	63	20	83	-13	70
Bantry General Hospital	15	3	19	-2	17
Sligo General Hospital	91	31	122	-17	105
Letterkenny General	88	27	115	-10	105
UCH Galway	200	107	307	-43	264

	Pay €m	Non Pay €m	Gross €m	Income €m	Net €m
St. Columcille's General Hospital	32	9	41	-2	39
Mayo General Hospital	65	26	91	-9	81
Roscommon General Hospital	17	4	21	-3	18
Portiuncula Acute Hospital	44	16	60	-11	49
Regional Hospital Dooradoyle	124	72	196	-31	165
Regional Maternity Hospital	19	5	24	-5	19
Regional Orthopaedic Hospital	10	7	17	-6	11
Ennis General Hospital	15	4	19	-2	18
Nenagh General Hospital	15	5	20	-3	17
Our Lady of Lourdes	110	36	146	-18	127
Louth County Hospital	15	5	19	0	19
Cavan Monaghan General Hospital	59	21	79	-7	72
Monaghan General Hospital	10	3	12	0	12
Our Lady's Hospital Navan	32	12	44	-3	41
Naas General Hospital	46	19	65	-3	62
Mullingar General Hospital	52	15	67	-9	58
Tullamore General Hospital	63	30	93	-11	82
Portlaoise General Hospital	43	9	52	-6	46
Connolly Memorial Hospital	73	26	99	-13	86
Hospital Total	1,805	699	2,504	-353	2,151
Community					
LHO Kerry	68	29	97	-13	83
LHO West Cork	54	175	229	-19	210
LHO Nth. Cork	51	32	83	-9	75
LHO Nth. Lee	59	18	78	-9	68
LHO Sth. Lee	77	44	121	-29	92
LHO Sth. Tipperary	51	25	76	-6	70
LHO Waterford	48	56	104	-10	94
LHO Wexford	57	30	87	-12	75
LHO Carlow / Kilkenny	66	57	123	-10	113
LHO Donegal	112	36	148	-18	130
LHO Sligo / Leitrim	89	53	142	-18	124
LHO Mayo	79	65	144	-18	126
LHO Roscommon	33	26	59	-10	48
LHO Galway	102	121	223	-19	205
LHO Clare	46	40	86	-11	75
LHO Limerick	71	75	146	-14	133
LHO Nth. Tipperary	28	81	109	-8	101
LHO Cavan Monaghan	66	29	95	-14	81
LHO Louth	62	29	91	-15	77
LHO Meath	38	29	67	-6	61
LHO 6 Dublin North	84	62	146	-21	125
LHO 7 Dublin North	42	92	134	-10	124
LHO 8 Dublin North	74	60	135	-6	128
Dublin South West / Kildare / West Wicklow	76	102	178	-31	147
Dublin Midlands	169	93	262	-42	220
Dublin South East / Wicklow	81	128	209	-19	190
Dublin South Central	157	95	252	-31	221
Total Community	1,941	1,683	3,624	-428	3,196
Total Statutory	3,746	2,383	6,129	-781	5,347
Total Provider Outturn	5,782	3,134	8,915	-1,415	7,500

*This table excludes HSE Regional and National services

EU Obligations

The amounts shown in the table reflect the position statements, as at 31 December 2011, submitted by Member States to, and recorded in the report of, the Rapporteur to the Audit Board of the EU Administrative Commission on Social Security for Migrant Workers, together with net movement (claims received less payments made) during 2012. Claims are subject to verification and, accordingly, the amounts shown need not necessarily represent actual liabilities.

Member State	Creditors End 2011 €000	Movement During Year €000	Creditors End 2012 €000
Austria	167	255	422
Belgium	0	0	0
Bulgaria	6	-1	5
Cyprus	74	20	94
Czech Republic	384	-170	214
Denmark	0	0	0
Estonia	13	-1	12
Finland	139	-23	116
France	1,555	1,381	2,936
Germany	1,092	1,019	2,111
Greece	65	119	184
Hungary	21	-4	17
Iceland	7	3	10
Italy	1,527	-853	674
Latvia	2	6	8
Liechtenstein	0	0	0
Lithuania	15	17	32
Luxembourg	0	0	0
Malta	60	75	135
Netherlands	1,247	-535	712
Norway	0	0	0
Poland	2,182	-172	2,010
Portugal	676	-342	334
Romania	21	4	25
Slovakia	338	-194	144
Slovenia	44	-4	40
Spain	13,282	-345	12,937
Sweden	973	757	1,730
Switzerland	886	-318	568
United Kingdom	(a)	(a)	(a)
Total	24,776	695	25,471
Claims projected in 2013			6,000
Charges to be raised in 2013			3,000
Estimated invoice payments 2013			10,000

Note (a): Ireland operates a bilateral healthcare reimbursement agreement with the United Kingdom whereby net liabilities are paid on a lump sum payment basis. Claims under the Treatment Abroad Scheme are not included.

Schemes

Schemes	Budget 2012 €m	Outturn 2012 €m	Budget 2013 €m
Medical Card Scheme (PCRS)	1,829	1,934	1,825
Sub-Total	1,829	1,934	1,825
Community Drug Schemes (PCRS)			
Drug Payment Scheme	122	127	109
Long Term Illness Scheme	118	116	116
High Tech	130	163	173
Dental Treatment Services	63	64	63
Health Amendment Act	1	2	1
Community Ophthalmic Scheme	24	30	33
Methadone Treatment	19	18	25
Childhood Immunisation	6	8	8
Doctors Fees / Allowances (Immunisations / Heartwatch)	7	14	9
Sub-Total	490	543	538
Primary Care Schemes			
Drug Payment Scheme (incl. Drug Refund)	43	74	43
Long Term Illness Scheme	7	8	7
High Tech	2	4	2
Dental Treatment Services	0	1	0
Health Amendment Act	4	6	4
Hardship	65	86	65
Mobility Allowance	13	18	13
Capitation	10	12	10
Blind Welfare Allowances	9	11	9
Maternity Cash Grants	0	0	0
Sub-Total	155	220	155
Oncology	45		45
TOTAL SCHEMES	2,518	2,697	2,562

The budget figures in this table include €27m in respect of appropriations in aid

Medical Card Scheme

2012	€m	Card Numbers
Forecast Outturn (accruals based)	1,934	1,861,245
2013	€m	Card Numbers
Budget 2013	1,825	1,921,245

Service Plan 2013 Income

Income Details A-in-A	Budget 2012 A-in-A	Estimated Outturn 2012 A-in-A	Variance 2012 A-in-A	Budget 2013 A-in-A
	€m	€m	€m	€m
D2 EU Levies	220,000	220,000	0	195,000
D3 Tobacco	167,605	167,605	0	167,605
D4 Opthalmic	2,000	2,000	0	1,000
D5 Dental	2,000	2,000	0	2,000
D6 Maintenance	417,016	406,168	-10,848	419,546
D8 Superannuation	199,986	201,455	1,469	181,086
D9 Miscellaneous	127,759	119,695	-8,064	127,759
D11 PCRS Rebate Income	32,000	32,000	0	25,000
D12 Pension Levy	337,156	343,976	6,820	337,156
TOTAL INCOME	1,505,522	1,494,899	-10,623	1,093,547

Income Details Not A-in-A	Budget 2012 Not A-in-A	Estimated Outturn 2012 Not A-in-A	Variance 2012 Not A-in-A	Budget 2013 Not A-in-A
	€m	€m	€m	€m
Superannuation Income*	191	187	-4	191
Maintenance Charges (private / semi)	299	246	-53	328
Inpatient Charges (public - statutory)	25	28	3	28
Outpatient Charges (public - statutory)	7	5	-2	7
RTA	6	7	1	6
Long Stay	11	53	42	11
Other Income	85	99	14	85
TOTAL INCOME	624	625	1	655

*Pay Analysis 2013

Pay Breakdown	Outturn 2011 €m	Forecast Outturn 2012 €m
Basic	4,806	4,674
Overtime	268	256
Allowances	166	161
On Call	82	86
Weekend / Public Holidays	254	240
Night Shift	99	97
PRSI Employers	469	474
Locum / Agency	220	216
Superannuation Total**	743	851
Pay Total	7,107	7,056

*Includes Voluntary Providers

Superannuation

	2012 Budget €m	2012 Forecast Outturn €m	Variance €m	2013 Estimate €m	Increase / Decrease over 2012 budget €m
Statutory Pensions	528.9	490.0	38.9	544.2	15.3
Statutory Lump Sums	154.0	205.4	-51.4	134.0	-20.0
Gross Statutory Superannuation	682.9	695.4	-12.5	678.2	-4.7
Superannuation Income	-180.3	-194.0	13.7	-181.1	-0.8
Nett Statutory	502.6	501.4	1.2	497.1	-5.5
Voluntary Pensions	119.6	112.0	7.6	119.6	0.0
Voluntary Lump Sums	26.0	44.1	-18.1	16.0	-10.0
Gross Voluntary Superannuation	145.6	156.1	-10.5	135.6	-10.0
Superannuation Income	-80.8	-80.9	0.1	-80.8	0.0
Nett Voluntary	64.8	75.2	-10.4	54.8	-10.0
Total Pensions	648.5	602.0	46.5	663.8	15.3
Total Lump Sums	180.0	249.5	-69.5	150.0	-30.0
Gross Total Superannuation	828.5	851.5	-23.0	813.8	-14.7
Superannuation Income	-261.1	-274.9	13.8	-261.9	-0.8
Nett Total	567.4	576.6	-9.2	551.9	-15.5

The NSP2012 budget was amended for the Grace Period to the budget shown above

2013 Financial Allocation

	Pay €m	Non Pay €m	Gross €m	Income €m	Net €m
Voluntary Providers					
Hospital Total	1,664	597	2,262	-554	1,707
Community Total	487	66	553	-101	452
Total Voluntary 2013	2,152	663	2,815	-655	2,160
Statutory Providers					
Hospital Total	1,761	649	2,410	0	2,410
Community Total	1,924	2,431	4,355	0	4,355
Total Statutory 2013	3,685	3,080	6,764	0	6,764

Agency Budget 2012

	Pay €m	Non Pay €m	Gross €m	Income €m	Net €m
Voluntary Providers					
Hospital Total	1,549	604	2,153	-500	1,653
Community Total	483	99	582	-125	457
Total Voluntary 2012	2,032	702	2,734	-625	2,110
Statutory Providers					
Hospital Total	1,736	607	2,344	-399	1,945
Community Total	1,924	1,694	3,618	-444	3,174
Total Statutory 2011	3,661	2,301	5,962	-843	5,119
Total Agency Outturn 2011	5,693	3,004	8,696	-1,468	7,228

Agency Forecast Outturn 2012

	Pay €m	Non Pay €m	Gross €m	Income €m	Net €m
Voluntary Providers					
Hospital Total	1,541	649	2,190	-495	1,695
Community Total	495	102	597	-139	458
Total Voluntary 2012	2,036	751	2,787	-634	2,153
Statutory Providers					
Hospital Total	1,805	699	2,504	-353	2,151
Community Total	1,941	1,683	3,624	-428	3,196
Total Statutory 2012	3,746	2,383	6,129	-781	5,347
Total Agency Outturn 2012	5,782	3,134	8,915	-1,415	7,500

Variance

	Pay €m	Non Pay €m	Gross €m	Income €m	Net €m
Voluntary Providers					
Hospital Total	-8	45	37	5	42
Community Total	12	4	15	-14	1
Total Voluntary 2012	4	49	52	-9	43
Statutory Providers					
Hospital Total	69	92	161	46	207
Community Total	17	-11	6	16	22
Total Statutory 2012	85	81	167	62	228

This table does not include National Services and only relates to Agency outturn and budget. The figures in this table are forecast year end positions completed before the end of the financial year. Expenditure is on an accruals basis.

APPENDIX B – HR Information

Breakdown of Employment Ceiling for start-2013

Pillar	WTE Dec 11	Ceiling Dec 11	Projected Outturn Dec 2012	Projected Ceiling 1 Jan 2013	Projected WTE Change
Hospital Care	16,554	16,315	16,284	15,853	-270
Primary & Community Care	14,447	14,773	14,015	14,379	-432
Portion of Ceiling to be allocated		21	-	47	+0
Dublin Mid-Leinster	31,001	31,109	30,299	30,279	-702
Hospital Care	10,774	10,397	10,592	9,978	-182
Primary & Community Care	10,359	10,452	9,946	9,957	-413
Portion of Ceiling to be allocated		109	-	387	+0
Dublin North-East	21,133	20,958	20,538	20,323	-595
Hospital Care	10,622	10,437	10,356	10,075	-266
Primary & Community Care	11,444	11,688	10,945	11,376	-499
Portion of Ceiling to be allocated		176	-	142	+0
South	22,067	22,301	21,301	21,594	-765
Hospital Care	10,788	10,712	10,560	10,528	-228
Primary & Community Care	13,109	13,384	12,460	12,771	-649
West	23,898	24,096	23,020	23,299	-877
Hospital Care	726	782	702	749	-24
Primary & Community Care	282	300	301	275	+19
Environmental Health	544	572	593	607	+49
Ambulance Services	1,535	1,504	1,536	1,512	+1
National	3,087	3,158	3,132	3,143	+45
Portion of Ceiling to be allocated		616	-	310	+0
ISD	101,184	102,238	98,290	98,941	-2,894
Other Services	3,208	3,196	3,110	3,024	-98
Total	104,392	105,434	101,400	101,970	-2,992

Note: unallocated ceiling refers to 1. Service Development Posts, 2. Posts held by the RDO for allocation

Staff Category	WTE Dec 11	% Total	Projected Outturn Dec 2012	Projected Ceiling 1 Jan 2013	Projected WTE Change
Medical / Dental	8,331	8.0%	8,324	Not allocated	-7
Nursing	35,902	34.4%	34,573		-1,329
Health & Social Care Professionals	16,217	15.5%	15,703		-514
Management / Admin	15,983	15.3%	15,703		-280
General Support Staff	10,450	10.0%	9,975		-476
Other Patient & Client Care	17,508	16.8%	17,122		-386
Total	104,392	100%	101,400		-2,992

APPENDIX C – Capital Projects by Care Group / Programme 2013

This appendix outlines capital projects that were completed in 2011/2012 but not operational, due to be completed and operational in 2013 and also projects due to be completed in 2013 but not operational until 2014. The full HSE Capital Plan for 2013 is available on www.hse.ie

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
PRIMARY CARE										
Dublin Mid-Leinster										
Primary Care	Kilnamanagh / Tymon	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0
Primary Care	Longford, Co. Longford	Primary Care Centre, by lease agreement	Q2 2012	Q1	0	0	0	0	0	0
Primary Care	Newbridge, Co. Kildare	Primary Care Centre, by lease agreement	Q1	Q1	0	0	0	0	0	0
Primary Care	Dun Laoighre, Co. Dublin	Primary Care Centre, by lease agreement	Q2	Q2	0	0	0	0	0	0
Primary Care	Athlone, Co. Westmeath	Primary Care Centre, by lease agreement	Q4	Q1 2014	0	0	0	0	0	0
Primary Care	Shankill, Co. Dublin	Primary Care Centre, by lease agreement	Q4	Q1 2014	0	0	0	0	0	0
Primary Care	Baggot Street, Dublin	Primary Care Centre, by lease agreement	Q4	Q1 2014	0	0	0	0	0	0
Primary Care	Clane, Co. Kildare	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0
Dublin North East										
Primary Care	Ashbourne, Co. Meath	Primary Care Centre, by lease agreement	Q4 2012	Q1	0	0	0	0	0	0
Primary Care	Blanchardstown, Grove Court, Dublin	Primary Care Centre, by lease agreement	Q3	Q4	0	0	0	0	0	0
South										
Primary Care	Schull, Co. Cork	Primary Care Centre, by lease agreement	Q3	Q4	0	0	0	0	0	0
Primary Care	Carrigtwohill, Co. Cork	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
West										
Primary Care	Athenry, Co. Galway	Primary Care Centre, by lease agreement	Q2	Q3	0	0	0	0	0	0
Primary Care	Manorhamilton, Co. Leitrim	Primary Care Centre	Q1	Q3	0	0	0.35	0.42	0	0
Primary Care	Loughrea, Co. Galway	Primary Care Centre	Q3	Q4	0	0	0.35	0.45	0	0
Primary Care	Castlegar –Ballinafoile, Co. Galway	Primary Care Centre, by lease agreement	Q2	Q4	0	0	0	0	0	0
Primary Care	Swinford, Co. Mayo	Primary Care Centre, by lease agreement	Q4	Q1 2014	0	0	0	0	0	0
Primary Care	Market, Garryowen, Pennywell, Limerick	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0.15	0.15	0	0
ACUTE and PRE-HOSPITAL EMERGENCY CARE										
Dublin Mid-Leinster										
Acute (Maternity)	Coombe Women's Hospital, Dublin	Emergency theatre and delivery suite upgrade	Q1	Q2	0	0	0.70	4.75	0	0
Acute (Maternity)	National Maternity Hospital, Holles Street, Dublin	Repair works to roof and relocation of the neo-natal intensive care unit	Q3	Q4 (phase 1)	0	0	0.50	1.50	0	0
Acute	St. James's Hospital, Dublin	Provision of a new haemophilia / hepatology centre	Q4 2012	Q2	14	0	0.50	0.50	0	0
Dublin North East										
Acute	Mater Misericordiae University Hospital, Dublin	Final phase of the re-development of Mater Adult Hospital on existing site	Q3	Q1-Q3 (phased)	0	176	20.00	264.35	0	0
Acute	Connolly Hospital, Blanchardstown, Dublin	Provision of an MRI scanner and associated building works	Q2	Q2	0	0	1.70	2.00	0	0
Acute	Beaumont Hospital, Dublin	Epilepsy monitoring beds	Q2	Q3	0	0	0.40	0.92	0	0
Paediatric Care	Temple Street Hospital, Dublin	Interim works including an ECG room, an admissions unit and cochlear implant / audiology facility	Q2	Q3	0	0	0.40	1.09	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
Acute Paediatric Care	Temple Street Hospital, Dublin	Upgrade and refurbishment of 6/7 North Frederick Street to relocate the school of nursing and support services to free up additional clinical space in the hospital	Q1	Q2	0	0	0.30	1.35	0	0
South										
Acute	Cork University Hospital	Upgrade and refurbishment of existing cardiac theatres to create new trauma and one emergency theatre	Q1	Q1	0	0	0.40	1.20	0	0
Acute	Cork University Hospital	Refurbishment of an existing ward area to provide a surgical assessment unit	Q4 2012	Q1	0	30	0.02	0.70	0	0
Acute	Cork University Hospital	Provision of an MRI and CT. Fit-out of area above existing PET scanner for MRI	Q3	Q4	0	0	1.52	2.50	0	0
Acute	Cork University Hospital	Final phase of the acute medical assessment unit	Q4	Q4 / Q1 2014	0	0	2.50	3.50	0	0
Acute	Waterford Regional Hospital	ED extension including neonatal unit	Q4 2012	Q1	0	6	1.00	12.87	0	0
Acute	Mallow General Hospital, Co. Cork	Day procedures unit – endoscopy suite	Q2	Q3	0	2	0.30	1.50	0	0
Acute	South Infirmary / Victoria University Hospital, Cork	Relocation of the ophthalmology out-patients department to SIVUH. Provision of a modular facility.	Q4	Q1 2014	0	0	1.50	2.00	0	0
Acute	Mercy University Hospital, Cork	Upgrade of the electrical supply and distribution system to comply with current standards	Q3	Q3	0	0	0.80	1.08	0	0
Acute	Mercy University Hospital, Cork	Extension to the existing radiology department to house one replacement CT scanner and one additional CT scanner (funded by the MUH Hospital Foundation)	Q2	Q2/Q3	1	1	0.40	0.90	0	0
West										
Acute	Mayo General Hospital	Refurbishment and upgrade of existing renal unit to comply with current standards and *National Renal Strategy*	Q2	Q3	0	0	0.82	1.80	0	0
Mid Western Hospitals Group										
Critical Care	Mid Western Regional Hospital, Limerick	Provision of a new critical care block (linked directly to the main theatre block), to provide 12 ICU, 16	Q4 2012	Q1	10	34	5.00	37.50	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
		HDU and 16 CCU beds								
Emergency Department	Mid Western Regional Hospital, Limerick	Completion of ED (shell space construction with fit out commencing early 2014)	Q4	Q4 2014	0	0	7.00	7.50	0	0
Acute	Mid Western Regional Hospital, Nenagh, Co. Tipperary	Theatre upgrade (Phase 1)	Q4	Q4	0	0	4.00	4.75	0	0
National										
Ambulance	Command and Control Centre for National Ambulance Service on two sites; National Ambulance Service Training College	Reconfiguration of National Ambulance Command and Control to a nationally integrated system working over two sites; Relocation of National Ambulance Service College.	Q3	Q3	0	0	7.00	14.00	55 (half-year)	4.44 (half - year)
Ambulance	Ambulance station, Tuam, Co. Galway	New ambulance station	Q4 2012	Phased basis in 2013	0	0	0.25	1.45	11.20	0.966
									Revenue funding not currently available to operate	
OLDER PEOPLE										
Dublin Mid Leinster										
Older People	Baltinglass Community Hospital, Co. Wicklow	Upgrade and refurbishment of Baltinglass Community Hospital to fully comply with HIQA guidelines	Q4	Q4	0	62	1.58	2.07	0	0
Dublin North East										
Older People	Cuan Ros Community Nursing Unit (CNU), Dublin	Refurbishment	Q4	Q1 2014	0	0	1.40	1.85	0	0
Older People	Lusk CNU, Co. Dublin	Refurbishment	Q1	Q2	0	0	0.75	1.80	0	0
Older People	St. Joseph's CNU, Trim, Co. Meath	Refurbishment - phase 1 and 2	Q1	Q2	0	20	0.75	3.00	0	0
Older People	St. Oliver Plunkett Hospital, Dundalk, Co. Louth	Refurbishment - phase 1	Q4	Q1 2014	0	40	1.10	1.50	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
South										
Older People	CNU, Kenmare, Co. Kerry	Kenmare Community Hospital replacement	Q2	Q2	20	0	2.22	8.00	0	0
Older People / Mental Health	CNU, Wexford	Joint project with Mental Health to relocate and accommodate current residents from Ely Hospital, Wexford and facilitate current residents of St. Senan's Hospital	Q4 2012	Q1	9	21	0	0	0	0
					See Mental Health					
West										
Older People	Borrisokane, Co. Tipperary	Provision of a day hospital / day centre for the elderly on existing (convent) site	Q2	Q4	20	0	0.09	1.30	0	0.4 Funding source not yet confirmed
PALLIATIVE CARE										
West										
Palliative Care / Chronic illness	Ballina, Co. Mayo	Provision of a 2 bedded end of life care facility in Ballina District Hospital (co-funded by the Roscommon Mayo Hospice Group)	Q3	Q3	2	0	0.33	0.33	0	0
MENTAL HEALTH										
Dublin Mid-Leinster										
Mental Health	St. Loman's Hospital, Mullingar, Co. Westmeath	Replacement of St. Edna's ward to provide a 20 bed special behavioural unit and up to 24 replacement beds	Q2	Q3	0	44	0.52	4.78	0	0
Dublin North East										
Mental Health	Grangegorman, Dublin	Provision of replacement accommodation on the existing site for all services, including accommodation for 54 residents	Q1	Q2	0	54	3.00	22.00	0	0
Mental Health	Beaumont Hospital, Dublin	44 bed psychiatric unit to allow relocation of acute psychiatric services from St. Ita's, Portrane and 9 beds for mental health and intellectual disability	Q1	Q2	0	53	3.37	12.70	0	0
Mental Health	St. Ita's, Portrane, Dublin	Provision of residential accommodation for existing residents of St. Ita's in Carraige House and Maryfield (14 beds) and St. Joseph's (8 beds)	Q3	Q4	0	22	1.50	2.50	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
South										
Mental Health	St. John's Hospital, Enniscorthy, Co. Wexford	Havenview, 14 place residence to provide accommodation to re-house residents from St. Senan's Hospital	Q4 2012	Q1	0	14	2.00	2.40	0	0
Mental Health	St. John's Hospital, Enniscorthy, Co. Wexford	Mill View, 13 place high support house on the grounds of St. John's Hospital to re-house residents from St. Senan's Hospital	Q4 2012	Q1	0	13	1.40	1.75	0	0
Mental Health	Waterford Regional Hospital	Upgrade acute mental health unit	Q1	Q1	0	0	0.25	1.50	0	0
Mental Health / Older People	CNU, Wexford	50 bed CNU to accommodate residents of St. Senan's Hospital	Q4 2012	Q1	0 (See Older People)	20	1.05	7.90	0	0
Mental Health	Kerry General Hospital, Tralee, Co. Kerry	High observation unit	Q4 2012	Q3	0	4	1.40	2.00	0	0
West										
Mental Health	Ennis, Co. Clare	Refurbishment of Gort Glas Day Centre	Q3	Q4	0	0	0.45	0.45	0	0
Mental Health	Nazareth House, Churchill, Sligo	Delivery of a centre for Child and Adolescent Mental Health Services (CAMHS) in Nazareth primary care centre	Q2	Q2	0	0	0	0	0	0
Mental Health	Unit 5B, Mental Health Acute Inpatient Unit, Limerick	Completion of refurbishment works in Unit 5B, mental health acute inpatient unit, Limerick	Q4	Q1 2014	0	0	3.75	8.0	0	0
Mental Health	Community Mental Health Team (CMHT) base, Donegal	Development of CMHT base in Donegal Town	Q4	Q1 2014	0	0	1.3	2.0	0	0
Mental Health	University Hospital Galway (Galway Roscommon Hospitals Group)	Enabling works for adult mental health unit - replacement car parking.	Q4	Q4	0	0	2.60	2.60	0	0
DISABILITY SERVICES										
South										

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2013 Implications	
							2013	Total	WTEs	Rev Costs €m
Disability	Cope Foundation Montenotte, Cork	Open 8 bed residential specialist unit for adults with major challenging behaviour (WTE including therapy nursing and support staff).	2010	Q2	8	000	0	4.13	40.71	2.76
									Funding not currently available to open additional beds	
OTHER										
Dublin North East										
Professional Education and Training	Our Lady of Lourdes Hospital, Drogheda, Co. Louth	Refurbishment of the former nurses home, purchased from the METR allocation in 2011, to provide a medical education centre.	Q4	Q1 2014	0	0	1.00	1.60	0	0

APPENDIX D – National Performance Indicator and Activity Suite

Health and Wellbeing				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Immunisations and Vaccines % children aged 12 months who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine Haemophilus influenzae type b (Hib_3) Polio ($Polio_3$) hepatitis B ($HepB_3$) (6 in 1)	AND HP Quarterly in arrears	95%	92%	95%
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV_2)		95%	91%	95%
% children at 12 months of age who have received two doses of the Meningococcal group C vaccine ($MenC_2$)		95%	91%	95%
% children aged 24 months who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine, Haemophilus influenzae type b (Hib_3), Polio ($Polio_3$), hepatitis B ($HepB_3$) (6 in 1)		95%	95%	95%
% children aged 24 months who have received 3 doses Meningococcal C ($MenC_3$) vaccine		95%	85%	95%
% children aged 24 months who have received 1 dose Haemophilus influenzae type B (Hib) vaccine		95%	88%	95%
% children aged 24 months who have received 3 doses Pneumococcal Conjugate (PCV_3) vaccine		95%	91%	95%
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine		95%	92%	95%
% children aged 4-5 years who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)		95%	87.9%	95%
% children aged 4-5 years who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine		95%	86.7%	95%
% children aged 11-14 years who have received 1 dose Tetanus, low dose Diphtheria, Accelular Pertussis (Tdap) vaccine		95%	Full reporting due 2013	95%
% of first year girls who have received third dose of HPV vaccine by August 2013	AND HP Annually	New PI 80%	Full reporting due 2013	80%
% of sixth year girls who have received third dose of HPV vaccine by August 2013		New PI 80%	Full reporting due 2013	80%
Child Health / Developmental Screening % of newborns who have had newborn bloodspot screening (NBS)	AND HP Quarterly	100%	Not due for reporting until Q4 2012	100%
% newborn babies visited by a PHN within 48 hours of hospital discharge		95%	84.2%	95%
% newborn babies visited by a PHN within 72 hours of hospital discharge		100%	95.8%	100%
% of children reaching 10 months within the reporting period who have had their child development health screening on time before reaching 10 months of age	AND HP Monthly in arrears	95%	85.7%	95%
Tobacco Control % hospital campuses with tobacco-free policy	AND EH Quarterly	17 35%	19 39%	100%
No. and % of smokers on cessation programme who were quit at one month	AND EH Monthly in arrears	---	---	Baseline to be established
No. of smokers who received intensive cessation support from a cessation counsellor	AND EH Monthly	---	---	9,000
No. of frontline healthcare staff trained in brief intervention smoking cessation		3,521	933	1,350
No. of sales to minors test purchases carried out	AND EH Quarterly	216	282	320
Food Safety % of Category 1, 2 and 3 food businesses receiving minimum inspection frequency as	AND EH Quarterly	100%	100%	100%

Health and Wellbeing				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
per FSAI Guidance Note Number 1				
Cosmetic Product Safety No. of scheduled chemical samples taken	AND EH Quarterly	533	533	540
International Health Regulations All designated ports and airports to receive an inspection to audit compliance with the IHR 2005	AND EH Bi-annually	8	8	8
Health Inequalities No. of PCTs who have completed, at a minimum, Step 1 of a Community Health Needs Assessment (CHNA)	AND HP Quarterly	---	---	21
No. of hospitals who have completed, at a minimum, Stage 1 of the 6 stage Health Equity Audit (HEA)		---	---	6

Social Inclusion				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Methadone Treatment No. of clients in methadone treatment (outside prisons) (monthly target)	National Lead SI Monthly	8,640	8,855	8,650
No. of clients in methadone treatment (prisons) (monthly target)		520	559	500
Substance Misuse No. of substance misusers (over 18 years) for whom treatment has commenced following assessment	National Lead SI Quarterly	---	---	New PI 2013
No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment		1,260 100%	1,025 96%	1,260 100%
No. of substance misusers (under 18 years) for whom treatment has commenced following assessment		---	---	New PI 2013
No. and % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment		105 100%	86 100%	105 100%
Homeless Services No. and % of individual service users admitted to statutory and voluntary managed residential homeless services who have medical cards (quarterly target)	National Lead SI Quarterly	1,346 75%	1,527 62%	1,847 > 75%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities whose needs have been formally assessed within one week (quarterly target)	National Lead SI Quarterly (commencing Q2)	80%	1,667 68%	1,839 75%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities who have a written care plan in place within two weeks (quarterly target)		80%	1,747 71%	1,845 75%
Needle Exchange No. of pharmacies recruited to provide Needle Exchange Programme	National Lead SI Bi-annually Q1 and Q4	45 in Q1 65 in Q3	65	130
No. of unique individuals attending pharmacy needle exchange	National Lead SI Quarterly	---	---	200 Q1, 250 Q2, 300 Q3, 400 Q4
No. of pharmacy needle exchange packs provided		---	---	1,500 Q1, 1,650 Q2, 1,800 Q3, 1,950 Q4
Average no. of needle / syringe packs per person		---	---	90
No. and % of needle / syringe packs returned		---	---	600 Q1, 660 Q2, 720 Q3, 780 Q4 (40%)
Traveller Health Screening No. of clients to receive national health awareness raising / screening programmes (breast check, cervical smear screening, men's health screening, blood pressure testing) delivered through the Traveller Health Units / Primary Health Care Projects	National Lead SI Bi-annually	1,650	3,539	2,580

Primary Care				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Primary Care No. of PCTs implementing the National Integrated Care Package for Diabetes (dependent on the appointment of the ICDNs)	AND PC Quarterly	---	Reporting to commence 2013	51
No. of Health and Social Care Networks in development (dependent on agreed governance model)		79	0	126
No. and % of Operational Areas with community representation for PCT and Network Development		17 100%	12 70%	17 100%
GP Out of Hours No. of contacts with GP out of hours	AND PCRS Monthly	957,126	975,609	975,609
Physiotherapy Referral No. of patients for whom a primary care physiotherapy referral was received in the reporting month	AND PC Monthly	169,006	172,385	172,387
Physiotherapy Assessments Total no. of Primary Care Physiotherapy patients seen for a first time Assessment		---	---	139,102
Physiotherapy Contacts Total no. of Primary Care Physiotherapy face to face contacts / visits / appointments that took place		---	---	720,026
Occupational Therapy No. of clients who received a direct service in the reporting month (monthly target)		---	---	12,254
Occupational Therapy Referrals No. of clients for whom a primary care occupational therapy referral was received in the reporting month		---	---	70,752
Orthodontics No. of patients on the assessment waiting list during reporting period	National Lead Oral Health Quarterly	---	---	New PI 2013
Waiting time from referral to assessment during reporting period: i). No. of patients waiting 1-6 months ii). No. of patients waiting 7-12 months iii). No. of patients waiting 13-24 months iv). No. of patients waiting over 2 years		---	---	New PI 2013
No. of patients on the treatment waiting list – grade 4 – during reporting period		---	---	New PI 2013
Waiting time from assessment to commencement of treatment during reporting period (Grade 4): i). No. of patients waiting 1-6 months ii). No. of patients waiting 7-12 months iii). No. of patients waiting 13-24 months iv). No. of patients waiting 2-3 years v). No. of patients waiting over 4 years		---	---	New PI 2013
No. of patients on the treatment waiting list – grade 5 – during reporting period		---	---	New PI 2013
Waiting time from assessment to commencement of treatment during reporting period (Grade 5): i). No. of patients waiting 1-6 months ii). No. of patients waiting 7-12 months iii). No. of patients waiting 13-24 months iv). No. of patients waiting 2-3 years v). No. of patients waiting over 4 years		---	---	New PI 2013
No. of patients receiving active treatment during reporting period		13,777	14,316	13,600

Community (Demand-Led) Schemes				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Medical Cards	AND PCRS			
No. persons covered by Medical Cards	Monthly	1,838,126	1,861,245	1,921,245
(Incl. no. persons covered by discretionary Medical Cards)		85,000	63,311	55,328
GP Visit Cards				
No. persons covered by GP Visit Cards		204,482	135,257	265,257
(Incl. no. persons covered by discretionary GP Visit Cards)		20,000	15,586	15,836
% of properly completed medical / GP visit card applications processed within the 15 day turnaround		New PI 2012	90%	90%
Long Term Illness				
No. of claims		844,241	898,173	923,794
No. of items		2,794,437	2,937,026	3,020,807
Drug Payment Scheme				
No. of claims		2,726,939	3,031,501	2,834,189
No. of items		8,453,510	9,488,598	8,871,012
GMS				
No. of prescriptions		22,154,661	19,641,468	20,864,890
No. of items		61,589,957	61,477,794	65,307,106
No. of claims – Special items of Service		859,123	875,047	883,796
No. of claims – Special Type Consultations		1,074,340	1,205,938	1,217,992
Hi-Tech				
No. of claims		452,267	452,616	461,668
DTSS				
No. of treatments (above the line)		1,164,805	1,131,182	1,127,410
No. of treatments (below the line)		50,867	54,538	54,357
No. of patients who have received treatment (above the line)		521,142	521,142	519,707
No. of patients who have received treatment (below the line)		56,479	56,479	56,323
Community Ophthalmic Scheme				
No. of treatments		739,579	782,738	798,393
i). Adult		677,007	716,322	730,649
ii). Children		62,572	66,416	67,744

Pre-Hospital Emergency and Retrieval Care				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Emergency Response Times	AND Ambulance			
% of Clinical Status 1 ECHO incidents responded to by first responder in 7 minutes and 59 seconds or less	Monthly	75%	50%	> 50%
% of Clinical Status 1 DELTA incidents responded to by first responder in 7 minutes and 59 seconds or less		75%	24%	> 24%
% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 85%)		80% by June 2012 85% by Dec 2012	70%	> 70%
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 85%)		80% by June 2012	68%	> 68%

Pre-Hospital Emergency and Retrieval Care				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
		85% by Dec 2012		

Acute Hospitals including Clinical Programmes				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Discharges Activity Inpatient	AND Acute Services Monthly	562,133	600,887	600,887
Inpatient same day discharge from AMUs*		---	---	To be established
Day Case		787,557	830,165	830,165
Elective		---	198,506	198,506
Non Elective / Emergency		---	402,381	402,381
Emergency Care No. of emergency presentations*		1,195,700	**1,207,099	**1,207,099
No. of emergency admissions*		357,600	380,090	380,090
% Discharges which are Public Inpatient	AND Acute Services Monthly	80%	78%	80%
Day Case		80%	85%	80%
Inpatient Elective		---	76%	80%
Inpatient Non Elective / Emergency		---	80%	80%
HIPE % cases entered into HIPE		100%	Reporting mechanisms being streamlined	100%
Average Length of Stay Overall ALOS for all inpatient discharges and deaths		5.6	5.8	5.6
Overall ALOS for all inpatient discharges and deaths excluding LOS over 30 days		4.5	4.6	4.5
Inpatient % of elective inpatients who had principal procedure conducted on day of admission		75%	54%	75%
Inpatient and Day Case Waiting Times No. of adults waiting > 8 months for an elective procedure (inpatient)		---	---	0
No. of adults waiting > 8 months for an elective procedure (day case)		---	---	0
No. of children waiting > 20 weeks for an elective procedure (inpatient)		---	---	0
No. of children waiting > 20 weeks for an elective procedure (day case)		---	---	0
Colonoscopy / Gastrointestinal Service No. of people waiting more than 4 weeks for an urgent colonoscopy		0	0	0
No. of people waiting >13 weeks following a referral for routine colonoscopy or OGD		---	---	0
Emergency Care % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge		9.6%	11%	9.6%
% of all attendees at ED who are discharged or admitted within 6 hours of registration		95% by Sept. 2012	67%	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration		100%	81.4%	100%

Acute Hospitals including Clinical Programmes				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)		95%	83%	95%
Delayed Discharges Reduction in bed days lost through delayed discharges	AND Acute Services / AND Older People Monthly	Reduce by 10%	5% Reduction	10% reduction
Reduction in no. of people subject to delayed discharges		Reduce by 10%	693	10% reduction
Births Total no. of births	AND Acute Services Monthly	73,216	71,096	71,096
Outpatients (OPD) No. of people waiting longer than 52 weeks for OPD appointment		---	---	0
New attendance DNA rates		New PI 2013	15.8%	12%
Dialysis Modality Haemodialysis	National Renal Office Bi-annually	1,760 – 1,870	1,624	1,699 – 1,714
Home Therapies		280 – 290	233	251 – 260
Total		2,040 – 2,160	1,857	1,920 – 1,974
Blood Policy No. of units of platelets ordered in the reporting period	ND Quality and Patient Safety Monthly	21,500 (3% reduction)	21,500	**21,178
% of units of platelets outdated in the reporting period		< 10%	< 6%	< 8%
% usage of O Rhesus negative red blood cells		< 11%	< 13%	< 11%
% of red blood cell units rerouted to hub hospital		< 5%	< 4%	< 5%
% of red blood cell units returned out of total red blood cell units ordered		< 2%	< 0.8%	< 1%
Acute Medicine % of all new medical patients attending the acute medical assessment unit (AMAU) who spend less than 6 hours from ED registration to AMAU departure (TMAT)	Clinical Lead Monthly	---	---	95%
Medical patient average length of stay		5.8	7.4	5.8
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission		---	---	85%
% of surgical re-admissions to the same hospital within 30 days of discharge		---	---	< 3%
Surgical patient average length of stay		---	---	4.5% reduction by end 2013
ED % of all patients arriving by ambulance wait < 20 mins for handover to doctor / nurse	Clinical Lead Monthly	95%	Due for reporting 2013	95%
% of ED patients who leave before completion of treatment		< 5% of new patient attendances	4%	< 5% of new patient attendances
% of patients spending less than 24 hours in Clinical Decision Unit		95%	Due for reporting 2013	95%
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Clinical Lead Bi-annually	50%	53%	50%
% of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis		At least 7.5%	9%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		50%	46%	50%

Acute Hospitals including Clinical Programmes				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Heart Failure Rate (%) re-admission for heart failure within 3 months following discharge from hospital	Clinical Lead Quarterly	27%	7.5%	25%
Median LOS and bed days for patients admitted with principal diagnosis of acute decompensated heart failure		7 days	8 days	7 days
% patients with acute decompensated heart failure who are seen by HF programme during their hospital stay		65%	92%	70%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Clinical Lead Quarterly	50%	67%	70%
% reperfused STEMI patients (or LBBB) who get timely				
a) PPCI or		70%	64%	70%
b) thrombolysis		70%	57%	70%
Medial LOS and bed days for				
a) STEMI		4	4	4
b) Non-STEMI pts		6.5	5	6
COPD Mean and median LOS (and bed days) for patients with COPD	Clinical Lead Quarterly	1 day reduction in AVLOS in sites with COPD outreach by end 2012	7.8 5	7.8 5
% re-admission to same acute hospitals of patients with COPD within 90 days		Reduce rate by 15% in hospitals with COPD outreach progs; all other acute hospitals with AMU / AMAU by 5%	25%	24%
No. of acute hospitals with COPD outreach programme	Clinical Lead Bi-annually	15 programmes	11	15
Access to structured Pulmonary Rehabilitation Programme in Local Health Area				20 / 32 (63%)
Access to structured Pulmonary Rehabilitation Programme in acute hospital services				25 sites
Asthma % nurses in primary and secondary care who are trained by national asthma programme	Clinical Lead Annually	90%	Approx. 7%	90%
No. of asthma bed days prevented annually		1,258	956	1,164 (10% Reduction)
No. of deaths caused by asthma annually		55	62	10% reduction (<56)
Diabetes % reduction in lower limb amputation from Diabetes	Clinical Lead Annually	40%	Due for reporting 2013	40%
% reduction in hospital discharges for lower limb amputation and foot ulcers in diabetics		40%	Due for reporting 2013	40%
% of registered Diabetics invited for retinopathy screening	Clinical Lead Quarterly	90%	Due for reporting 2013	90%
Epilepsy % reduction in median LOS for epilepsy inpatient discharges	Clinical Lead Quarterly	10%	0%	10%
% reduction in no. of bed days for epilepsy inpatient discharges		10%	6%	10%
Dermatology OPD No. of new patients waiting > 3 months for dermatology OPD appointment	Clinical Lead Bi-annually	New PI 2012	Due for reporting 2013	10% improvement on baseline
No. of new dermatology outpatients seen per hospital per year		Increase of 30% on 2009 attendances	Increase of 45%	40,000

Acute Hospitals including Clinical Programmes				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Referral: New Attendance ratio		1:2	1:2	10% improvement on baseline
Rheumatology OPD No. of new rheumatology patients seen per hospital per year	Clinical Lead Bi-annually	Increase of 30% on 2009 attendances	Increase of 39%	12,400
Referral: New Attendance ratio		1:4	1:4	10% improvement on baseline
Neurology OPD No. of new neurology patients seen per year	Clinical Lead Bi-annually	Increase of 30% on 2009 attendances	Increase of 23% (14,004)	15,404
Referral: New Attendance ratio		1:3	1:2.6	1:3

* Discharges from AMUs, AMAUs, MAUs in 2013 will be recorded and returned as inpatients. The numbers returned for this category will be reported separately to establish a baseline and confirm that consistent and reliable reporting is in place. Once this is established figures for emergency presentations and admissions, which will be impacted by this, will be adjusted accordingly.

** This figure is an amendment to that shown in NSP2013

National Cancer Control Programme				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Symptomatic Breast Cancer Services No. of urgent attendances	NCCP Quarterly	13,000	13,890	13,900
No. of non urgent attendances		25,000	25,176	25,200
No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals *(No. and % offered an appointment that falls within 2 weeks)*		12,350 95%	13,600 98%	13,200 95%
No. and % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals *(No. and % offered an appointment that falls within 12 weeks)*		23,750 95%	23,565 94%	23,940 95%
Breast Cancer Screening No. of women who attend for breast screening	NCCP Quarterly	140,000	118,000	140,000
Lung Cancers No. of attendances at rapid access lung clinic	NCCP Quarterly	New PI 2012	2,705	2,700
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre		95%	2,354 87%	2,565 95%
Prostate Cancers No. of centres providing surgical services for prostate cancers	NCCP Quarterly	6	8	7
No. of attendances at rapid access prostate clinics		New PI 2012	2,700	2,970
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre		90%	1,377 51%	2,600 90%
Rectal Cancers No. of centres providing services for rectal cancers	NCCP Quarterly	8	13	8
Radiotherapy No. of patients who completed radical radiotherapy treatment in the preceding quarter (palliative care patients not included)	NCCP Quarterly	---	To be determined	To be determined
No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)		---	To be determined	To be determined

Palliative Care				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Inpatient Units Waiting Times i) Specialist palliative care inpatient bed within 7 days (during the reporting month)	AND Acute Services Monthly	91%	92%	92%
ii) Specialist palliative care inpatient bed within 1 month (during the reporting month)		98%	98%	98%
No. of patients in receipt of treatment in specialist palliative care inpatient units (during the reporting month)		349	340	340
No. of new patients seen or admitted to the specialist palliative care service (reported by age profile) (during the reporting month)		174	173	173
No. of admissions to specialist palliative care inpatient units (monthly cumulative)		2,865	2,892	2,892
Community Home Care Waiting Times i) Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	AND Acute Services Monthly	79%	82%	82%
ii) Specialist palliative care services in the community provided to patients in their place of residence within 1 month (Home, Nursing Home, Non Acute hospital) (during the reporting month)		97%	99%	99%
No. of patients in receipt of specialist palliative care in the community (monthly cumulative)		3,026	2,948	2,948
No. of new patients seen or admitted to specialist palliative care services in the community (reported by age profile) (during the reporting month)		645	664	664
Day Care No. of patients in receipt of specialist palliative day care services (during the reporting month)	AND Acute Services Monthly	320	331	331
No. of new patients in receipt of specialist palliative day care services (monthly cumulative)		---	848	848
Community Hospitals No. of patients in receipt of care in designated palliative care support beds (during the reporting month)	AND Acute Services Monthly	154	149	149

Mental Health				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Adult Inpatient Services No. of admissions to adult acute inpatient units	AND MH Quarterly	14,163	14,044	14,044
Median length of stay		11	11	11
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area		77.3	76.5	76.5
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area		24.6	24.9	24.9
Acute re-admissions as % of admissions		68%	67%	67%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area		52.7	51.6	51.6
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area		22.6	23.2	23.2
No. of adult involuntary admissions		1,388	*1,624	*1,624
Rate of adult involuntary admissions per 100,000 population in mental health catchment area		7.6	8.8	8.8
General Adult Community Mental Health Teams (CMHT) No. of General Adult CMHT	AND MH Monthly	---	---	New PI 2013

Mental Health				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
No. of referrals (including re-referred) received by General Adult CMHT		---	---	New PI 2013
No. of referrals (including re-referred) accepted by General Adult CMHT		---	---	New PI 2013
No. of new (including re-referred) General Adult CMHT cases offered first appointment and seen or DNA by Wait Time (time period to be decided)		---	---	New PI 2013
No. of cases closed / discharged by General Adult CMHT		---	---	New PI 2013
Psychiatry of Old Age Community Mental Health Teams (CMHT) No. of Psychiatry of Old Age CMHT	AND MH Monthly	---	---	New PI 2013
No. of referrals (including re-referred) received by Psychiatry of Old Age CMHT		---	---	New PI 2013
No. of referrals (including re-referred) accepted by Psychiatry of Old Age CMHT		---	---	New PI 2013
No. of new (including re-referred) Old Age Psychiatry Team cases offered first appointment and seen or DNA by Wait Time (time period to be decided)		---	---	New PI 2013
No. of cases closed / discharged by Old Age Psychiatry CMHT		---	---	New PI 2013
Child and Adolescent No. of child and adolescent Community Mental Health Teams	AND MH Quarterly	57	58	58
No. of child and adolescent Day Hospital Teams		2	2	2
No. of Paediatric Liaison Teams		3	3	3
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	AND MH Monthly	140	165	165
No. of children / adolescents admitted to adult HSE mental health inpatient units i). < 16 years ii). < 17 years iii). < 18 years	AND MH Quarterly	< 100 0 20 80	94 2 22 70	< 50 0 15 35
No. and % of involuntary admissions of children and adolescents	AND MH Annually	16 5%	16 5%	16 5%
No. of child / adolescent referrals (including re-referred) received by mental health services	AND MH Monthly	12,493	13,089	13,089
No. of child / adolescent referrals (including re-referred) accepted by mental health services		8,461	10,285	10,471
Total no. of new (including re-referred) child / adolescent referrals offered first appointment and seen		7,824	8,727	10,025
No. and % of new / re-referred cases offered first appointment and seen i). < 3 months		70%	67%	70%
No. and % of cases closed / discharged by CAMHS service		7,740 80%	8,499 82%	8,377 80%
Total no. on waiting list for first appointment at end of each quarter (reduce no. waiting by > 5%)	AND MH Quarterly	1,799	1,889	1,778
No. and % on waiting list for first appointment at end of each quarter by wait time i). < 3 months		624 35%	799 42%	761 43%
ii). 3-6 months		452 25%	344 18%	327 18%
iii). 6-9 months		365 20%	258 14%	246 14%
iv). 9-12 months		358 20%	258 14%	443 25% Refocusing a zero wait over 12 months will impact on the 9-12 months target

Mental Health				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
v). > 12 months		0	230 12%	0

* This figure is shown in NSP2013 as 1,642 due to a typographical error

Older People				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Home Care Packages Total no. of persons in receipt of a HCP (Monthly target)	AND SOP Monthly	10,870	10,942	10,870
i). No. and % direct provision		3,308 30.4%	3,213 29.4%	3,308 30.4%
ii). No. and % indirect provision		7,562 69.5%	7,729 70.6%	7,562 69.5%
iii). No. and % cash grants		955 8.7%	854 7.8%	955 8.7%
iv). No. and % respite		41 0.3%	32 0.3%	41 0.4%
v). No. and % multiple types		818 7.6%	868 7.9%	818 7.6%
No. of HCPs provided		5,300	5,300	5,300
No. of new HCP clients, annually		4,800	5,300	4,800
Home Help Hours No. of home help hours provided for all care groups (excluding provision of hours from HCPs) Following a review of DNE data and direction from ISD there has been a technical adjustment to the HH target from 10.7m in NSP2012 to 10.3m hours	AND SOP Monthly	10.30m	10.10m	10.30m
No. of people in receipt of home help hours (excluding provision of hours from HCPs) (Monthly target)		50,002	48,013 (Oct)	50,002
Day Care No. of day care places for older people	To be determined	New PI 2012	18,919	21,460
NHSS No. of people being funded under NHSS in long term residential care at end of reporting month	AND SOP Monthly	23,611	22,188 (Oct)	22,761
No. and proportion of those who qualify for ancillary state support who chose to avail of it		Demand-led	Not collected in 2012	Demand-led
% of complete applications processed within four weeks		100%	100%	100%
Subvention and Contract Beds No. in receipt of subvention	AND SOP Monthly	760	900	700
No. in receipt of enhanced subvention		540	480	380
No. of people in long-term residential care who are in contract beds		To be reported in 2012	1,460	1,250
No. of long stay residents in public and voluntary nursing homes admitted before 27 Oct 2009 (saver cases)		To be reported in 2012	2,800	2,200
Public Beds No. of NHSS Beds in Public Long Stay Units	AND SOP Monthly in arrears	New PI 2013	5,477	Subject to viability plan
No. of Short Stay Beds in Public Long Stay Units		New PI 2013	1,900	Subject to viability plan
Average length of Stay for NHSS clients in Public, Private and Saver Long Stay Units	AND SOP Annually	---	---	New PI 2013
% of population over 65 years in NHSS / Saver Beds (based on 2011 Census figures)		---	---	New PI 2013

Older People				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Elder Abuse No. of new referrals by region	AND SOP Quarterly	2,000	2,467	2,640
No. and % of new referrals broken down by abuse type: i). Physical		---	11.5%	---
ii). Psychological		---	29.5%	---
iii). Financial		---	20.2%	---
iv). Neglect		---	15.2%	---
No. of active cases		---	1,261	---
% of referrals receiving first response from senior case workers within four weeks		100%	96.9%	100%

Disability Services				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Day Services No. of work / work-like activity WTE places provided for persons with intellectual disability (ID) and / or autism	AND Disabilities Bi-annually	1,578	1,557	1,557
No. of persons with ID and / or autism benefiting from work / work-like activity services		3,084	3,123	3,123
No. of work / work-like activity WTE places provided for persons with physical and / or sensory disability		71	72	72
No. of persons with physical and / or sensory disability benefiting from work / work-like activity services		138	144	144
No. of Rehabilitative Training places provided (all disabilities)	AND Disabilities Monthly	2,627	2,627	2,627
No. of persons (all disabilities) benefiting from Rehabilitative Training (RT)		2,991	2,948	2,948
No. of persons with ID and / or autism benefiting from Other Day Services (excl. RT and work / work-like activities)	AND Disabilities Bi-annually	12,430	13,382	13,382
No. of persons with physical and / or sensory disability benefiting from Other Day Services (excl. RT and work / work-like activities)		2,581	2,793	2,793
Residential Services No. of persons with ID and / or autism benefiting from residential services	AND Disabilities Quarterly	8,416	8,172	8,172
No. of persons with physical and / or sensory disability benefiting from residential services		708	847	847
Respite Services No. of bed nights in residential centre based respite services used by persons with ID and / or autism	AND Disabilities Quarterly	231,213 Baseline recast	213,346	213,346
No. of persons with ID and / or autism benefiting from residential centre based respite services		5,115	5,087	5,087
No. of bed nights in residential centre based respite services used by persons with physical and / or sensory disability		28,329 Baseline recast	32,917	32,917
No. of persons with physical and / or sensory disability benefiting from residential centre based respite services		1,220	2,571	2,571
Personal Assistant (PA) / Home Support Hours Total no. adults and children with physical and / or sensory disability benefiting from Home Support hours (incl. PA)	AND Disabilities Quarterly	4,038	4,166	4,166
Total no. of Home Support hours (incl. PA) delivered to adults and children with physical and / or sensory disability.		1.68m	2.11m	1.68m

Disability Services				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
No. of adults with a physical and / or sensory disability in receipt of personal assistant (PA) hours		Revised breakdown 2013	---	Subset of above
No. of Personal Assistant (PA) hours delivered to adults with physical and / or sensory disability		Revised breakdown 2013	---	Subset of above
No. of adults and children with physical and / or sensory disability benefiting from Home Support hours		Revised breakdown 2013	---	Subset of above
No. of Home Support hours delivered to adults and children with physical and / or sensory disability		Revised breakdown 2013	---	Subset of above
No. of adults and children with an intellectual disability and / or autism in receipt of Home Support hours		---	---	New PI 2013
No. of Home Support hours delivered to adults and children with an intellectual disability and / or autism		---	---	New PI 2013
Disability Act Compliance No. of requests for assessments received	AND Disabilities Quarterly	3,636	3,365	3,501
No. of assessments commenced as provided for in the regulations		3,327	3,168	3,294
No. of assessments commenced within the timelines as provided for in the regulations		3,327	2,353	3,294
No. of assessments completed as provided for in the regulations		3,327	2,291	3,294
No. of assessments completed within the timelines as provided for in the regulations		3,327	644	3,294
No. of service statements completed		2,828	2,388	2,766
No. of service statements completed within the timelines as provided for in the regulations		2,828	1,456	2,766
Services for Children and Young People % of Local Implementation Groups which have Local Implementation Plans for progressing disability services for children and young people	AND Disabilities Bi-annually Q2 and Q4	100%	25%	100%
No. of established geographically based teams having current individualised plans for each child		---	---	New PI 2013
% of established geographically based teams having current individualised plans for each child		---	---	New PI 2013

Notes to Performance Indicators / Activity Measures: During 2012, the Disability Services PI suite was the subject of a major review and validation exercise which has resulted in amendments being made to the "Expected Activity/Target 2012" data contained in the National Service Plan 2012. Furthermore, refinements made to the definitions attaching to the service types has resulted, in some cases, in the "Projected Outturn 2012" data differing significantly from original expectations.

Children and Family Services				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
After Care No. of young adults aged 18 to 20 (inclusive) in receipt of an aftercare service on the last day of the reporting period	Office of ND Quarterly	New PI 2012	1,341	1,363
No. of young adults aged 18 to 20 (inclusive) in receipt of an aftercare service who are in full time education on the last day of the reporting period		New PI 2012	683	703
Child Protection – Child Abuse i). No. of referrals of child abuse	Office of ND Quarterly (in arrears)	Demand-led	Under review	Demand-led
ii). % of referrals of child abuse where preliminary enquiry(s) (National Intake Form) took place and were completed within 24 hours of receipt of the referral		New PI 2012		74%
iii). % of referrals of child abuse which required an initial assessment following a preliminary enquiry		Demand-led		72%
iv). % of these initial assessments completed within 21 days of receipt of the referral		New PI 2012		25%
v). % of initial assessments which led to the child being listed on the Child Protection Notification System (CPNS)		Demand-led		Demand-led

Children and Family Services				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Child Protection – Child Welfare i). No. of referrals of child welfare concerns	Office of ND Quarterly (in arrears)	Demand-led	Under review	Demand-led
ii). % of referrals of child welfare concerns where preliminary enquiry(s) (National Intake Form) took place and were completed within 24 hours of receipt of the referral		New PI 2012		60%
iii). % of referrals of child welfare concerns which required an initial assessment following a preliminary enquiry		Demand-led		55%
iv). % of these initial assessments completed within 21 days of receipt of the referral		New PI 2012		30%
v). % of initial assessments which led to the child being listed on the Child Protection Notification System (CPNS)		Demand-led		Demand-led
Residential and Foster Care No. and % of children in care by care type on the last day of the reporting period	Office of ND Monthly	6,526	6,249	6,560
i). Residential Special Care		0.3%	22	23
ii). Residential High Support		0.5%	17	18
iii). Residential General Care (Note: Include special arrangements)		< 7%	330	346
iv). Foster care General (not including day fostering)		59%	3,945	4,142
v). Foster care with relatives		30%	1,799	1,888
vi). Other care placements		3%	136	143
Private Residential Care No. and % of children in private residential care: Special Care	Office of ND Monthly	---	6	6
No. and % of children in private residential care: High Support		---	2	2
No. and % of children in private residential care: residential General		---	128	134
No. and % of children in foster care private: Foster care General		1%	205	215
No. and % of children in other care placements in private care		---	13	14
No. of children in single care residential placements		0	7	7
No. of children in residential care age 12 or under	Office of ND Quarterly	0	30	32
Children in Care in Education i). No. of children in care aged 6 to 16 inclusive	Office of ND Quarterly	4,365	4,326	4,544
ii). No. and % of children in care between 6 and 16 years, in full time education		100%	4,190	4,399
Allocated Social Workers No. and % of children in care who have an allocated social worker at the end of the reporting period:	Office of ND Monthly	100%	93.9%	100%
i). No. and % of children in residential special care with an allocated social worker		100%	100%	100%
ii). No. and % of children in residential high support with an allocated social worker		100%	100%	100%
iii). No. and % of children in residential general care with an allocated social worker		100%	96.4%	100%
iv). No. and % of children in foster care general with an allocated social worker		100%	94.3%	100%
v). No. and % of children in foster care with relatives with an allocated social worker		100%	92.1%	100%
vi). No. and % of children in other care placements with an allocated social worker		100%	97.1%	100%
Care Planning No. and % of children in care who currently have a written care plan as defined by *Child Care Regulations 1995*, at the end of the reporting period	Office of ND Monthly	100%	89.6%	100%

Children and Family Services				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
i). No. and % of children in residential special care with a written care plan		100%	100%	100%
ii). No. and % of children in residential high support with a written care plan		100%	100%	100%
iii). No. and % of children in residential general care with a written care plan		100%	92.7%	100%
iv). No. and % of children in foster care general with a written care plan		100%	89.1%	100%
v). No. and % of children in foster care with relatives with a written care plan		100%	90.1%	100%
vi). No. and % of children in other care placements with a written care plan		100%	88.2%	100%
Foster Carer Total no. of foster carers	Office of ND Quarterly	4,263	4,225	4,658
No. and % of foster carers approved by the foster care panel		3,837 90%	3,558 84.2%	88%
No. and % of relative foster carers where children have been placed for longer than 12 weeks whilst the foster carers are awaiting approval by the foster care panel, Part III of Regulations		New PI 2012	90%	90%
No. and % of approved foster carers with an allocated worker		100%	2,956 83.1%	90%
Out of Hours No. of referrals made to the Emergency Out of Hours Place of Safety Service (YTD at end of Q3 2012)	Office of ND Quarterly	395	494	518
No. of children placed with the Emergency Out of Hours Placement Service (YTD at end of Q3 2012)		270	408	427
No. of nights accommodation supplied by the Emergency Out of Hours Placement Service (YTD at end of Q3 2012)		*585	2,294	2,408
Early Years Services No. of notified early years service in operational areas at Q3	Office of ND Quarterly	4,841	4,481	4,705
% of early years services which received an inspection		100%	48.0%	42.1%
No. and % of early years services that are fully compliant at Q3 YTD		New PI 2012	388 21.7%	21.7%
No. of notified full day early years services at Q3		1,569	1,534	1,611
% of full day services which received an annual inspection at Q3 YTD		100%	43.4%	43.4%
% of complaints investigated		100%	100%	100%

*This figure is as appears in the Performance Reports and not as appears in NSP2013

Governance (QPS and Corporates)				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Quality and Patient Safety Audit Service (QPSAS) No. of QPSAS audits commenced as specified in annual QPSAS strategic plan	ND Quality and Patient Safety Quarterly	100% 24	100% 24	24
No. of QPSAS audits completed within the timelines agreed in approved QPSAS audit plans		90% 20	90% 19	20
% of QPSAS audits incorporating structured service user involvement		50%	20%	50%
Complaints % of complaints investigated within legislative timeframe	ND Quality and Patient Safety Quarterly	75%	70%	75%
Health Care Associated Infection (HCAI) Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	ND Quality and Patient Safety	< 0.067	0.063	< 0.060

Governance (QPS and Corporates)				
Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2012	Projected Outturn 2012	Expected Activity / Targets 2013
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	Quarterly	< 3.0	2.7	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	ND Quality and Patient Safety Bi-annually	83	85	83.7
Alcohol Hand Rub consumption (litres per 1,000 bed days used)		23	21.5	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool		85%	81.6%	90%
Health Care Associated Infection: Antibiotic Consumption Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	ND Quality and Patient Safety Bi-annually	21	23.3	23
Finance and HR Variance from budget under: i). I&E	AND Finance Monthly	≤ 0%	To be reported in the Annual Financial Statements 2012	≤ 0%
ii). Income collection		≤ 0%		≤ 0%
iii). Pay		≤ 0%		≤ 0%
iv). Non pay		≤ 0%		≤ 0%
v). Revenue and Capital Vote		≤ 0%		≤ 0%
Absenteeism rates	AND HR Monthly	3.5%	4.82%	3.5%
Variance from approved WTE ceiling		≤ 0%	-0.70%	≤ 0%
Parliamentary Questions % of Parliamentary Questions dealt with within 15 days	ND Communications Quarterly	75%	75%	75%

APPENDIX E – Reforming the Health Services: Responding to *Future Health*

In November, 2012, the Minister for Health launched *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015.* This new framework, based on Government commitments in its *Programme for Government*, outlines the main healthcare reforms that will be introduced in the coming years as key building blocks for the introduction of Universal Health Insurance in 2016.

Key to success will be to deliver conjoint working with the DoH to address the four pillars of reform:

- Health and Wellbeing - a renewed focus on keeping people healthy, not just treating people when they are ill.
- Service Reform - moving away from the current situation where many people are treated in hospitals when they could have been treated in the community and focusing on 'integrated care' so that services are well co-ordinated around the needs of the patient.
- Structural Reform - to promote good governance, avoid duplication and ensure a strong regional focus in managing performance and delivering value for money.
- Financial Reform - to ensure that the financing system is based on incentives that promote fairness and efficiency, while also reducing costs, improving control and improving quality.

The NSP2013 will be the HSE's response to the first full year's implementation of the reform programme therefore particular areas of focus in 2013 for the HSE will be:

Area	Action	Summary DoH Actions Impacting 2013	HSE Response 2013
Governance Arrangements	Actions 2 - 4	⌐ Establish robust overseeing governance structures by Q1, 2013 to drive, co-ordinate and monitor the reform process. ⌐ Develop a communications and consultation plan by Q4, 2012.	⌐ We will work with the new Programme Management Office in the DoH and participate in active consultation with all stakeholders in relation to implementation of the reform programme.
Patient Safety and Quality	Actions 5 - 8	⌐ Establish a new Patient Safety Authority on an administrative basis in 2013. ⌐ Develop a risk based approach to provision of indemnity to services and professionals by end of 2013. ⌐ Establish a National Task Force on Prescribing and Dispensing Practice by end Q4, 2012.	⌐ We will work with DoH to build on the existing functions of the HSE Quality and Patient Safety Directorate. Actions in relation to addressing initial priorities are outlined on pages 11-13. ⌐ We will respond to recommendations from the Health Information Quality Authority (HIQA) in relation to their health and social service regulatory and monitoring functions and work with the State Claims Agency in relation to indemnity services.
Health and Wellbeing	Actions 9 -13	⌐ Produce a comprehensive Health and Wellbeing Policy Framework by end of 2012. ⌐ Extend age range for BreastCheck screening commencing 2014. ⌐ Complete first round of colorectal screening by end 2015. ⌐ Deliver on targets for routine and urgent endoscopy procedures by end Q4, 2012.	⌐ A HSE Health and Wellbeing Directorate will be established in the HSE. Actions arising from the Framework once published are referenced on page 18. ⌐ NCCP will plan for the BreastCheck age extension in 2013 and will also continue the implementation process for colorectal screening in order to meet the 2015 target (as referenced on page 46). ⌐ We will continue to work with the SDU on the Endoscopy Performance Improvement Programme to meet the targets.
Structural Reform	Actions 14 - 17	⌐ Recommend composition and criteria for hospital groups by Q4, 2012 and establish first wave immediately after. ⌐ Review ISAs in Q2, 2013. ⌐ Develop Sectoral Plans for Shared	⌐ The HSE will continue to work with DoH on restructuring the hospitals and putting in place associated governance arrangements pending primary legislation to give full effect to establishing public hospitals as independent not-for-profit trusts. Actions are noted on page 39. ⌐ We will also assist the DoH in the review of corporate /

Area	Action	Summary DoH Actions Impacting 2013	HSE Response 2013
		Services and External Service Delivery by Q4, 2012. ⌐ Review of corporate functions and resources within HSE in 2013.	support / shared services and prepare for structural change – details of these actions are outlined on pages 74-88.
Financial Reform	Actions 18 - 25	⌐ Vote to be provided through the Office of the Minister for Health from Q1, 2014. ⌐ Develop Programme Based Budgeting (PBB) in 2013. ⌐ Implement recommendations from the review of financial management systems commencing Q4, 2012. ⌐ Develop and roll out a comprehensive financial management system as a matter of priority. ⌐ Develop time bound plans for the implementation of Money Follows the Patient by end 2012.	⌐ Preparation for the Vote transfer back to the DoH will take place in 2013. ⌐ We will work with the DoH and the Department of Public Expenditure and Reform (DPER) to develop PBB in 2013 within the confines of existing financial systems. ⌐ Work commenced in late 2012 to respond to the recommendations of the review of financial systems, this will continue in early 2013. ⌐ Our financial systems are fragmented and not fit for purpose. A proposal for a financial and procurement system was submitted to Government in October 2012 to enable detailed financial information support decision making at all levels in the organisation. We will continue to work with DoH and CMOD to obtain approval. ⌐ Actions to support financial reform and detailed actions to prepare for Money Follows the Patient are outlined on page 39.
Reforming Primary Care	Actions 26 - 29	⌐ Extend GP care without fees on a phased basis. ⌐ Introduce chronic disease management programmes commencing 2013. ⌐ Increase number of healthcare professionals working in primary care from 2013. ⌐ Implement programme of investment in primary care centres commencing 2012.	⌐ Once enacted, we will respond to the change in legislation in regard to eligibility for free GP care for people with certain conditions in the first instance. ⌐ A number of new programmes will commence in 2013 in relation to chronic disease management such as in diabetes and palliative care and are referenced throughout this plan. ⌐ €20m made available in 2012 will be carried forward to support the recruitment of prioritised frontline primary care team posts. ⌐ A number of new primary care centres are identified in the Capital Programme 2013 and outlined on page 31 and on pages 98-99.
Reforming Our Hospitals	Actions 30 - 33	⌐ Reduce waiting time for scheduled and emergency care in hospitals. ⌐ Establish hospital groups on administrative basis during Q1 2013 (Linked to Action 14). ⌐ Publish framework to develop smaller hospitals in Q4, 2012. ⌐ Reconfigure Ambulance Service by Q1, 2014.	⌐ Reduction of waiting times for scheduled and emergency care has been prioritised for action in 2013, with national targets set in areas such as emergency departments (EDs), inpatient and day case treatments, the details of which can be seen on page 109. ⌐ We will work with the DoH on establishing hospital groups and associated management and governance structures, pending primary legislation. ⌐ We will commence implementation of the small hospitals framework to ensure that patients receive high quality care in the most appropriate setting resulting in best possible outcomes. ⌐ The actions to reconfigure the Ambulance Service are set out on page 36.
Reforming Social and Continuing Care	Actions 34 - 41	⌐ Support the HSE on the roll out of a Single Assessment Tool (SAT) for older people services in 2013. ⌐ Commence work on a national standard assessment tool for people with disabilities in 2013. ⌐ Extend HIQA regulatory regime to residential services for people with disabilities in 2013. ⌐ Review the Fair Deal scheme by Q4, 2013 and applicability to	⌐ Actions on the SAT are set out on pages 60 and 83, subject to CMOD approval. ⌐ A standardised assessment tool, addressing the implication for disability residential facilities, implementing the *Value for Money and Policy Review* and the initiation of demonstration projects as 'proof of concept' have all been identified as priority areas for Disability Services with associated actions outlined on pages 63-65. ⌐ The HSE will participate in the DoH substantive review of the Fair Deal scheme and any recommendations it may make to its potential applicability to disability and mental

Area	Action	Summary DoH Actions Impacting 2013	HSE Response 2013
		disability and mental health services by Q4, 2013. ⌐ Develop implementation plan for *Value for Money and Policy Review of Disability Services* by Q4, 2012. ⌐ Complete a prospective funding model for palliative Care in 2013.	health services. ⌐ Palliative Care services will develop a prospective funding model for submission to the DoH Universal Health Insurance Implementation Group in Q3, 2013.
Tackling the Capacity Deficit	Actions 42 - 48	⌐ Develop an eHealth Strategy by Q1, 2013. ⌐ Publish the *Health Information Bill* by end Q2, 2013. ⌐ Establish an Information and ICT Strategy Unit in Q1, 2013. ⌐ Continue to maximise use of the Public Service Agreement (PSA) between 2012 – 2014. ⌐ Implement an approach to workforce planning and development from 2012. ⌐ Develop a series of leadership and learning sets for governance, quality and safety of healthcare delivery. ⌐ Address short and long term succession requirements at senior management team level from 2012.	⌐ We recognise that critical to the success of the reform agenda will be ICT and the wider information and informatics agenda, including enactment of essential legislation. ⌐ We will work with the DoH in the establishment of the Information and ICT Strategy Unit to ensure that the necessary information, technical and governance infrastructure is in place. ⌐ We will continue to use the provisions of the PSA to enable us to adapt in ways that protect service levels to the maximum extent and cognisant of the need to reduce staffing numbers and cost. ⌐ Detailed actions in relation to Human Resources are identified on pages 77-79. ⌐ Under the governance of the Quality and Patient Safety Directorate, in 2013 we will also deliver a number of training programmes on quality improvements and patient safety to clinical leaders and develop a specific programme for Clinical Directors.

ABBREVIATIONS

ACS	Acute Coronary Syndrome
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
AMNCH	Adelaide and Meath, incorporating the National Children's Hospital
AMAU	Acute Medical Assessment Unit
AMP	Acute Medicine Programme
AMU	Acute Medical Unit
ASIST	Applied Suicide Intervention Skills Training
bn	billion
CAMHS	Child and Adolescent Mental Health Services
CAMHT	Child and Adolescent Mental Health Team
CEO	Chief Executive Officer
CLÁR	Ceantair Laga Árd-Riachtanais
CMHT	Community Mental Health Team
CMOD	Centre for Management and Organisational Development
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CPP	Crisis Pregnancy Programme
DML	Dublin Mid Leinster
DNA	Did Not Attend
DNE	Dublin North-East
DoH	Department of Health
DPER	Department of Public Expenditure and Reform
DTSS	Dental Treatment Services Scheme
ECD	Executive Clinical Directorate
ED	Emergency Department
EH	Environmental Health
EMP	Emergency Medicine Programme
ePCR	Electronic Patient Care Record
EU	European Union
FSAI	Food Safety Authority of Ireland
GMS	General Medical Services
GP	General Practitioner
HCAI	Healthcare Associated Infection
HCP	Home Care Package
HIPE	Hospital Inpatient Enquiry Scheme
HIQA	Health Information Quality Authority
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HR	Human Resources
HSCN	Health and Social Care Network
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
ICS	Intermediate Care Service
ICT	Information and Communication Technology
ICU	Intensive Care Unit
ID	Intellectual Disability
IHR	International Health Regulations
ISA	Integrated Service Area
ISD	Integrated Services Directorate
KPI	Key Performance Indicator
LAN	Local Area Network
LGBT	Lesbian, Gay, Bisexual and Transgender
LHO	Local Health Office
LRC	Labour Relations Commission
LTI	Long Term Illness
m	million
MAU	Medical Assessment Unit
MHC	Mental Health Commission
MMR	Measles, Mumps, Rubella vaccine
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAS	National Ambulance Service
NCCP	National Cancer Control Programme

NCHD	Non Consultant Hospital Doctor
NCPOP	National Centre for the Protection of Older People
NCRI	National Cancer Registry of Ireland
NDA	National Disability Authority
NEWS	National Early Warning Score
NHSS	Nursing Homes Support Scheme
NIMIS	National Integrated Management Imaging System
NGO	Non-Governmental Organisation
NOSP	National Office for Suicide Prevention
NSP	National Service Plan
OGD	Oesophagogastroduodenoscopy
OPAT	Outpatient Parenteral Antimicrobial Therapy
OPD	Outpatient Department
PA	Personal Assistant
PBB	Programme Based Budgeting
PCRS	Primary Care Reimbursement Service
PCT	Primary Care Team
PHN	Public Health Nurse
POA	Psychiatry of Old Age
PPCI	Primary Percutaneous Coronary Intervention
PSA	Public Service Agreement
QA	Quality Assurance
QPS	Quality and Patient Safety
QPSA	Quality and Patient Safety Audit
RAPID	Revitalising Areas by Planning, Investment and Development
RDO	Regional Director of Operations
SAT	Single Assessment Tool
SDU	Special Delivery Unit
STEMI	ST Elevation Myocardial Infarction
TB	Tuberculosis
TPOT	The Productive Operating Theatre
VFM	Value for Money
WHO	World Health Organisation
WTE	Whole Time Equivalent

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