National Service Plan **2018**

Building a Better Health Service

Seirbhís Sláinte Níos Fearr á Forbairt

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

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

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

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

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

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Foreword from the Director General

The National Service Plan 2018 (NSP 2018) sets out the type and volume of health and social care services to be provided by the Health Service Executive (HSE) in 2018, having regard to the funding made available to us. The plan seeks to balance priorities across all of our services that will deliver on our *Corporate Plan 2015-2017.* Priorities of the Minister for Health and Government as set out in *A Programme for a Partnership Government, 2016* are also reflected.

The 2018 budget of €14.5 billion represents an overall increase of €608 million (m) (4.4%) which is a substantial and very welcome additional level of funding. There has been cumulative additional funding in recent years and this has supported growth in targeted service areas and developments and further funding has been made available in 2018 for new development and the expansion of some services.

The growing cost of delivering core services is such that the HSE faces a very significant financial challenge in 2018 in maintaining the existing level of overall activity, to which we are fully committed. In mitigating this, we are conscious that maintaining services and driving improvements in patient safety and quality remain over-riding priorities across the health sector, and all savings and efficiency measures will be assessed with these priorities in mind. It is our intention, from the start of 2018, to put in place a Value Improvement Programme, targeting improvement opportunities up to €346m, to address the financial challenge (see Section 6 and Section 7 for more detail).

Within the over-arching Value Improvement Programme we will focus on three broad priority themes: improving value within existing services; improving value within non-direct service areas; and strategic value improvement. Robust governance and appropriate support arrangements will be established to manage the Programme.

Against this financial background, the plan sets out the services that we will aim to provide in 2018, together with our priorities, focusing on a small number of key themes that signal a direction towards a more sustainable and safe healthcare service for the people of Ireland. The issues and opportunities in respect of delivery are also set out within the plan.

The following areas are covered in NSP 2018:

- The plan identifies our key reform themes within Building a Better Health Service, including: improving population health; delivering care closer to home; developing specialist hospital care networks and; improving quality, safety and value.
- The plan provides details on priorities, actions and the type and volume of service that will be provided by our operational service areas which include: health and wellbeing, primary care, mental health, disability, older persons, acute hospitals, cancer and pre-hospital emergency care.
- The plan describes the Financial Framework that supports the plan. It details the expenditure limits for the HSE at national level and also sets out specific areas of investment in 2018.
- The plan describes how we will refocus our efforts to achieve the best outcomes and value for every euro spent through the establishment of a comprehensive Value Improvement Programme.
- The plan focuses on our Workforce, all of whom are fundamental to delivering health and social care services across the country. Their contribution and commitment, much of which is showcased in our Achievement Awards, is at the heart of an effective health service, and their effective engagement is essential to successful transformation in the future.

- The plan outlines the priorities of the key functions that support our services.
- The plan lists the performance indicators against which performance will be measured. These indicators are dependent on the type and volume of services being provided and the underlying assumptions about the level of demand for our services, access arrangements and efficiency, including intended improvements.

The HSE continues to deliver its services in an environment where the population is growing, the number of people seeking to access services is higher than ever before and where public expectations for quality services continue to increase.

I contributed to the Future of Healthcare Committee at the end of 2016 and I argued that our health services model and design, as it currently exists, is no longer fit for purpose. It was designed for a time when we had a different demographic profile and the expectations around clinical governance and standards were not as they are today. Today our population is older. Modeling forecasts tell us that the people aged over 65 will increase by nearly 110,000 in the next five years. That is great news; however a large proportion of this older age group now lives with two or more chronic conditions, which make many of them more vulnerable and frail.

For several years we have been aware of the need for a shift in health service delivery in order to move from the more traditional focus of treatment and cure, to that of prevention and treatment, when required. The challenges referenced in this service plan are recognised fully in the recent *Sláintecare,* which signals a new direction of travel in relation to eligibility, delivery, and funding of health and social care in Ireland into the future. The cross-party support for *Sláintecare* presents a huge opportunity and, appropriately resourced and governed, it has the potential to transform the health and wellbeing of the population, and how and where they access services.

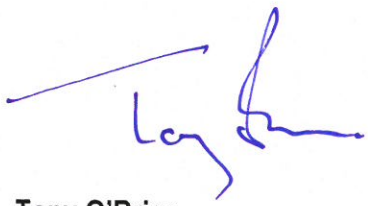
In this context therefore, 2018 provides a powerful opportunity to create much needed strategic certainty for the health and social care delivery system in Ireland. We are committed to working with Government to develop an implementation plan for *Sláintecare*. An appropriately governed transitional fund to ensure that necessary strategic repositioning of services is achieved, will be critical to success.

Risks to delivery of NSP 2018

In seeking to address the challenges in 2018 which I have outlined above, the HSE will operate to a set of key assumptions including those provided by the Department of Health (DoH). There remain, however, some risks to our ability to deliver the level and type of service as set out in the service plan, including:

- Delivering a volume of activity, driven by need, which is beyond funded levels.
- Sustaining a level of service in areas where the nature of the response is such that activity cannot be stopped or spend avoided, examples are emergency services in hospitals and emergency placements for people with a disability.
- Progressing at scale and pace the required transformation agenda within the funding levels available.
- Meeting the regulatory requirements in the disability sector, long-stay facilities and mental health and hospital services, within the limits of the revenue and capital available and without impacting on planned service levels.

- Responding to urgent safety concerns and emergencies such as carbapenemase-producing enterobacteriaceae (CPE). We will work with the National Public Health Emergency team to mitigate this risk, including how to manage emerging resource implications.
- Meeting new drug costs.
- Effectively managing our workforce including recruitment and retention of a highly skilled and qualified workforce, required rationalisation of the use of agency personnel and staying within our pay budget.
- Working within the constraints posed by limitations to clinical, business financial and human resource (HR) systems.
- Investing in and maintaining our infrastructure, addressing critical risks resulting from ageing medical equipment and physical infrastructure, and adhering to health and safety regulations.



Tony O'Brien
Director General
Chairman of the Directorate
20th December 2017

Section 1: Introduction and Key Reform Themes

The NSP 2018 sets out the type and volume of health and social care services which the HSE expects to deliver in 2018. It has regard to available funding, planning assumptions agreed with or planned by the DoH and what can be delivered by realistic and achievable measures to improve the economy, efficiency and effectiveness of our services during 2018. NSP 2018 provides details on the size and nature of our population, the needs of patients and clients and how these are changing. The plan also sets out the current services that are in place to respond to these needs, the issues and challenges with these services and the opportunities for improvement. The plan provides a view of our transformational priorities, including the areas of *Healthy Ireland*, the Integrated Care Programmes and the Programme for Health Service Improvement (PHSI). Finally, NSP 2018 sets out the overarching priorities and specific actions to be progressed by the HSE during 2018 to deliver both improved population health, and health and social care services, within a given financial framework and consistent with Ministerial and Governmental priorities, as set out in the *Programme for a Partnership Government, 2016* and the HSE's *Corporate Plan 2015-2017*.

Our population

According to the 2016 Census, there are just over 4.7m people living in Ireland, an increase of approximately 4% (nearly 170,000 people) since 2011. Our population is growing older, with the number of people aged 65 years and over increasing from 11% in 2011 to 13% in 2016. And this trend will continue; forecasts tell us that the number of people aged over 65 will increase by a further 18% to 753,000 in the next five years. The increase in the older persons' population is welcome; it is an acknowledgement of improved health, supported by health services which are continuingly developing and other societal changes. Increased longevity offers opportunities and also requires a response to ensure that health and social care services are delivered at adequate levels, in an integrated way, to meet the needs of older people.

A particular focus is needed for the management of chronic illness. Nearly two thirds of people in the older age group now live with two or more chronic conditions and these affect the quality of their lives. There is a need for a multi-annual action plan to deal with lifestyle changes which could make a difference, as well as introducing new ways of managing chronic illness both in our primary care and acute hospital services.

Approximately three quarters of all deaths in Ireland are due to three chronic diseases – cancer, cardiovascular disease (diseases of the heart and circulation including angina, heart attacks and strokes), and respiratory disease (diseases of the lungs and airways such as chronic obstructive pulmonary disease (COPD)). These diseases are significantly related to lifestyle-based health determinants such as smoking, alcohol consumption, lack of exercise and obesity.

The need for change

The current arrangements for service delivery in Ireland are characterised by an over-reliance on more costly, hospital-based care, with continuing opportunities to deliver care more appropriately in primary and community settings. There are challenges in responding effectively to the planned, unplanned and emergency needs of patients. Similar pressures are faced by services in primary and community services,

including services for people with disabilities and people who need mental health support, with demand outstripping supply in many areas.

As we look to the future, it is likely to prove very challenging for health and social care services in Ireland to secure the additional annual funding increases that would be required each year sufficient to allow:

(i) the existing arrangements and approaches to service delivery to expand at the pace required necessary to respond to the increasing needs of our population; and

(ii) the population to have access to the latest models of care, evidence-based technologies, drugs and devices.

In addition, there is a growing need to maintain or replace our current infrastructure and equipment.

If we continue with our existing arrangements and approaches to service delivery, it will become more difficult for patients and staff as the capacity of available services is increasingly outstripped by the demands placed upon them.

It is essential that we seek now, as quickly as possible, within available resources and with appropriate transitional support to radically reshape how health and social care services are delivered in Ireland. Significant work will be undertaken in 2018, in line with *Sláintecare*, to plan for the changes required. For 2018, our objective is to maintain quality, deliver good outcomes and recognise that there are opportunities, even in a constrained financial environment, to provide excellent health and social care services to the population. In so doing, the system will ensure that the resources available to health and social care are targeted towards providing care and support for those patients and clients most in need, and ensuring that these services are delivered efficiently and effectively, consistent with best available evidence.

NSP 2018 pursues this approach, building on, and adding pace and momentum to the good work already underway across the health and social care system in Ireland. It will be more important than ever that we secure value for money, achieving maximum benefit from the available financial, staffing and infrastructure resources. Neutral decisions are rare in the healthcare environment; this means that all decisions have to be carefully assessed for the potential benefits for particular groups of patients and clients, and potential opportunity costs for others. Equally, a failure to take action to maximise the cost effectiveness in any one service area or location will simply translate into wasteful expenditure and therefore lost opportunities to develop or improve services elsewhere.

Details of our priority reform themes and associated initiatives and actions that we will seek to progress in 2018, are set out below and in the following chapters.

Key reform themes

Consistent with the need to improve the health of the population, and to radically reshape where and how services are provided, we shall be pursuing four key reform themes during 2018 and beyond, namely:

1. Improving population health.
2. Delivering care closer to home.
3. Developing specialist hospital care networks.
4. Improving quality, safety and value.

Improving population health

Keeping people well, reducing ill health and supporting people to live as independently as possible, will all be essential if we are to manage the demands on the finite capacity of the health and social care system. Prevention is the most cost-effective way to maintain the health of the population in a sustainable manner, creating healthy populations that benefit everyone. During 2018 and beyond, we will seek to progress a range of initiatives and actions that:

- Tackle inequalities in health status and access to services.
- Support the independence and social inclusion of older people, people with disabilities, people with long term health conditions and vulnerable groups.
- Tackle the main causes of chronic illness.
- Target children and families to improve health outcomes.
- Secure the engagement of local communities to improve community health and wellbeing.
- Strengthen existing screening and health protection activities.

Delivering care closer to home

There is a significant opportunity to shift care out of acute and congregated institutions and into community and home settings. This is more convenient for patients and supports them to self-manage and live more independently, offers better value for money, and facilitates greater service integration and proactive delivery of care. Over time, the aim is to meet the vast majority of the population's health and social care needs in local settings, with institutional and hospital-based care being reserved for only those individuals requiring complex, specialised and emergency care, and even then only for the shortest period possible. During 2018 and beyond, we will seek to progress a range of initiatives and actions that:

- Use the learning from the Patient Narrative Project: Your Voice Matters to inform service development.
- Support the pro-active management of the health of local populations using a risk-stratification approach.
- Support the development of local, integrated multi-disciplinary teams, working seamlessly to anticipate and respond to the needs of local populations.
- Strengthen staffing and infrastructure capacity in primary and community services, maximising the use of smaller hospital sites.
- Support the development of new roles and competencies for staff.
- Support general practitioners (GPs) to work individually and collectively, with access to diagnostics and specialist opinion, to minimise referrals to acute services to those patients who truly need them.
- Demonstrably provide health and social care closer to the home, at the lowest appropriate level of complexity, significantly reducing the need for patients to attend hospital.
- Strengthen ambulatory services at the 'front door' of hospitals, with more multi-dimensional urgent and emergency care provision models and enhanced patient pathways, significantly reducing the need for patients to be admitted to hospitals.
- Reduce acute length of stay safely by building community services and capacity in rehabilitation, residential or home settings.
- Support collaboration and integrated working across professions, across pre-hospital, acute and primary and community services settings, and across localities.

Developing specialist hospital care networks

In parallel with the requirement to shift less complex acute care from hospital to community settings, there is a need to ensure that the secondary and tertiary care sectors are able to deliver the complex, specialised and emergency care that will be required by patients.

As the practice of medicine has become more specialised, there is clear evidence that outcomes for patients are improved by aggregating particular services in a specific place. This provides the necessary critical mass and clinical throughput with specialised infrastructure to retain specialist skills, ensuring services are safe, sustainable and high quality. Consistent with this shift towards greater specialisation, there is also a need to separate certain elective (planned) activities from emergency care.

Increasingly, hospital services must be delivered as a package of acute, specialist and emergency services, provided to populations through networked arrangements with appropriate ambulance routing. Changes will be required to the current pattern of service delivery on hospital sites, consistent with national policy and these will ensure that populations have timely access to services, regionally and nationally, that consistently deliver the best clinical outcomes. These changes are linked to how services are organised within and between Hospital Groups, and strategic planning to develop more specialist hospital care networks will progress in 2018. During 2018 and beyond, we will seek to progress a range of initiatives and actions that:

- Progress our national clinical and integrated care programmes.
- Demonstrably support the delivery of safe, high quality complex, specialised and emergency care in specific locations.
- Maximise the value of all hospital sites as part of wider specialist hospital care networks.
- Build the capacity of hospitals to effectively manage the flow of patients from arrival at ED, to admission and timely discharge as soon as acute care is completed.
- Support the delivery of appropriate elective (planned) activity separately from emergency activity.

Improving quality, safety and value

In the context of the very significant financial and operational pressures faced by health and social care services in Ireland, it is essential that we ensure a relentless focus on improving quality, safety and delivering better value care. We must continually seek to improve the quality of care and outcomes for patients, ensuring that care is:

- Safe care that avoids harm to patients and learns lessons when things go wrong.
- Effective care that is delivered according to the best evidence as to what is clinically effective in improving health outcomes, and consequently reducing or ceasing to provide services that are of limited benefit.
- Person-centred care that is respectful and responsive to individual needs and values, and partners with patients and service users in designing and delivering that care.
- Timely care that is delivered within clinically indicated timescales.
- Efficient care that avoids waste.
- Equitable care that is delivered to the same quality regardless of where patients live, their gender, background or socio-economic status.

There is a strong relationship between the quality of care and finance. Failure to deliver high quality care wastes resources and can lead to poor outcomes for patients. It is essential that we reduce variation in how care is delivered, ensuring that people receive timely and appropriate care in an appropriate setting provided by an appropriate professional, and that we take steps to remove waste, delay and duplication in processes. During 2018 and beyond, we will seek to progress a range of initiatives and actions that:

- Ensure a systematic approach to delivering tangible quality and value improvement, both regionally and nationally, with a focus on organisation-wide and national programmes to ensure that quality and value improvement happens at scale.
- Develop the skills and capacity for quality improvement by training staff in the use of improvement techniques and encouraging them to identify and act on areas for improvement.
- Ensure appropriate data is available, regionally and nationally, to support the identification of improvement opportunities and to monitor the impact of improvement actions.

Structure

The remainder of this document is structured as follows:

- Section 2: Our Population
- Section 3: Building a Better Health Service
- Section 4: Quality and Safety
- Section 5: Health and Social Care Delivery
- Section 6: Finance
- Section 7: Improving Value and Services
- Section 8: Workforce
- Section 9: Enabling Healthcare Delivery.

Section 2: Our Population

Over 4.7m people live in Ireland according to the 2016 Census, an increase of approximately 4% or almost 170,000 people since 2011. The greatest change in this time period is in the number of people aged 65 years and over, which increased from 11% in 2011 to 13% in 2016. Each year, the population aged over 65 years increases by almost 20,000 people, and by over 2,500 for those aged 85 years and over. The number of adults aged 65 years and over will increase by up to 21%, or 131,000, by 2020. If the current trend continues, the number of adults aged 85 years and over is projected to increase by approximately 4% annually.

Over 344,000 births and 148,000 deaths have been registered since Census 2011, resulting in a natural increase in our population of over 196,000. A quarter of the population are children aged 0-17 years.

These figures help us understand the size, growth and distribution of the population – the demographic change. Information on demographic change is taken into account when considering the resources, including finance, required to maintain an existing level of public health and social care services to a population which is changing in size and distribution. Unmet need, unmet demand and implementation of new services or initiatives are additional considerations when planning services.

Life expectancy and health status

Life expectancy in Ireland has increased by almost two and a half years since 2005 and is now above the EU average, with women at just over 83 years and men at 79.3 years. The greatest gains in life expectancy have been achieved in the older age groups, reflecting decreasing mortality rates from major diseases.

Mortality rates from circulatory system diseases fell by 28% between 2006 and 2015 and cancer death rates decreased by 13% over the same period. Transport accident mortality rates have fallen by 51% in the past decade, and suicide rates by 6% *(Health in Ireland - Key Trends 2016, DoH)*.

Approximately three quarters of deaths in Ireland are due to three chronic diseases – cancer, cardiovascular disease and respiratory diseases. These are largely preventable by modifying lifestyle risk factors such as obesity, smoking and alcohol. From 2017 to 2022, it is estimated there will be more than a 17% increase in the number of adults aged 65 years and over with two or more chronic conditions.

Approximately 86% of people aged 65 years and over have one or more chronic diseases, and 65% of people aged 65 years and over live with multi-morbidity (two or more chronic conditions) *(The Irish Longitudinal Study on Ageing (TILDA), wave1, 2010)*.

Arthritis affects 44% of those aged 65 years and over *(The Irish Longitudinal Study on Ageing (TILDA), wave2, 2014)*.

Health inequalities

There is a strong link between poverty, socio-economic status and health. In 2014, 11% of children experienced consistent poverty *(Survey in Income and Living Conditions (SILC) 2014, Central Statistics Office (CSO))*.

Life expectancy is greater for professional workers compared to the unskilled. This pattern has increased since the 1990s (*Layte R, Banks J., Socioeconomic differentials in mortality by cause of death in the Republic of Ireland, 1984–2008; European Journal of Public Health, 2016)*.

Death rates are two times higher for those who only received primary education compared to those with third level education. If economic mortality differentials were eliminated, it would mean 13.5m extra years of life for Irish people *(Burke S, Pentony S., Eliminating Health Inequalities, A Matter of Life and Death; Think-thank for Action on Social Change, 2011)*.

Homeless

Nationally, latest figures indicate that over 8,000 people are homeless, with more than a third of these being children. The total number of people homeless rose by 25% from July 2016 to July 2017 *(Department of Housing, Planning and Local Government; Homeless Report, July 2017).*

Travellers and Roma

The 2016 Census recorded 30,987 Travellers living in the Republic of Ireland, an increase of 5.1% from Census 2011 *(CSO, 2016).*

Irish Travellers are much younger than the general population. Almost three quarters of Travellers are aged 34 years or younger, while just over 7% are 55 years and over.

The estimated Roma population is between 3,000 and 5,000 (*Department of Justice, National Traveller and Roma Inclusion Strategy 2017-2021)*.

Healthy Ireland Framework

Many diseases and premature deaths are preventable. Increased morbidity and mortality are strongly related to lifestyle-based health determinants such as smoking, alcohol consumption, lack of exercise and obesity. They are also related to inequalities in our society. The *Healthy Ireland* framework sets out a comprehensive and co-ordinated plan to improve health and wellbeing over the coming years. This is being actively implemented across all areas of the HSE.

Section 3: Building a Better Health Service

A number of programmes are underway, supported by evidence, that offer potential to shift the balance of care. We are prioritising the continuation and further support for initiatives under these programmes in 2018, in the knowledge that they will lay the necessary foundations for developing a more sustainable health service into the future.

Building strategic certainty in 2018

The case for scaling up the current and future capacity of the health services, and at the same time shifting the balance in delivery to provide structural capability for high value care, is robust and overwhelming. The case for change and the requirements for transitional funding to support and underpin it are highlighted in *Sláintecare*. Meeting current and future challenges with the current service design is not sustainable, since incremental spending on health is of low value, failing to return the most health gain for the population. A key priority for the health service in 2018 is to develop an agreed strategic position with the DoH and with our partners, in the interests of building a better health service, designed to meet the needs of our population which represents higher value care, in terms of return on the money invested in health.

Actions 2018

- Develop a comprehensive, integrated health service transformation and delivery plan, fully aligned with and in support of the forthcoming *Sláintecare* implementation plan and the related policies of the DoH and Government.
- Clarify and set out in some detail the specifics and phasing of the changes required, matched to detailed resource and implementation requirements in conjunction with the DoH.
- In conjunction with the DoH, consider and give effect to governance arrangements to ensure all transformation funds are dedicated and not required to address operational funding deficits.
- Establish capacity to monitor, evaluate and report on the impact of agreed transitional funding.

Laying the foundations for transformation and sustainable long term healthcare delivery

As is the case in many developed health systems, we face the challenge of growing user expectations, unmet need and core infrastructural deficits. We are implementing a range of programmes to 'bend the curve in spending' and prepare the ground for longer-term transformation. There are tens of thousands of dedicated staff working in our health services, changing practices, improving care for patients, advocating for and driving service improvements day in, day out. Staff and management working locally are providing leadership and support for nationally supported initiatives with the aim of reforming our services and seeking to deliver higher value care. A number of transformational programmes will continue in 2018, with a focus on:

- Building a leadership culture and enabling and supporting staff to live our values and further embed them in our working lives – Care, Compassion, Trust and Learning.
- Transformation through our workforce: *Health Services People Strategy 2015-2018*.

- Prevention through *Healthy Ireland* implementation and improved care management for patients with chronic conditions.
- Clinical leadership and clinical models of care, particularly care for the frail elderly and patient flow from community services to hospitals and vice versa.
- Higher rates of efficiency growth across key service areas.
- Addressing serious information and knowledge management gaps in the healthcare system, and the creation of a research and development function.
- Enabling and supporting change in our delivery systems.
- Enhancing EU and North South Co-operation and preparing for Brexit.

Care, Compassion, Trust and Learning – Our culture and our values

Within our community and hospital services, staff, managers, patients and service users are engaged in many formal and informal activities to improve the way we lead and act with staff and service users to ensure that the culture of our services is aligned with our core values. A significant challenge for all parts of healthcare is to nurture cultures that ensure the delivery of continuously improving, high quality, safe and compassionate healthcare. Two nationally supported approaches to building leadership capacity and embedding values in practice will be further prioritised in 2018.

Values in Action

Values in Action is based on the understanding that, every day, thousands of health service staff around Ireland live our values of Care, Compassion, Trust and Learning. Sometimes this is very visible, sometimes it is not. Values in Action is a nationally supported approach to shaping the culture of the health services around these values, so that they are evident every day in every workplace. This is led at the local level by health service managers and by staff at every level of service through a peer to peer grassroots social movement. The objective of Values in Action is to create better working environments for our staff, and importantly, give patients and clients a positive experience when they come into contact with our health service. In 2018, we will:

- Grow our community of Values in Action champions across the health services to lead the movement in their workplaces.
- Commence the roll-out of Values in Action in Community Healthcare Organisations (CHOs), Hospital Groups and other service areas.
- Move to the sustain phase in the Mid West (UL Hospitals Group and Mid West CHO).
- Continue the roll-out of Values in Action in the national divisions (Centre Programme).
- Integrate the behaviours that underpin Values in Action within other processes in the health service so that our nine behaviours are evident in all that we do for staff and patients.

Transformation through our workforce: Health Services People Strategy 2015-2018

Through our *Health Services People Strategy 2015-2018*, we recognise the vital role of staff at all levels in addressing the many challenges in delivering health services. Our commitment is to engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them. Staff

who are valued, supported in their development and treated well, improve patient care and overall performance. Improved people management is the responsibility of all leaders, managers and staff. Priorities in 2018 include:

- Embed an approach to staff engagement through our Staff Engagement Forum.
- Operationalise the *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning, 2017* across the health services.
- Support *Healthy Ireland* and the Workplace Health and Wellbeing Unit to manage staff, support services and ensure that policies and procedures are designed to enable staff to maximise their work contributions and work life balance.
- Introduce performance management systems in areas of the public health sector where these are not already in place.

Leadership Academy

Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. 2017 marked a year that established the Leadership Academy.

The Leadership Academy is a strategic investment in developing staff at all levels so that a better, more patient-focused, more efficient and compassionate health service can be developed. The aim is to provide a consistent approach to leadership development programmes for staff as they progress in their careers. The Leadership Academy will support the development of leadership skills that patients, carers, service users and communities deserve, by supporting staff at every level in health and across every sector in healthcare. In 2018, we will enhance leadership development by building and strengthening the Leadership Academy, taking on two new groups of participants for both of the two flagship programmes and evaluating the work of the Academy to ensure it is meeting its objectives.

Healthy Ireland: Chronic disease prevention and management

The projections of future utilisation of healthcare show us that a strong and comprehensive response to chronic diseases is required. This needs a focus on both prevention and management, and a rebalancing of the roles of primary care and acute hospital care.

Evidence demonstrates there are many factors which point to a possible 'expansion of morbidity' over the coming years and this scenario would mean that the estimates of future health service utilisation and costs derived from demographic pressure may be difficult to estimate and plan for.

Health service planning must balance a focus and investment between health promotion and disease prevention to control the onset of ill health and management of established illness.

A national policy framework and health service implementation plan is already in place, *Healthy Ireland in the Health Services - Implementation Plan 2015-2017*, and the HSE has developed an Integrated Care Programme for the Prevention and Management of Chronic Disease to prioritise this work. Both of these will continue to be progressed in 2018.

It is estimated that one million people suffer from cardiovascular disease, diabetes, COPD or asthma. Comprehensive chronic disease management offers the potential to redirect significant numbers of people from acute hospital inpatient, day case and outpatient care to primary care.

In 2018, a significant element of our work will be to identify appropriate transitional funding in support of a shift in the balance of care for chronic disease management. It is important to note that the scale of investment is likely to be sensitive to assumptions about how chronic disease management will be contracted from GPs. In 2018, we will work in conjunction with the DoH to agree a new contract for GPs.

During 2018, we will continue to work with CHOs, Hospital Groups and external partners to implement the *Healthy Ireland* framework. Priorities in 2018 include:

- Implement actions in support of national policy priority programmes for tobacco, alcohol, healthy eating active living, healthy childhood, sexual health, positive ageing and wellbeing, and mental health.
- Progress the implementation of the national healthy childhood and nurture programmes.
- Progress the Integrated Care Programme for the Prevention and Management of Chronic Disease. In 2018, the programme will embed the existing demonstrator sites and complete the detailed planning for the provision of integrated care at scale.
- Agree feasible and evidence-based costings detailing funding required to address chronic disease management.
- Work with the DoH to negotiate a new GP contract.

National Clinical and Integrated Care Programmes

Mobilisation of clinical leadership and engagement in healthcare strategy, planning and management is a key critical success factor in achieving longer term reform and transformation in healthcare delivery. The national clinical and integrated care programmes have embarked on a long term programme of work to re-design care from traditional hospital-centric models, to models of care delivered in the community which will provide improved care and outcomes for patients, while ensuring the acute service is redesigned to meet the long term needs of the population. Tackling unwarranted variation, exploiting the potential to shift the balance of care, optimising technology and implementing evidence-based care will have a material impact on service delivery, and improved quality, safety and value. Clinical leadership and the experience of patients, clinicians and frontline staff is essential in designing and leading improvements in patient-focused care. The national, regional and local governance structures are now in place to guide and support the implementation of the required changes.

The work of the national clinical and integrated care programmes to date, when piloted and evaluated, provides strong evidence to demonstrate that significant improvements in the delivery of health and social care services can be achieved when compared to previous models and ways of working. For example, the national musculoskeletal physiotherapy triage initiative has seen 74,766 new patients and reviewed a total of 89,609 patients, reducing the number on the rheumatology and orthopaedic waiting lists.

In 2018, the national clinical and integrated care programmes are focused on developing new integrated care models and pathways to ensure safe, timely, efficient healthcare which is provided as close to home as possible. The work of the national clinical programmes and integrated care programmes is interdependent. The associated priorities and actions have been selected to generate improvements as set out below.

Delivering care closer to home

Design new community-based models to provide improved care and outcomes for service users, close to their home and at the lowest level of complexity that is deemed safe, and redesign care from traditional secondary care models to community-based models.

Integrated care and user feedback are key to developing models and delivery of care that can succeed in moving away from institutional and acute settings, to appropriate care as close to the person as possible. The Patient Narrative Project: Your Voice Matters, positions the patient / service user voice centrally in a partnership approach to the design and delivery of healthcare through the integrated care programmes. Phase 1 of the project has established that people in Ireland want to experience person-centred, co-ordinated care when they require a number of health services at one time or over time. In 2018, phase 2 of the project will create a process to hear and use the experiences of a large number of individuals, who require multiple health services, to influence and guide the development of current and future services and strategy. This will provide information to support service planning.

Integrated Care Programme for Children

This programme aims to improve the way in which healthcare services are designed and delivered to children and their families. In 2018, the programme will complete the design of the screening programme for infants at risk of developmental dysplasia of the hip, continue to progress the consultant delivered services pilot in Waterford and continue the development of an integrated care pathway for children with neuromuscular disorders. The programme will also work with key stakeholders to design an implementation plan for the national model of care for paediatric healthcare services, within existing resource levels.

Integrated Care Programme for Older Persons

This programme is building on local initiatives to incrementally develop pathways for older people across primary and secondary care, especially those with more complex care needs. They will consolidate the deployment of the 10 Step Framework and evaluate the impact on the current 12 sites. In 2018, further work will be progressed to estimate costs for developing care for frail elderly and to model the potential impact on patterns of health service utilisation between primary care and acute hospital care. The HSE will work with the DoH to examine the policy and service implications of widening eligibility for older persons' services with the aim of rebalancing service use between acute hospital care and primary care. Eligibility may be a barrier for some social and community services, and reduced access to social care for older people is associated with increased hospitalisation.

Integrated Care Programme for Patient Flow

This programme is developing a standardised approach to managing patient flow in a number of areas including urgent and emergency care, scheduled care, outpatients and community healthcare. The programme will develop a plan to support the reorganisation of urgent and emergency care in line with best outcomes and the best experience for patients.

In parallel with the requirement to shift less complex acute care from hospital to community settings, there is a need to ensure that the secondary and tertiary care sectors are able to deliver the complex, specialised and emergency care that will be required by patients. The provision of integrated care is a key element of this model of care.

Develop specialist hospital care networks

Redesign acute service to meet the long term needs of the population, providing timely access to the right services, regionally and nationally, that consistently deliver best clinical outcomes.

In parallel with the requirement to shift less complex acute care from hospital to community settings, there is a need to ensure that the secondary and tertiary care sectors are able to deliver the complex, specialised and emergency care that will be required by patients. The provision of integrated care is a key element of this model of care.

National Clinical Programmes

- Acute Medicine National Clinical Programme (NCP) will design the development of the acute floor model. It will also provide guidance and advice in the design of an acute floor information system.
- Emergency Medicine NCP will provide guidance on the development of Emergency Care Networks in Ireland and, as part of this, it will support the development of injury units.
- Acute Coronary Syndrome NCP will maintain and improve the Optimal Reperfusion Service Protocol across Ireland in all the primary percutaneous coronary intervention (PPCI) centres.
- Stroke NCP will continue to support on a pilot basis the implementation of early supported discharge teams.
- Surgery NCP will embed its Theatre Quality Improvement Programme in three sites with the aim of facilitating sustainable improvements in theatre efficiency. The focus is on embedding quality improvement skills tools and techniques to support sustainable change.
- Radiology NCP will support the implementation of and compliance with the National Radiology Quality Improvement Guidelines.
- Cystic Fibrosis (CF) NCP will develop an accreditation process for CF.
- Older Persons' NCP will develop a national nursing transfer tool to support the transfer of residents from residential services to acute hospitals.
- Mental Health NCP will develop integrated care pathways for eating disorders. Ultimately, this investment will see a reduction in ED attendances and re-attendances for this group and an overall improvement in patient experiences and outcomes.

Improving performance, efficiencies and effectiveness

Performance and Accountability Framework

The Performance and Accountability Framework has been enhanced in 2018 in line with new governance arrangements and organisational changes in the HSE.

While living within their financial allocation must be a fundamental priority for managers, the Performance and Accountability Framework is explicit in its intent that performance be managed across *Access* to and *Integration* of services, the *Quality and Safety* of those services, achieving this within specific *Finance*, *Governance* and *Compliance* requirements, and by effectively harnessing the efforts of our *Workforce*.

The membership and role of the National Performance Oversight Group has been revised and accountability and responsibility for performance is more embedded within the service delivery system.

Performance oversight and escalation processes have been updated and clearly specified. A quarterly and annual oversight process will also be put in place in 2018.

The emphasis within the framework is on recognising good performance and on improving performance at all levels of the health service. It also sets out how CHOs, Hospital Groups, the National Ambulance Service (NAS), the Primary Care Reimbursement Service (PCRS), heads of other national services and individual managers are held to account for their performance.

Performance Management Unit

A Performance Management Unit will be put in place in 2018. Its role will include to:

- Act as an immediate response unit to support performance improvement and drive whole system performance improvement.
- Co-ordinate selected national performance improvement initiatives linked to whole system improvement and to spread best practice.
- Develop metrics to monitor service improvement.
- Develop national capability in improvement techniques such as Lean.
- Establish a Value Improvement Programme supported by a unit to improve service value, aligned to outcomes, through economy, efficiency and effectiveness in the use of resources.
- Identify across both CHOs and Hospital Groups opportunities to reduce cost and improve productivity.
- Work with clinical, management and staff in a collaborative way while maintaining the role of constructive challenge.
- Develop the ability to carry out comparative benchmarking through the use of existing and new data.

Research and development

Health research is essential to generate new knowledge to inform evidence-based practice. Knowledge and learning are also key requirements for effective change and transition planning for the health services in Ireland.

A research and development function is being established within the health services to support the delivery of key actions originally set out in the *Action Plan for Health Research 2009-2013*. The appointment of a research and development lead is a key component of this development. The aim is to foster a research culture within our health services by providing an enabling governance framework, increasing the integration of research into health service delivery, strengthening research networks and developing our research capacity.

We will further improve our research and development capacity by augmenting our research and knowledge transfer capability, including library services capability, and building on the *Planning for Health* series of publications in support of a consistent approach to the measurement of population health need and service demand. We will also expand co-ordination and input into multi-agency and cross-organisational partnerships to harness and maximise the impacts of our efforts. Priorities for 2018 include:

- Design a health research governance framework for all areas of research within the health service and provide clear guidance where required.

- Complete a scoping exercise of current research activity, capabilities and infrastructure within the HSE to establish benchmarking for future planning and development.
- Establish channels of communication and collaborative mechanisms with key external (e.g. the DoH, Health Research Board, other funders, external partners) and internal stakeholders (e.g. Chief Officers of CHOs, Chief Academic Officers of the Hospital Groups, National Directors and their teams). This will contribute to a joined-up 'health eco-system' and organisational response to a demanding and growing health research and development agenda in Ireland.
- Restructure the library service to focus on value added service provision as well as further development in the Health Intelligence function to meet existing and future demand.
- Develop a research and development management plan for the HSE, responding to the *Action Plan for Health Research 2009-2013*, in consultation with relevant stakeholders.

Implementing eHealth Ireland

A modern Irish health service will depend upon high quality information and digital technology. Fragmentation of data sources in health has long been recognised as a major obstacle to the effective use of information in support of new ways of working to achieve person-centred care. In 2018, the HSE will work to consolidate information services into a single function based on the following principles:

- Provision of a single source of data.
- Clear responsibility for the delivery of information for analysis.
- Capacity to collect and clean data and create information sets.

We have published a *Knowledge and Information Strategy* to support implementation of the *eHealth Strategy for Ireland, 2013* with the objectives of:

- Knowing our patients: by providing access to data when and where it is legitimately needed most, to identify what is happening and predict what will happen next.
- Engaging the population: by connecting patients to their care teams to better manage care delivery and engage people individually in their health and wellbeing.
- Managing our services: by putting data into action to improve outcomes, manage demand and optimise service delivery, maximising value and providing better services for the population.

Examples of projects to enhance eHealth capacity are included in the Enabling Healthcare Delivery section of the plan.

Enabling and supporting sustainable and enduring change

Since the *HSE (Governance) Act 2013*, large scale structural changes have been advanced through the creation of nine CHOs and seven Hospital Groups. Significant and large scale transformation programmes are required to address the four pillars of healthcare reform – service reforms, financial reforms, structural reforms, and health and wellbeing reforms.

Since 2014, the health service has established and resourced a national function to support long term transformation of the heath service and to take an evidence-led, consultative and outcomes focused approach to all changes.

The PHSI will continue to work with the DoH in the development of an implementation plan for *Sláintecare.*

The work and priorities of the Programme for Health Service Improvement will be reviewed in early 2018 to ensure all resources and expertise are aligned to service delivery priorities and are delivered in defined and measureable ways. Key enablers will be progressed, and work prioritised within them, to support the implementation of the priority models of care. Enabling work will include:

- Support implementation of key foundational elements of healthcare reform including *Healthy Ireland*, eHealth and research and development functionality.
- Work with management and staff in CHOs, Hospital Groups, the NAS and other national services to support increasing levels of autonomy in service delivery and implementation of integrated models of patient care across service delivery boundaries.
- Provide support for the development of the new children's hospital.
- Support strategic programmes including quality and safety, and operational productivity, efficiency and value improvement projects.
- Support the development of an integrated and agile strategic planning and commissioning function.
- Work in partnership with the International and Research Policy Unit of the DoH and the enterprise and health sectors to plan the development of the National Health Innovation Hub initiative.

Enhancing EU and North South Co-Operation and preparing for Brexit

There are services where it makes sense to develop an all-island approach or where provision needs to be made for patients or professionals moving across the border on the island to receive a service. The North West Cancer Centre and the PPCI service in Altnagelvin commenced in November 2016. The service provides for patients on both sides of the border. Another good example of North-South co-operation is the all-island paediatric congenital heart disease network.

Given the strategic impact of Brexit, the HSE has established a steering group in order to prepare for the UK's withdrawal from the EU. The EU / North South Unit have taken on the project management of the Brexit process. Five work streams have been established under the Brexit Preparation Programme including eligibility, supply of goods and services, cross-border health services, public health, regulatory standards and workforce. This entails input from all parts of the HSE and close co-operation with the DoH, as part of wider cross-governmental work being co-ordinated by the Department of Foreign Affairs and Trade.

The HSE EU / North South Unit will support our services to identify appropriate programmes and establish projects where possible. The strategic priorities for 2018 are:

- Broker partnerships between the health services to share ideas, develop practical solutions to common health challenges and develop new ways to improve health and social care services for the wellbeing of people on the island, where appropriate.
- Ensure successful implementation of the projects under the EU Interreg programme with partners in Northern Ireland and Scotland.
- Support key structures including government departments, the North South Ministerial Council, the Special EU Programmes Body (SEUPB) and other relevant agencies.
- Continue to conduct, with full support from across the HSE, detailed analysis of the implications of Brexit, undertake full contingency planning to mitigate risks, and provide timely support to the DoH and the cross-departmental structures in place, to support the on-going work being undertaken by the Government in the context of the EU-UK negotiations.

Section 4: Quality and Safety

Introduction

The HSE places significant emphasis on the quality of services delivered and on the safety of those who use them. A three-year National Safety Programme to develop and oversee the implementation of national safety priorities and initiatives across all parts of the health system is continuing and we will work with the National Patient Safety Office to deliver on national patient safety priorities.

The National Patient Safety Programme

Insufficient attention to patient safety is a leading cause of harm across healthcare systems worldwide. It impacts on health outcomes causing increased morbidity, temporary or permanent disability and sometimes even death. The safety of patients and service users is therefore the number one priority for the health service.

The National Patient Safety Programme aims to continue the work already undertaken in supporting improvements in patient and service user safety across the entire health system to ensure changes are integrated into the 'business as usual' activities of individual services.

The programme aims to:

- Improve the quality of the experience of care including quality, safety and satisfaction.
- Implement targeted national patient safety initiatives and improvements in the quality of services (e.g. preventing healthcare associated infection (HCAI); use of anti-microbials and anti-microbial resistance (AMR); addressing sepsis, falls, pressure ulcers and medication errors; clinical handover; and recognising and responding to deteriorating patients including the use of Early Warning Score systems.
- Respond to the public health emergency by tackling CPE.
- Build the capacity and capability in our services to improve quality and safety and improve the response of the healthcare system when things go wrong.
- Put in place appropriate governance for patient safety across our services.
- Strengthen quality and safety assurance, including audit.

Service user involvement and experience

A key focus will be to listen to the views and opinions of patients and service users and consider them in how services are planned, delivered and improved. Key priorities for 2018 include:

- Implement the National Patient Experience Survey in acute hospitals and maternity services.
- Use the feedback received from the National Patient Experience Survey and the Patient Narrative Project: Your Voice Matters to inform health service priorities and actions.
- Involve patients and family members in the design, delivery and evaluation of services through the National Patient Forum, Patients for Patient Safety Ireland, and focus groups with the Patient Representative Panel.

- Ensure that the information gathered through the HSE's feedback system 'Your Service Your Say', the National Appeals Service Office and the Confidential Recipient are used to inform health service priorities and actions.
- Implement the national complaints system.

Improving the quality and safety of services

Improving quality and safety requires us to further build the capacity and capability of frontline services to implement the *Framework for Improving Quality in our Health Service*. Key priorities for 2018 include:

- Further develop quality and safety teams across CHOs, Hospital Groups and the NAS.
- Provide resources and toolkits to staff to support them in implementing the *Framework for Improving Quality in our Health Service.*
- Promote the continuous development of quality improvement skills amongst all staff through use of the *Improvement Knowledge and Skills Guide, 2017*.
- Deliver leadership education programmes through the Diploma in Leadership and Quality in Healthcare for multi-disciplinary teams, and the Executive Clinical Leadership course for Clinical Directors.
- Roll out the culture of person-centredness programme across all services.
- Implement quality and patient safety committees across all services to drive quality improvement and patient safety.
- Develop and use quality profiles and specialty quality programmes.
- Develop the capacity and capability for staff engagement to maximise the contribution of staff to improving quality.
- Use results from the patient safety culture survey to ensure continued staff engagement in improving quality.

Maintaining standards and minimising risk

Robust quality and patient safety systems and processes, that are an integral part of the day to day operations of healthcare delivery, are essential to maintain standards of care, identify areas for improvement, support learning and responses when things go wrong, and manage risk. Key priorities for 2018 include:

- Support the development and implementation of National Clinical Effectiveness Committee (NCEC) clinical guidelines and audits.
- Develop a Quality Assurance Framework and further develop national clinical audits, healthcare audits and specialty quality programmes.
- Further develop the capability to report, manage, investigate, disseminate and implement learning from safety incidents that occur.
- Increase our analytical capacity to understand quality and service user safety, including the development and use of quality profiles.
- Expand the activity of the National Independent Review Panel.
- Roll out assisted decision-making and open disclosure processes.

Section 5: Health and Social Care Delivery

Health and Wellbeing Services

Population served

Health and wellbeing is about helping our whole population to stay healthy and well by focusing on prevention, health promotion and improvement, reducing health inequalities, and protecting people from threats to their health and wellbeing.

Services provided

As part of the promotion of health and wellbeing, a number of national services are provided. The national screening service provides population-based screening programmes for BreastCheck, CervicalCheck, Bowelscreen and Diabetic RetinaScreen. These programmes aim to reduce morbidity and mortality in the population through early detection and treatment across the programmes.

The environmental health service protects the health of the population by taking preventative actions and enforcing legislation in areas such as tobacco, food, alcohol, sunbeds and water fluoridation.

The health promotion and improvement service provides a range of preventative health education and training services, focused on positively influencing the key lifestyle determinants of health such as smoking, alcohol, sexual health, healthy eating and physical activity.

The public health service protects our population from threats to their health and wellbeing through its provision of national immunisation and vaccination programmes, national infectious disease monitoring and health screening.

Issues and opportunities

There is an unsustainable horizon for future health services and for our population's wellbeing driven by lifestyle disease patterns and ageing population trends. Through the implementation of *Healthy Ireland* plans at CHO and Hospital Group level, there is an opportunity for health and wellbeing services to support the health service to shift from treating patients to keeping people healthy and well.

From a service perspective, some issues will require a particular management focus this year including the delivery of a comprehensive health and wellbeing reform programme, prioritising prevention and early intervention approaches within existing resources.

Changing demographics means increasing demand for services beyond planned and funded levels, particularly within the context of delivering population-based national screening services.

The capacity to recruit and retain a highly-skilled and qualified medical and clinical workforce needs to be prioritised, particularly in high-demand professions such as screening radiographers and specialists in public health medicine.

Fully enforcing legislative and regulatory requirements in areas such as water fluoridation, tobacco, food, alcohol and sunbeds, within available resources, is also a key issue due to current capacity of the environmental health service.

In cases where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved, the available funding level and planning assumptions provided by the DoH, the HSE is required to manage within the available resources while seeking to prioritise services to

those in greatest need. The potential financial challenges within health and wellbeing services are summarised within Section 6.

Priorities 2018

- Support the implementation of *Healthy Ireland* in CHOs and Hospital Groups.
- Improve the health and wellbeing of the population.
- Protect our population from threats to their health and wellbeing.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Support the implementation of *Healthy Ireland* in CHOs and Hospital Groups
  - Complete the development of *Healthy Ireland* implementation plans in all CHOs and in the remaining three Hospital Groups.
  - Progress the implementation of key actions for Making Every Contact Count in CHOs and Hospital Groups as part of their *Healthy Ireland* implementation plans.
- Improve the health and wellbeing of the population
  - Continue to implement the age-extension of the BreastCheck Programme in 2018 by extending screening to all women aged 66 and half of those aged 67 in line with the agreed programme, and maintain uptake amongst the eligible population within the overall programme.
  - Maintain the uptake of screening amongst relevant eligible populations through CervicalCheck, BowelScreen and Diabetic RetinaScreen Programmes.
  - Implement the Health Information and Quality Authority (HIQA) health technology assessment which recommends a change in primary screening testing to human papillomavirus (HPV) testing for the CervicalCheck Programme.
  - Develop a plan in collaboration with the DoH to ensure the roll-out of sufficient capacity within the wider endoscopy service to support extension of the BowelScreen programme as outlined in the *National Cancer Strategy 2017-2026*.
  - Develop a community intervention to increase physical activity levels in adults over 50 years of age, in collaboration with key stakeholders and academic partners.
  - Complete the consultation and publication, and commence implementation, of clinical guidelines for the identification, diagnosis and treatment of tobacco dependence.
  - Implement the information technology (IT) health behaviour patient management system for smoking cessation staff and commence the process of integration with existing IT systems.
  - Deliver a multi-component social marketing campaign to progress the development of the Healthy Weight for Children Framework in partnership with Safefood.
  - Plan for the provision of enhanced community-based weight-management programmes and specialist treatment services.

- Increase awareness and create compassionate inclusive communities for people with dementia and their carers, by building a network of local and national partnerships under the Dementia Understand Together campaign.
- Design and launch the Dementia Understand Together community activation programme as a sustainable approach to reducing stigma around dementia in collaboration with campaign partners.

- Protect our population from threats to their health and wellbeing
  - Provide overall co-ordination across the health service for capacity building for the prevention, surveillance and management of HCAIs and AMR and the implementation of an agreed action plan for HCAIs in line with new governance structures.
  - Provide overall co-ordination and targeted support on actions required to ensure a comprehensive whole system response to CPE as part of a cross-sectoral approach as outlined in *iNAP - Ireland's National Action Plan on Antimicrobial Resistance 2017-2020.*
  - Collaborate with the DoH to develop a health protection policy.
  - Support the implementation of the national clinical guideline on hepatitis C screening through the National Hepatitis C Treatment Programme spanning the entire continuum of care.
  - Develop an improved model of care for tuberculosis control.

  Immunisation
  - Complete implementation of the rotavirus and meningococcal B vaccination programmes within available resources.
  - Improve immunisation and influenza uptake rates within relevant target populations including staff.
  - Commence a communications campaign to raise awareness amongst pregnant women regarding the need for the pertussis vaccination.

  Environmental Health
  - Enforce HSE environmental health tobacco control statutory responsibilities focusing on areas of greatest non-compliance and the *European Union (Manufacture, Presentation and Sale of Tobacco and Related Products) Regulations 2016* and tobacco control legislation.
  - Implement the *Food Safety Authority of Ireland Service Contract 2016-2018*.
  - Undertake the inspection, test purchase and mystery shopping of establishments under the *Public Health (Sunbeds) Act 2014.*

- National priorities
  - Support the implementation of *iNAP - Ireland's National Action Plan on Antimicrobial Resistance 2017-2020*.
  - Contribute to the development of a health sector climate change adaptation plan which is being led by the DoH.
  - Support the development and implementation of relevant national clinical guidelines and audits in conjunction with the relevant clinical programmes and the National Patient Safety Programme (asthma, COPD, diabetes, HCAI / AMR, under-nutrition, smoking cessation) ensuring that the essential clinical leadership is in place.

Primary Care Services

Population served

The demand for primary care services is highly influenced by demographic and population changes. While birth rates are decreasing, the child population (aged 0 to 17 years) represents 25% of our total population, approximately 7% more than the EU average.

The population is also ageing. The number of people aged 65 years and over has increased from 11% in 2011 to 13% in 2016. Each year, the population aged 65 years and over increases by almost 20,000 people, and by over 2,500 for those aged 85 years and over. Approximately 65% of people aged 65 years and over currently have two or more chronic medical conditions and the prevalence of age related disease continues to show signs of increase.

The increasing demand for expanded primary care services and improved access to services reflects these changes in population and demographic patterns.

Services provided

Primary care services include primary care teams (PCTs), community network services, general practice, community schemes, social inclusion and palliative care services. Reference to primary care throughout the plan includes reference to all of these services.

The PCT is the starting point for service delivery, consisting of general practice, community nursing, physiotherapy, occupational therapy and speech and language therapy and covers populations of approximately 7,000 to 10,000 people. Community network services include audiology, ophthalmology, dietetics, podiatry, psychology and oral health services and are typically provided for populations of approximately 50,000 people. Other primary care services include GP out of hours, diagnostic services and community intervention teams (CITs). In excess of 743,000 patients are seen by community nursing services each year, over 1.5m patients are treated by therapy services, over 36,000 patients receive care from CITs and over 2m patients are managed by GP services. Approximately 520 children are supported at home by way of paediatric home care packages.

Primary care services also provide for those people who are most vulnerable in society, details of which can be seen further in this section within social inclusion services. In addition, services are also provided to those who require palliative care and these are also detailed further in the sections below.

Issues and opportunities

Ensuring accessible, comprehensive, continuous, and co-ordinated primary care is central to better serving the needs of the population. Internationally, the strategic repositioning of health services is recognised as a better approach to meet the challenges of escalating demand from an ageing population and the prevalence of chronic diseases, while at the same time ensuring better access to care, addressing inequalities in health and delivering sustainability and best value for population health. The changing demographic profile has resulted in an increased demand for GP services, community nursing services, therapy services, social inclusion and palliative care services. Diagnostic (ultrasound) services have commenced in certain geographic areas of greatest need. However, GP access to diagnostics remains a key capacity deficit in

supporting the decisive shift to primary care, which the €25m investment in primary care in 2018 will assist in beginning to address.

A key issue in primary care for 2018 will be the capacity to maintain existing levels of service in a number of key areas due to overall resource constraints. This can be partially mitigated on the assumption that certain developments will have implementation time delays. However, the reduction to funded levels of activity still has implications in relation to community demand-led schemes.

Opportunities to make improvements in areas such as CITs, occupational therapy access and GP out of hours service have been funded in 2018 and are set out in the activity profile for 2018. The commissioning of primary care centres continues to be a key enabler for the effective and efficient delivery of PCT and network services. Improving GP access to diagnostics will be aided by the phased expansion of community diagnostic provision in primary care sites in 2018.

The lack of digital information systems continues to be a significant challenge, as are further deficits in ICT to enable communication, co-ordination and continuity of care. The development and implementation of a primary care patient management system to facilitate inter PCT / network / specialist and acute referrals, improve communication and support integrated patient care is a key priority.

The development of a new, modernised contract for the provision of GP services is key to developing a more comprehensive and accessible primary care service. The aim is to develop a contract which has a population health focus providing, in particular, for health promotion and disease prevention and for the structured care of chronic conditions. The HSE will work with the DoH with the objective of reaching agreement with GP representatives in this phase of engagement on service developments that can be introduced during 2018.

Primary care will continue to focus on improving the quality, safety, access and responsiveness of services, including through use of the €25m development funding, to support the decisive shift of services to primary care.

The financial challenges within primary care services and the associated mitigating actions are summarised within Section 6 and Section 7.

Priorities 2018

- Improve quality, safety, access and responsiveness of primary care services to support the decisive shift of services to primary care.
- Implement the primary care elements of *eHealth Strategy for Ireland, 2013* to funded levels.

Implementing priorities 2018 in line with Corporate Plan goals

- Improve quality, safety, access and responsiveness of primary care services to support the decisive shift of services to primary care

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

Immunisation rates

- Improve influenza vaccination uptake rates for those aged 65 years and over, and among staff in frontline settings.

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

- Expand CIT and outpatient parenteral antimicrobial therapy coverage and services, and refocus CITs to facilitate a high volume of complex hospital avoidance and early discharge cases, and strengthen the governance and quality of services provided.
- Provide additional packages of care for children discharged from hospital with complex medical conditions to funded levels.
- Improve access for primary care occupational therapy service with a focus on addressing patients waiting over 52 weeks.
- Expand structured GP out of hours provision in CHO 6.

Please see Appendix 3 in respect of the additional capacity for the areas above.

- Implement the Integrated Care Programme for the Prevention and Management of Chronic Disease.
- Increase the provision of diagnostic services in primary care sites.
- Implement, within existing resources and on a phased basis, the recommendations from the reviews of the primary care physiotherapy, occupational therapy and speech and language therapy services, psychology service, dietetic model of care, GP out of hours service, primary care eye care services and civil registration.
- Improve access waiting times for orthodontic services for children.
- Commission additional primary care centres.

Hepatitis C

- Ensure treatment is offered to patients with hepatitis C in line with the National Hepatitis C Treatment Programme goal of eliminating hepatitis C by 2026.
- Develop integrated models of hepatitis C treatment across community and acute settings and implement screening guidelines.

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

Quality

- Promote quality and safety of services in line with the *Framework for Improving Quality in our Health Service*.
- Promote safe services in line with the Integrated Risk Management and Incident Management Frameworks.
- Support initiatives to develop a more person-centred approach through the roll-out of the primary care patient experience survey.

Children First

- Implement the *Children First Act 2015*, conferring new statutory obligations on HSE employees, funded services and contracted services to report child abuse / neglect.

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

- Work with key stakeholders to progress the integrated model of care for community nursing and midwifery.

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

- Implement the primary care elements of *eHealth Strategy for Ireland, 2013* to funded levels
  - Roll out primary care eHealth systems to support safe and effective provision of services.
  - Develop a primary care patient management system to support safe and efficient delivery of services.

Social Inclusion Services

Population served

Improving health outcomes for the most vulnerable in society is the key focus of social inclusion services. This includes provision of targeted interventions for people from marginalised groups who experience health inequalities, have difficulties accessing services and present with multiple, complex health and support needs. Various studies have illustrated that homeless, Traveller and migrant populations face greater healthcare needs than the general population. Primary care has a major role to play in relation to the health of people with addictions or who are homeless and in delivering on commitments such as the Refugee Relocation Programme. Vulnerable people and communities include Travellers and Roma, asylum seekers, refugees and lesbian, gay, bisexual, transgender and intersex service users.

Services provided

Social inclusion works across a range of statutory services in partnership with the community and voluntary sectors, to improve access to health services for disadvantaged groups. Examples include the 9,700 clients receiving opioid substitution treatments, 1,600 clients attending the pharmacy needle exchange programme and 1,000 homeless clients admitted to emergency accommodation who have their health needs addressed within two weeks of admission.

Issues and opportunities

Ensuring that we improve patient outcomes for those most vulnerable in society is a key priority. Capacity to meet government commitments as set out in the Refugee Protection Programme / EU Relocation and Resettlement Programme, *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016* and the national drug strategy *Reducing Harm, Supporting Recovery – A health led response to drug and alcohol use in Ireland 2017-2025* will support more effective social inclusion.

Priorities 2018

- Improve health outcomes for the most vulnerable in society including those with addiction issues, the homeless, refugees, asylum seekers and Traveller and Roma communities.

Implementing priorities 2018 in line with Corporate Plan goals

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

Addiction services

- Implement actions in *Reducing Harm, Supporting Recovery - A health-led response to drug and alcohol use in Ireland 2017-2025* for which the HSE has lead responsibility.
- Establish a supervised injecting facility in the Dublin city centre area.
- Expand drug and alcohol treatment services with a particular focus on strengthening governance structures, increasing access to opioid substitution treatment by reducing waiting times across CHO areas, and by providing increased access to buprenorphine / naloxone and buprenorphine only products (200 episodes).
- Expand naloxone training and distribution to target a reduction in drug-related deaths and non-fatal overdoses.
- Recruit two additional drug and alcohol liaison midwives.

Homeless services

- Implement the health actions, identified as a priority in 2018, in *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016*, in order to provide the most appropriate primary care and specialist addiction / mental health services for homeless people.

Social inclusion services for other vulnerable people and communities

- Improve access to primary care services for refugees in emergency reception and orientation centres / resettlement phase, with a focus on chronic disease management, increasing access to mental health supports and addressing the oral health needs of children and adults.
- Provide targeted interventions as a means of reducing health inequalities in the Traveller and Roma communities, with a focus on improving mental health and reducing the rate of suicide.
- Implement agreed HSE assigned actions under the *Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021* within existing resources.
- Develop and launch a national lesbian, gay, bisexual, transgender and intersex strategy.

Palliative Care Services

Population served

Demand for palliative care services is growing as the population ages. The total number of new invasive cancer cases (including non-melanoma skin cancer) is projected to increase by 84% for females and 107% for males between 2010 and 2040. Palliative care services also play a key role in the management of patients with many life-limiting non-cancer conditions. It is estimated that 50% of deaths from non-cancer conditions, such as heart disease, respiratory disease, cerebrovascular disease and dementia can benefit from palliative care support.

Services provided

The scope of palliative care includes cancer-related diseases and non-malignant / chronic illness. Palliative care services support people wherever they are being cared for – at home, in hospices and in hospitals. In

any month, in excess of 310 patients access specialist inpatient beds and a further 3,300 patients receive specialist palliative care treatment in a home setting.

Issues and opportunities

Enhanced palliative care offers potential to improve patient outcomes and to shift care from acute hospitals to the community, ensuring better efficiency and value for money. Improving access to specialist palliative care inpatient beds for adults is a challenge in a number of geographic areas. Supporting individuals to remain at home at end of life stage remains a priority. We are continuing to work with local hospice organisations to progress the hospice development plan. Implementation of the *Palliative Care Services – Three Year Development Framework 2017-2019* and the *Evaluation of the Children's Palliative Care Programme, 2016* will inform palliative care service delivery in 2018.

Priorities 2018

- Improve access, quality and efficiency of palliative care services.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Improve access, quality and efficiency of palliative care services
  - Commence implementation of the *Palliative Care Services – Three Year Development Framework 2017-2019* for palliative care within existing resources.
  - Provide for expansion of specialist inpatient beds in 2018 and plan for the expansion of specialist inpatient beds for 2019.
  - Commence the implementation of the model of care.
  - Implement quality improvement plans.
  - Progress the implementation of the recommendations contained in the *Evaluation of the Children's Palliative Care Programme, 2016* within existing resources.
  - Increase access to palliative medical care for children.
  - Improve integration and care pathways for children.

Primary Care Reimbursement Service

Population served

3.7m people are registered for community services provided by GPs, pharmacists, dentists and optometrists and / or ophthalmologists. Of this, in excess of 2m people are eligible for a medical card or GP visit card.

Services provided

The primary care community schemes account for a significant proportion of primary care services. Scheme services are delivered by over 7,000 primary care contractors including GPs, pharmacists, dentists, optometrists and / or ophthalmologists. In excess of 75m individual contractor claims are processed for payment each year.

Issues and opportunities

The community schemes operated by PCRS, many of which are demand-led in nature, are managed in accordance with legislation and policy direction provided by the DoH. The PCRS budget for 2018 has been set at the level outlined in the Letter of Determination (LoD), received from the DoH on 26th October 2017, and in subsequent correspondence. A key task for PCRS is to ensure that those who have eligibility for services can access their entitlements as efficiently and responsively as possible. The actual demand and cost of services provided is therefore determined by demographic, economic and other variable factors, given the demand-led nature of the various factors involved. In relation to medicines in particular, the costs are related to the demographic and eligibility factors, but also to new product developments, particularly in the high-tech area and the prescribing behaviour of clinicians. The PCRS budget and activity profile for 2018 has been framed on the basis of the projected activity assumptions notified by the DoH, i.e. that the funding allocated is sufficient to fund PCRS schemes in the context of the General Medical Services (GMS) and GP visit card projections outlined for 2018.

Persons eligible for services will continue to receive them in a timely manner and in accordance with the turnaround times for processing applications as outlined in the plan. Appropriate measures will continue to ensure the accurate administration of the various schemes. This will also involve enhanced monitoring of claims and payments to primary care contractors.

The capacity to meet the demand for drug therapies within the funded levels for 2018 will be a major challenge in view of the existing run rate pressures, especially in the high-tech sector. Provision for new drug approvals is a key challenge due to the pattern of high pricing of medicines by pharmaceutical companies and affordability provisions within budget. Nevertheless, opportunities are available to optimise value through the HSE drugs management portfolio which should provide increasing value and more cost effective provision of medicines. The allocation for the long term illness scheme also assumes no growth in this sector in 2018.

The overall containment of PCRS activity and costs in 2018 to funded levels is reliant on the demographic and demand projections underlying the plan and the delivery of price control and probity measures in full. To the extent that the actual position differs due to variations between these volumes and cost assumptions and actual experience, the DoH will work with the HSE to consider options which will not impact on service levels as set out in the plan. All aspects of activity will be monitored jointly with the DoH during the course of the year, and especially those elements which are outside of the HSE's control.

Priorities 2018

- Ensure equitable access to services in line with health policy, regulations and within service level arrangements governing administration of health schemes through reimbursement of contractors.
- Implement the provisions of the *Framework Agreement on the Supply and Pricing of Medicines 2016-2020*.
- Strengthen accountability and compliance.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Ensure equitable access to services in line with health policy, regulations and within service level arrangements governing administration of health schemes through reimbursement of contractors
  - Reduce prescription charges for medical card holders from €2.50 per item to €2 and reduce the monthly cap on prescription charges from €25 to €20 per month.
  - Reduce drug payment scheme family threshold from €144 per month to €134 per month.
  - Provide persons in receipt of full time carers allowance with a GP visit card.

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

- Implement the provisions of the *Framework Agreement on the Supply and Pricing of Medicines 2016-2020*
  - Realign downwards the price of qualifying medicines on the 1st July 2018.
  - Collect the rebate of 5.25% or 5.5% as provided in the Framework Agreement.
  - Reference price medicines as appropriate.
  - Reduce the price of patent-expired, non-exclusive, non-biologic medicines where first generic products become available and the price of patent-expired, non-exclusive, biologic medicines where first biosimilar products become available.
  - Assess and reimburse applications in relation to new drugs and new uses of existing drugs in 2018 in accordance with the procedures outlined in the Framework Agreement.
- Strengthen accountability and compliance
  - Implement the High Tech Ordering and Management Hub for high tech medications.
  - Ensure medicines are procured, provided and used in a cost-effective, efficient and rational manner.
  - Centralise primary care schemes, through PCRS, with priority being the Long Term Illness and Drug Payment Schemes.
  - Centralise reimbursement of community funded HIV drugs to PCRS.

Mental Health Services

Population served

Mental health describes a spectrum that extends from positive mental health, through to severe and disabling mental illness. A strategic goal for mental health services is to promote the mental health of our population in collaboration with other services and agencies including reducing the loss of life by suicide. This requires a whole population approach to mental health promotion. Over 90% of mental health needs can be successfully treated within a primary care setting, with less than 10% being referred to specialist community-based mental health services. Of this number, approximately 1% are offered inpatient care and nine out of every ten of these admissions are voluntary.

Services provided

In general terms, specialist mental health services are provided to serve a particular group within the population, based on their stage of life. Child and adolescent mental health services (CAMHs) serve young people aged up to 18 years, general adult services for those aged 18 to 64 years and psychiatry of later life provides services for those aged 65 years and over. Mental health services have consistently sought to develop and enhance community-based services and reduce, where appropriate, those treated in more acute services.

Specialist mental health services are provided through CHOs. These services include acute inpatient services, day hospitals, outpatient clinics, community-based mental health teams (CAMHs, general adult and psychiatry of later life), mental health of intellectual disability, community residential and continuing care residential services. Sub-specialties include rehabilitation and recovery, eating disorders, liaison psychiatry and perinatal mental health. A national forensic mental health service is also provided, including inpatient and in-reach prison services.

Issues and opportunities

The challenge associated with a growth in population and resulting increase in demand for mental health services along with changing expectations of service users and their families, requires the further development of improved cross-sectoral and inter-sectoral approaches to service provision. In particular, the increase in the number of children under the age of 18 years is likely to lead to increased demand for CAMHs with a corresponding requirement for service provision both in primary care and in specialist CAMHs.

Many people develop mental illness for the first time over the age of 65 years and older adults with mental health difficulties have specific needs that require specialist intervention. The expected increase in the population aged over 65 years, and especially those over 85 years, potentially will have significant implications for the psychiatry of later life services.

There is an increasing and more complex nature in the demand for services, particularly for CAMHs which has seen a 26% increase in referrals between 2012 and 2017. Opportunities to continue to develop services that will treat individuals at the lowest level of complexity, avoiding the need for specialist interventions, remain challenging. Developing these services will also enhance community teams to ensure higher quality services for those individuals with higher acuity / greater need.

Additionally, there are requirements for enhanced care for vulnerable groups within the population and these are being addressed through the clinical care programmes, homeless initiatives, the national forensic service, services for those who are deaf and mentally ill, and initiatives in Traveller mental health. The clinical care programmes include early intervention for first episode psychosis, eating disorder services spanning CAMHs and adult services, responses to self-harm presentations at ED, those with dual diagnosis of mental health and substance misuse, and attention deficit hyperactivity disorder in adults.

Youth mental health is a key issue for mental health services and will be a focus for 2018. Service developments will be in line with the recommendations arising from the work of the National Youth Mental Health Task Force.

There is a significant challenge in the recruitment and retention of staff, particularly nursing and medical staff. This challenge can provide opportunities to deliver services that are focused on maximising productivity and on service improvement and also expansion of different disciplines / workers in mental health services. Mental health services will continue to deliver a number of service improvement initiatives that will assist services and increase productivity and efficiency. These improvements will also be enabled by the development of a range of eHealth initiatives to support awareness and support improved responses to meeting mental health needs of the general population.

Mental health services are increasingly operating in a more regulated environment. This enhanced regulation is welcomed as it contributes to patient safety and quality of care. Best practice guidance will be further expanded as one strand of a more proactive approach to patient safety.

The funding available has provided for an agreed level of mental health services nationally. However, where demand for services exceeds what can be supplied, taking account of realistic and achievable efficiencies, the available funding level and planning assumptions provided by the DoH, the HSE is required to manage within the available resources, while seeking to prioritise services to those in greatest need. Within mental health services, this primarily applies to the requirement to provide placements for those with severe mental illness and challenging behaviour, whose needs cannot be met within the current statutory system, as well as providing safe levels of service through the use of non-permanent staffing arrangements.

Priorities 2018

Mental Health Strategic Priorities

- Promote the mental health of the population in collaboration with other services and agencies including reducing the loss of life by suicide.
- Design integrated, evidence-based and recovery-focused mental health services.
- Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements.
- Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services.
- Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Promote the mental health of the population in collaboration with other services and agencies including reducing the loss of life by suicide
  - Progress implementation of *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020* through implementation of *Connecting for Life* plans at CHO level by delivering evaluated evidence-based programmes through non-governmental organisations and implementation of the national training plan for suicide reduction.
  - Increase access to counselling services in primary care through the appointment of assistant psychologist posts nationally which will provide psychological interventions / supports in primary care to those under 18 years, to reduce the need for onward referrals to specialist mental health services.
  - Implement agreed actions arising from the work of the National Youth Mental Health Taskforce for those aged 18 to 25 years including the appointment of agreed youth mental health co-ordinators.
  - Promote the mental health of the population through the enhancement of *www.yourmentalhealth.ie* and the *#littlethings* campaign, as well as the further development of active listening and dynamic signposting services to ensure that the population has access to support and advice on a 24 / 7 basis.

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

- Design integrated, evidence-based and recovery-focused mental health services
  - Progress development and implementation of the five agreed clinical programmes, specifically the development of the model of care for attention deficit hyperactivity disorder in children and adults and model of care for dual diagnosis as well as implementation of individual placement support workers for early intervention in psychosis clinical programme.
  - Implement the recently launched model of care for specialist perinatal mental health services through the appointment of agreed new staffing resources nationally.
- Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements
  - Deliver a major improvement initiative to increase the numbers of CAMHs referrals to be seen in 2018 by 27%, compared to 2017 i.e. over 3,000 additional service users year on year. This will be dependent on agreement with our existing multi-disciplinary teams to the delivery of incentivised work taking place outside core hours, as well as the continued delivery of the current activity in parallel with this targeted improvement. This will be funded, once-off, through the new *A Programme for a Partnership Government* 2018 funding.
  - Provide a seven day per week service for CAMHs to ensure supports for vulnerable young persons in line with *Connecting for Life.*
  - Progress day hospital services within CAMHs.
  - Develop eating disorder specialist community teams.

- Enhance Jigsaw and other early intervention services specific to those aged 18 to 25 years identified as requiring particular community-based responses.
- Enhance access by older adolescents to specialist mental health services and, for those requiring acute admission, their continued appropriate placement and care in child and adolescent-specific settings.
- Expand out of hours responses for general adult mental health services by moving to the 7 / 7 model and appointment of agreed new staffing.
- Continue development of liaison services across all specialties.
- Implement enhanced services for those who are deaf and mentally ill.
- Increase capacity in the national forensic service for those admitted under section 21(2) of the *Mental Health Act 2001* and enhance prison in-reach services including the appointment of agreed new staffing.
- Develop adult and child mental health intellectual disability teams including the appointment of agreed new staffing.
- Further enhance the community mental health team capacity for CAMHs, general adult and psychiatry of later life at a consistent level across all areas including the appointment of agreed new staffing.
- Continue to appoint and develop peer support workers across mental health services.
- Further develop low secure, high dependency rehabilitation services for those with severe mental illness and complex presentations through investment in new services.
- Continue to progress preventative and early intervention approaches with regard to chronic illness and to minimise other debilitating situations developing such as social withdrawal, social isolation and loss of employment.
- Enhance service responses to improve the physical health of mental health service users.
- Deliver agreed stepped model of care for those who are homeless and with mental illness.
- Implement the recommendations of the recently launched National Recovery Framework in Mental Health.
- Improve compliance through monitoring services, in collaboration with the Mental Health Commission, to achieve real time oversight supported by ICT automation.
- Implement the HSE *Best Practice Guidance for Mental Health Services*, including development and delivery of training and reporting for quality surveillance.
- Implement a revised HSE incident management framework.

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

- Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services
  - Improve mental health engagement in the design and delivery of services through the further development of forums in each CHO, in conjunction with service users, family members and carers and the development of standardised reimbursement methods.

- Develop a standardised approach to inclusion of service users in care planning, and promote enhanced self-management for service users in line with the recommendations of the National Recovery Framework.
- Complete and launch the mental health engagement standards to ensure a consistent national model of engagement by service users and carers.
- Implement the recently developed CAMHs advocacy model.

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

and

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

- Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure
  - Develop the mental health workforce to ensure the right staff with the right skills are allocated to the right services:
    - Develop and implement workforce plans for all disciplines.
    - Progress implementation of the postgraduate nursing programme, develop postgraduate non-nursing programmes and appoint agreed increased undergraduate nursing numbers to address critical staffing challenges in mental health nursing.
    - Progress enhanced clinical psychology training capacity.
  - Commence the design and implementation of additional quality and performance indicators in mental health services aligned to increased / new services.
  - Participate in the development of a HSE-wide programme for the implementation of the assisted decision-making legislation in mental health services delivery.
  - Roll out the agreed minor capital fund to enhance facilities and infrastructure and continue to progress the major capital development of the national forensic service.
  - Standardise and move towards more equitable resource allocation models based on a revised costing model for mental health services in line with *A Vision for Change* and continue the mental health multi-year approach to budgeting.
  - Through the performance management process, seek to ensure that current resources allocated to the CHOs are utilised in an effective manner which maximises outcomes for service users.

Disability Services

Population served

The rate of disability has risen in Ireland over the last number of years with an additional 47,796 or 13.5% of the population now reporting at least one disability since 2011 (Census 2016). The rate of reported disability has risen to 5.9% for those aged 0 to 14 years and 9.3% for those aged 15 to 24 years. This has led to an increased demand across all services for children and young people. Over the past nine years, registrations on the National Intellectual Disability Database (NIDD) have increased by over 2,000 to a current total of 28,275.

The rate of those aged 65 years and over with a reported disability has risen by 20,319 to 9.5% since 2011. People are living longer and adults with intellectual disability have age-related illnesses and conditions. In addition, more people with a disability have more complex needs. Of people reporting with a disability, the number of people aged 35 years and over with moderate, severe and profound intellectual disability has increased from 28.5% in 1974 to 49.3% in 2016 (NIDD, 2016). There are 10,679 people who will require alternative, additional or enhanced services in the period 2017-2021.

This change in demographics, increased life expectancy and changing needs for those with both a physical and sensory disability, and an intellectual disability has led to a significant increase in the need for disability services across all settings. This includes day supports, residential and respite services, personal assistant and home support services.

Services provided

Disability services focus on enabling people with disabilities to achieve their full potential, living ordinary lives in ordinary places, as independently as possible while ensuring that the voices of service users and their families are heard, and that they are fully involved in planning and improving services to meet their needs.

A wide range of disability services are provided to those with physical, sensory, intellectual disability and autism. Over 60% of the resources available are allocated to provide a range of residential services to approximately 8,400 people with a disability. A further 20% is targeted at the provision of over 18,000 day places and supports to nearly 25,000 people. The remaining 20% provides respite care services to just over 5,700 people, over 4m personal assistant and home support hours, as well as multi-disciplinary teams and other community services and supports. Disability services are delivered through a mix of HSE direct provision as well as through voluntary section 38 and 39 service providers, and private providers.

Issues and opportunities

The increase in funding for disability services in recent years is welcome. The HSE will in 2018 face a significant financial challenge in meeting essential demand, particularly in relation to residential placements for people with an intellectual disability. This and the associated mitigating actions are summarised in Section 6 and Section 7.

To meet the challenges arising from the increase in the number of people living with disability, the increase in age and life expectancy and the changing needs of people with a disability, collaborative working is

required across the wider health and social care setting with the aim of improving access to services for all people with a disability. It is important to recognise that the needs of people with a disability extend well beyond health service provision, and the health service will participate fully with other governmental departments and services in the development of cross-sectoral strategies to maximise access to services and supports for people with disabilities.

Disability services have a significant programme of reform which is informing a new model of service provision. *Transforming Lives* sets out the recommendations of the *Value for Money and Policy Review of Disability Services in Ireland, 2012.* It provides the framework for the implementation of the recommendations of *Time to Move on from Congregated Settings, 2011* in respect of residential centres to support the transition of people from institutional settings to community-based living. The *New Directions* programme is improving day services and aims to meet the needs of school leavers and young people graduating from rehabilitation training. Taken together, the implementation of these programmes will enable us to maximise the use of existing resources and develop sustainable models of service provision with positive outcomes for service users, delivering best value for money and moving towards an inclusive model of community-based services and supports.

As we move through our programme of reform and consolidation of the disability sector, an increasing challenge has been striking the appropriate balance in relation to the competing need for resources across the national policy objectives.

Time to Move on from Congregated Settings, 2011 identified over 4,000 people in congregated settings which has been reduced to below 2,500. However, significant additional resources will be required to fully implement this programme.

A significant underlying challenge relates to the latent unmet need for residential and respite care, which exists in our services as a result of the absence of investment during the economic downturn. At the same time, our national database figures indicate an annual requirement of 400 residential places per year to meet identified needs. As a result of this we are now experiencing a high annual demand for emergency residential places to respond to the most urgent cases on our waiting list.

While recognising the challenge in relation to complying with the *Disability Act 2005*, we will improve access to therapy services for children by implementing *Progressing Disability Services for Children and Young People*.

At the same time, the disability sector is working hard to comply with the national standards for residential care as regulated by HIQA and to achieve registration for all residential centres by end 2018. While compliance with HIQA standards has improved over recent years from 35% to over 70%, significant work remains to be completed across a range of our residential centres if full compliance is to be achieved within the timescales set out.

While we will continue to work with CHOs, voluntary sector partners and private providers in addressing service requirements within the funding provided, a critical challenge for 2018 and future years will be the development of a more sustainable model of service and supports which achieve these key policy objectives within the resources available and the timelines required to achieve HIQA standards.

There is a need to further reduce the cost and reliance on agency staff. The use of agency staffing and / or overtime will be strictly controlled. A key risk for disability services is ensuring control over pay and staff numbers at the same time as managing specific safety, regulatory, demand and practice driven pressures while seeking to ensure recruitment and retention of a highly skilled and qualified workforce.

In cases where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved, the available funding level and planning assumptions provided by the DoH, the HSE is required to manage within the available resources while seeking to prioritise services to those in greatest need. Within disability services, this primarily relates to home support, personal assistant and respite services.

Priorities 2018

- Continue the implementation of *Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures, 2014* and the programme of system wide change led by the National Task Force to ensure quality and safety of all services through empowering and safeguarding vulnerable people.
- Progress implementation of the national policy for reform of the disability services *Transforming Lives* - the programme for implementing the *Value for Money and Policy Review of Disability Services in Ireland, 2012*.
- Progress implementation of *Time to Move on from Congregated Settings, 2011.*
- Progress implementation of *New Directions* national policy on the provision of day services for people with disabilities.
- Progress Disability Services for Children and Young People (0-18) Programme.
- Progress implementation of the *National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015*.
- Provide further respite care and support to persons with disabilities and their families through the provision of additional €10m funding.
- Continue to develop our workforce to ensure the delivery of a person-centred social care model of service.
- Strengthen and enhance governance and accountability for CHOs, service providers / statutory section 38 and 39 service providers, and private providers.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Progress implementation of the national policy for reform of the disability services *Transforming Lives* - the programme for implementing the *Value for Money and Policy Review of Disability Services in Ireland, 2012*
  - Develop a strategic five year framework to support multi-annual planning for residential care services and community supports taking account of national database projections and the need to develop sustainable models of services which achieve HIQA compliance within approved timeframes (such as additional places and changing needs).
  - Support the recommendations of the taskforce on personalised budgets, arising from *A Programme for a Partnership Government, 2016.*
  - Advance implementation of a standardised assessment tool for disability services.

  - Participate in development of cross-sectoral strategies, including the *National Disability Inclusion Strategy 2017-2021* and the *Comprehensive Employment Strategy for People with Disabilities 2015-2024*, as well as enhanced cross-sectoral working on children's disability issues.
  - Develop a medium term programme in conjunction with the Department of Housing, Planning and Local Government, the DoH, housing authorities, approved housing bodies and HSE Estates to effectively meet housing requirements for those transitioning to community services from institutional care.
- Implement the following specific initiatives in line with *Time to Move on from Congregated Settings, 2011*
  - Complete the move of 170 people from large congregated settings to community-based service models.
  - Improve compliance with national residential care standards as regulated by HIQA.
- Progress implementation of *New Directions* national policy on the provision of day services for people with disabilities
  - Provide additional day service supports for approximately 1,500 young people leaving school or graduating from rehabilitative training programmes.
- Progress Disability Services for Children and Young People (0-18) Programme
  - Complete reconfiguration of 0-18s disability services into children's disability network teams to increase the integration of services while improving *Disability Act* compliance for assessment of need.
  - Implement the National Access Policy in collaboration with primary care to ensure one clear pathway of access for all children with a disability.
- Progress implementation of the *National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015*
  - Progress the demonstration project in CHO 6 and CHO 7 on the managed clinical network pathway.
- Provide further respite care and support to persons with disabilities and their families through the provision of additional €10m funding
  - Provide an additional respite house in each of the nine CHO areas which will support 450 individuals in a full year and 251 in 2018 (€5m).
  - Provide 3 additional respite houses in the greater Dublin areas (CHOs 7, 8 and 9) to support a further 225 individuals in a full year and 143 in 2018 (€3m).
  - Provide alternative models of respite to support 250 individuals with disability (€2m).

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

- Implement *Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures, 2014* and implement assisted decision-making
  - Embed operation of the national independent review panel for disability services across all CHOs.
  - Complete the review of the *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures, 2014* on a cross-divisional basis, having regard to emerging legislation on assisted decision-making and prepare an action plan for implementation.

- Continue to support the National Safeguarding Committee.

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

- Continue to develop our workforce to ensure the delivery of a person-centred social care model of service
  - Realign workforce to person-centred social care model with a specific focus on congregated settings (voluntary and statutory).
  - Further embed workforce plan in association with the National Recruitment Service for locations where trends indicated that there is significant staff turnover.

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

- Strengthen and enhance governance and accountability for CHOs, service providers / statutory section 38 and 39 service providers, and private providers
  - Strengthen capacity in CHOs to implement the governance and management arrangements as set out by the National Compliance Unit in a consistent way across all service providers.
  - Continue engagement with the DoH national working group on HSE funded disability services, to drive the potential for strategic alliances and collaborative partnerships between service providers.
  - Develop a national case management eHealth resource system for CHOs and providers to track and co-ordinate residential and home support / emergency respite services. This system will effectively provide for management information requirements in respect of service planning.
  - Support the development of the National Ability Support System in collaboration with the DoH and the Health Research Board.
  - Implement and initiate the CHO home support operating model including the substructure design in each CHO for disability services.

Older Persons' Services

Population served

The biggest increase in Ireland's population is within the older age groups. The number of people aged 65 years and over has increased from 11% in 2011 to 13% in 2016. Each year, the population aged 65 years and over increases by almost 20,000 people, and by over 2,500 for those aged 85 years and over. We now have 456 centenarians, an increase of 17.2% from 2011 (Census 2016). Recent research suggests that the projected increase in the population aged 80 years and over may be up 94% (135,000) in 2030, from a base in 2015.

This increase in the older persons' population is welcome; it is an acknowledgment of improved health and greater longevity. It brings its opportunities as well as presenting the challenge to ensure that health and social care services can be delivered at adequate levels, in an integrated manner to meet the needs of older people.

It is also important to acknowledge the role of carers in the context of their support to older people. There are over 195,000 carers (people providing regular unpaid help for a friend / family member) providing at least 6.6m hours of care per week (Census 2016). Almost 1,800 carers are aged over 85 years.

Services provided

Older persons' services are delivered through a community-based approach, supporting older people to live in their own homes and communities and, when needed, high quality residential care will also be provided. A wide range of services are provided including home supports, short stay and long stay residential care, transitional care and day care, through HSE direct provision and through voluntary and private providers.

In 2018 there will be measures within older persons' services to improve unscheduled care access through investment of a total of €25m in additional home support, transitional care and bed capacity in rehabilitation settings. Home support and transitional care will be increased over the full year as follows:

- €18.25m for home support services will provide 754,000 hours to support 1,170 people to leave hospitals.
- €3.55m for transitional care (additional 20 approvals to an average of 170 per week).
- €1.4m for rehabilitation and step down beds in Limerick (4 beds) and Cork (30 beds).
- €0.85m for complex case discharges from acute hospitals.
- €0.65m for an additional 6 beds in the National Rehabilitation Hospital.
- €0.45m for out-reach specialist team and day hospital in Our Lady's Campus, Cashel.

Funding has also been provided on an on-going basis to support older people with dementia, who have high needs, to live in their own homes. Within the overall budget, €9m is provided for intensive home care packages (IHCPs). This innovative investment provided over the past number of years, a joint agreement between Atlantic Philanthropies, the DoH and the HSE, will be sustained on an on-going basis.

The Nursing Homes Support Scheme (NHSS) is forecast in 2018, to support 23,334 people in residential care at year end with a budget of almost €962m.

The on-going implementation of *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures, 2014* is a key service provision for older persons who may be vulnerable and requiring support, whether they are in their own homes or in residential care.

Issues and opportunities

The provision of appropriate home supports and community-based services maximises the potential of older people to remain well in their own home, helping to prevent unnecessary admissions to acute hospital facilities and subsequently may defer the requirement for admission to long stay care. Community and acute hospital services will continue to work across the health and social care settings to ensure the successful delivery of a range of services to support older people.

In 2018, home support services will be delivered through a single funding model, combining the resources for home help and home care packages (HCPs) which provide an enhanced level of care, improving the availability, accessibility and experience of these services for older people and their families. This will simplify the process of applying for home support services. The additional resources made available in 2018 brings the total budget for home support services to €408m, delivering over 17m home support hours to approximately 50,000 people. This is the equivalent of 10.57m hours of home help combined with 20,175 HCPs and a total of 235 IHCPs of 360,000 hours. The additional resources made available in 2018 are welcome, but demand for these services will continue to exceed the funded levels. The HSE will continue to support the DoH in relation to the development of plans for a new statutory scheme and system of regulation for home support services.

Our focus is to reform our services to maximise the use of existing resources and to develop sustainable models of service provision with positive outcomes for older people, delivering best value for money. Managing the year on year growth in demand for community-based social services is one of our key challenges. We will continue to encourage local integration of services and build appropriate care pathways, in particular for people with dementia and those with complex needs.

With the provision of €21.7m additional funding to the NHSS, increasing the overall budget to almost €962m, the intention is to support 23,334 people in residential care and maintain the waiting list for funding for new applicants to the scheme at no greater than four weeks on average throughout the year, on the assumption that there will be no increase in the cost of the provision of the service. Similar to previous years, and dependent on demand, this goal will require careful management and review on a regular basis, in conjunction with the DoH.

The Integrated Care Programme for Older Persons will, in 2018, consolidate progress to date within the existing 12 pioneer sites in accordance with the 10-step integrated care framework and share the early programmatic lessons from this process. The focus of the Integrated Care Programme for Older Persons activity will include embedding multi-disciplinary teams, continuing to promote a case management approach and developing care pathways for older persons with complex care needs. An additional site, CHO 5, South Tipperary will be brought on stream in 2018. Linkages with and learning from other strategic initiatives, specifically the community healthcare pilot networks and the implementation of candidate advanced nurse practitioners will be harnessed where appropriate.

There is a need to further reduce the cost of and reliance on agency staff. The use of agency staffing and / or overtime will be strictly controlled. A key risk for older persons' services is ensuring control over pay and staff numbers at the same time as managing specific safety, regulatory, demand and practice

driven pressures, while seeking to ensure recruitment and retention of a highly skilled and qualified workforce to appropriate levels of staffing and skill mix.

In cases where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved, and the available funding level, and planning assumptions provided by the DoH, the HSE is required to manage within the available resources while seeking to prioritise services to those in greatest need. Within older persons' services, this primarily applies to the provision of home support.

In the case of some services, given that the HSE is the statutory provider of last resort and the realities around the relatively fixed nature of certain costs, there is a requirement to respond to need even if this exceeds what can be supported by the available funding level. The financial challenges within older persons' services and the associated mitigating actions are summarised within Section 6 and Section 7.

Priorities 2018

- Provide older people with appropriate supports following an acute hospital episode focusing on delayed discharges.
- Implement the single funding model for home support services and improve quality of service through review and audit, and as part of an overall home support service improvement plan.
- Finalise the review of the Safeguarding Policy to ensure that the learning from its implementation over the previous years is fully aligned.
- Implement *The Irish National Dementia Strategy, 2014* through the National Dementia Office.
- Further develop the Integrated Care Programme for Older Persons.
- Continue to administer the NHSS within the available budget and implement the outstanding recommendations of the review of the scheme.
- Continue to provide day care and other community supports either directly or in partnership with other providers.
- Continue to engage with service users to ensure that services are responsive and person-centred.
- Continue to progress the implementation of the Single Assessment Tool (SAT) across all CHOs.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Implement *The Irish National Dementia Strategy, 2014* through the National Dementia Office
  - Deliver nationwide social media campaign Understand Together, in association with health and wellbeing services.
  - Utilise funding from dormant accounts to:
    - Develop a national post-diagnostic support pathway.
    - Develop the most appropriate model for a dementia registry.
    - Expand on memory technology services.

- Implement the learnings and outcomes from the HSE / Genio supported dementia specific initiatives.
- Continue the provision of IHCPs for people with dementia.

- *The National Carers' Strategy, 2012*
  - Continue to implement *The National Carers' Strategy, 2012.*

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

- Provide older people with appropriate supports following an acute hospital episode focusing on delayed discharges
  - Continue to provide dedicated home supports and transitional care to acute hospitals as part of the 2017 / 2018 winter measures.
- Implement the single funding model for home support services and improve quality of service through review and audit, and as part of an overall home support service improvement plan
  - Support the DoH in the development of plans for a new statutory scheme and system of regulation for home support services.
  - Commence a single funding home support service for older people.
  - Work towards implementation of consumer directed home support.
- Continue to provide day care and other community supports either directly or in partnership with other providers
  - Provide a menu of services across the health and social care spectrum to meet the needs of older people, through the provision of home supports, day care and other local community services.
- Further develop the Integrated Care Programme for Older Persons
  - Consolidate improvements across the 12 current sites, develop the new South Tipperary site and evaluate and transfer the learning from pioneer sites established in 2016 and 2017 to other locations.
- Continue to administer the NHSS within the available budget and implement the outstanding recommendations of the review of the scheme
  - Continue to implement the findings from the NHSS review.
  - Improve efficiency and responsiveness following the work completed in 2017 in reconfiguring to five nursing home support offices.
  - Support the DoH and interdepartmental agency / working group in relation to the value for money and policy review of the cost differentials in public and private / voluntary residential facilities and the examination of additional charges in nursing homes.
- Provide quality residential services
  - Continue to refurbish / replace public residential care centres in line with the Capital Plan funding provision.

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

- Finalise the review of the Safeguarding Policy to ensure that the learning from its implementation over the previous years is fully aligned
  - Complete the review of the National Safeguarding Policy on a cross-divisional basis, having regard to emerging legislation on assisted decision-making and prepare an action plan for implementation.
  - Support the strategic planning process of the Intersectoral Committee on Safeguarding.
  - Support the DoH in development of a national health sector policy on safeguarding adults at risk and associated legislation, subject to Government approval.
- Continue to engage with service users to ensure that services are responsive and person-centred
  - Ensure effective implementation of recommendations arising from inspections by HIQA.
  - Continue to work collaboratively through the service improvement team with CHOs, to provide support through evidence-based decision-making and ensure practices are in line with required standards.
  - Continue to self-evaluate and implement quality improvement plans to support person-centred care in public residential services.

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

- Continue to foster engagement with our workforce to deliver best possible care
  - Provide on-going person-centred learning programmes to staff working in residential care.
  - Commence audit reviews of home support services to ensure standardised practices are in place.
  - Work cross-divisionally with all areas, to develop and implement an Integrated Falls Prevention Programme.
  - Progress the CHO substructure design for older persons' services.

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

  - Agree and implement an appropriate staffing level and skill mix for public residential care services.
- Continue to progress the implementation of the Single Assessment Tool (SAT) across all CHOs
  - Influence service delivery and strategic planning for older persons' services through reviewing and optimising options in relation to SAT roll-out across home care and residential services.
  - Further develop the working group established in 2017 to review the appropriate discharge of patients with high complex needs from acute hospitals.

Acute Hospital Services

Population served

As populations continue to grow and age, there will be increasing demand for acute services that are responsive to life-threatening emergencies, acute exacerbation of chronic illnesses and many routine health problems that nevertheless require prompt action. Each year, the population aged 65 years and over increases by almost 20,000 people, and by over 2,500 for those aged 85 years and over. The total population growth in Ireland for 2017-2018 is projected at 0.8% (39,691 people). During this time, the number of adults aged 65 years and over is projected to increase by 3.4% (21,943 people) and the number of adults over 85 years is projected to increase by 3.6% (2,513 people). As individuals age, the likelihood of developing chronic diseases or cancer, requiring acute hospital care, increases. Acute services continue to optimise the management of chronic diseases and older persons' care in conjunction with primary and older persons' services to help patients avoid hospital, wherever possible, and receive quality care at home.

There has been an increase of 26.5% in hospital discharges of patients over 65 years of age between 2011 and 2016. The demographic trends show that demand for acute hospital services is increasing year on year and has a cost increase implication of 1.7% for 2018, without taking into account any new developments or treatments. In 2016, acute hospitals treated 51,542 additional day cases compared to 2014. During this time, day of surgery admission rates improved by approximately 7.5% and an additional 115,212 outpatient consultations were also provided. Despite the continued transfer of care towards ambulatory settings, there was an increase of 89,858 emergency presentations during this period of time. Inpatient discharges are growing, albeit at a slower rate (14,858), and the complexity of care required by those admitted is also increasing.

Services provided

Acute services include emergency care, urgent care, short term stabilisation, scheduled care, trauma, acute surgery, critical care and pre-hospital care for adults and children. Hospitals continually work to improve access to scheduled and unscheduled care, ensuring quality and patient safety within the allocated budget. The seven Hospital Groups provide the structure to deliver an integrated hospital network of acute care in each geographic area. This is progressing in a phased manner, providing for devolved decision-making, and fostering flexibility, innovation and local responsiveness. The Hospital Groups will be guided by strategic guidance to be issued by the DoH.

The hospitals have a key role in improving the health of the population by providing a range of services from brief intervention training and self-management support, offering advice and support in staying well, to optimising care pathways for patients admitted with exacerbations of chronic diseases, to reducing length of stay, accelerating return to usual health and supporting an integrated approach with GPs in the long term surveillance of patients who have had cancer. Healthy lifestyle choices are promoted across a range of paediatric, maternity and adult services, aimed at avoidance of ill health and best management of conditions such as asthma, COPD and diabetes.

Early detection of disease is central to optimising patient outcomes and the acute hospitals continue to support the delivery of screening services for bowel and breast cancer and follow-up care for cervical screening in line with the National Screening Service.

The National Women and Infants' Health Programme (NWIHP), National Cancer Control Programme (NCCP), and the NAS work closely with the acute hospitals and lead the strategic development of these services.

Issues and opportunities

The increase in funding for acute hospital services in recent years is welcome. The HSE will in 2018 face a significant financial challenge in meeting essential demand, maintaining and where possible, improving quality and containing costs. This and the associated mitigating actions are summarised in Section 6 and Section 7.

Patients expect to be cared for in the most appropriate environment and in an efficient manner, therefore acute services are increasingly provided in ambulatory settings as clinically appropriate. Acute hospitals are therefore challenged in addressing increased demand in terms of the number of patients presenting to hospitals and the complexity of their conditions. In addressing this challenge, acute hospitals continue to support initiatives which improve GP access to diagnostics and specialist opinion, to ensure that acute referrals are clinically appropriate. Currently, there is an over reliance on hospital-based care, with many services nationally accommodated in facilities that are no longer appropriate to meet patient needs.

There are critical care capacity deficits in hospitals across the country. Following the organisation of hospitals into Hospital Groups, it is clear that critical care capacity building is required in the 'hub' hospitals to meet the on-going and increasing critical care requirements of complex, multi-specialty, severely critically ill patients. It is known that access delays for critically ill patients arising from capacity deficits is associated with increased mortality, increased costs and poorer outcomes.

Management of bed capacity is challenged by the large number of delayed discharges in acute hospitals and in particular in regard to patients who require rehabilitation, the need for complex care for younger adults and those with disability and residential care needs, particularly children, and cases of homelessness. Pressure on bed capacity is also impacted on by the lack of single room availability, in particular for patients with HCAIs and, on discharge, beds closed for deep cleaning in order to prevent spread of infection. We are utilising bed capacity at maximum efficiency by reducing time spent in hospital by patients, and by monitoring patient flow along scheduled and unscheduled care pathways. Bed utilisation rates are greater than 90%, particularly in larger hospitals where discharge by 11am is promoted to improve admission waiting times for patients from EDs. Improving co-ordination between acute services, such as emergency physicians, surgeons and obstetricians, will deliver acute services more efficiently and effectively. Acute hospitals are also working collaboratively with primary and older persons' services in improving access to appropriate services outside of the acute hospital.

Additional bed capacity will be provided in 2018 to address some of the demand for inpatient beds. Using performance improvement tools (e.g. NQAIS systems), the acute hospitals will continue to monitor performance, identifying areas that will maximise ambulatory care services, improving day of surgery rates, and minimising length of stay.

Improving access times to inpatient, day case elective procedures and outpatient consultations is a constant challenge which the service is continuing to address by implementing waiting list action plans and by working with the National Treatment Purchase Fund (NTPF) to drive the roll-out of the *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.* The acute hospitals will optimise capacity to undertake insourcing of NTPF elective surgery cases. A key focus in 2018 will be on

improving access to emergency care and continuing the on-going work to reduce trolley waits and improve ED performance. Acute services will be pursuing, during 2018, implementation of the acute floor clinical design model as an important integration and co-ordination mechanism for unscheduled care presentations. The acute floor implementation process will incorporate implementation of the acute floor information system and will target a number of phase 1 implementation sites. The process will be linked to the patient flow projects and will involve a number of distinct work streams related to clinical standards, the necessary operational governance structures and appropriate activity based funding (ABF) mechanisms. An Acute Floor Implementation Oversight Group, comprising representatives of acute services, the clinical programmes and Hospital Groups, will be formed to lead the implementation process.

Providing specialist services within acute hospitals remains a priority as we respond to increasing complexity of presentations and advances in medical technology and interventions. The Hospital Groups are continuing the development of clinical networks of specialist services. These will consolidate secondary and tertiary care in appropriate locations, improving clinical outcomes and streamlining elective and emergency pathways across hospitals (such as orthopaedics and endoscopy services).

We are focusing on implementing a sustainable plan for scoliosis and paediatric orthopaedic care in 2018.

Other specialist national services will be supported in 2018 including further development of the national adult narcolepsy service at St. James's Hospital and investment in spina bifida services which, up to now, have had limited access to a urology team, in the Children's University Hospital, Temple Street, Dublin. The publication of the report of the Trauma Steering Group is expected in early 2018.

The *National Cancer Strategy 2017-2026* was published in 2017 and support for the implementation of its recommendations will address some of the current deficits in cancer services nationally. Details of the NCCP's priorities can be seen further in the plan.

Meeting increased demand for urgent colonoscopy waiting times, urgent GI endoscopy waiting times and targeting significant reductions in overall waiting lists and efficiencies is a key focus for acute services. The endoscopy programme undertook a review of services nationally in 2017 in order to identify capacity within a targeted set of priority hospitals. This will be a particular focus for 2018.

Ensuring that services for children are managed in an integrated way, including improving paediatric access, are key challenges for acute services. The new children's hospital, when completed, will transform general paediatric and emergency care for children. A key milestone in the Children's Hospital Project and Programme (CHP&P) is the planned opening of the new Paediatric Outpatient and Urgent Care Centre at Connolly Hospital in early 2019. The programme will support the development of an integrated clinical network for paediatrics across the health system as the system works towards developing outreach and regional services across the country in advance of moving services into the new children's hospital. This is supported by the national model of care for paediatrics and neonatology, as set out by the Integrated Care Programme for Children, of a single integrated national service for paediatrics. It is also envisaged that, in 2018, legislation to establish a new single entity to run the new hospital and outpatient care centres will be progressed, which will be a milestone in the structure and approach for healthcare delivery.

A range of initiatives need to be prioritised to improve the quality of care for patients and deliver better value for money, including ensuring maximum benefit for patients from the health service's expenditure on medicines and allowing new effective medicines to be adopted in the future. The Acute Hospital Drugs Management Programme has a number of initiatives underway and in development, aimed at achieving efficiency through procurement practices, closer scrutiny of outcomes and maximising the use of drugs with

proven cost effectiveness such as biosimilars. In particular, in order to ensure affordability of medicines into the future, value from patent-expired medicines must be maximised. The Irish Pharmaceutical Healthcare Association and HSE *Framework Agreement on the Supply and Pricing of Medicines 2016-2020* include clauses on both generic medicines and biosimilar medicines, which will provide savings on generic products and on patent-expired biological products where used. Phase 2 of the Patient Income Process Improvement Project will see the roll-out of standardisation of patient income processes nationally.

Priorities 2018

- Improve patient and staff health and wellbeing by implementing *Healthy Ireland* plans.
- Increase critical care capacity.
- Improve the provision of unscheduled care and scheduled care maximising the resources available.
- Increase acute hospital capacity by opening additional beds.
- Continue to oversee the new children's hospital development including the Paediatric Outpatient and Urgent Care Centre.
- Develop and improve national specialties.
- Ensure quality and patient safety.
- Continue to implement the *National Maternity Strategy 2016-2026* in conjunction with the NWIHP.
- Continue to support implementation of the *National Cancer Strategy 2017-2026* in conjunction with the NCCP.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Improve patient and staff health and wellbeing by implementing *Healthy Ireland* plans
  - Develop and implement clinical guidelines for under-nutrition and an acute hospital food and nutrition policy.
  - Continue implementing *Healthy Ireland* plans in the Hospital Groups.
  - Improve staff uptake of the flu vaccine.
  - Prioritise the implementation of Making Every Contact Count in all care settings.

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

- Increase critical care capacity
  - Enhance critical care capacity with the opening of additional capacity at Cork University Hospital and Mater Misericordiae University Hospital, Dublin.
- Improve the provision of unscheduled care
  - Improve pathways for care of older people living with frailty in acute hospitals in association with the Integrated Care Programme for Older Persons.
  - Ensure that no patient remains over 24 hours in ED.

- Implement measures to address seasonal increase and reduce delayed discharges in association with community healthcare.
- Support the continued roll-out of the Integrated Care Programme for Patient Flow.
- Generate improved capacity by improving internal efficiencies and more appropriate bed usage by reducing length of stay, early discharge and improving access to diagnostics.

- Improve the provision of scheduled care
  - Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate.
  - Implement waiting list action plans for all patients and particularly those waiting for significant periods across outpatient and inpatient / day case waiting lists.
  - Improve efficiencies relating to inpatient and day case activity by streamlining processes and maximising capacity in acute hospitals.
  - Work with the NTPF to implement the *National Inpatient, Day Case and Planned Procedure (IDPP) Waiting List Management Protocol.*
  - Work with the NTPF to develop and implement a waiting list action plan for 2018.
  - Work with the clinical programmes to complete a suite of pathways of care at condition-level, through the Outpatient Services Performance Improvement Programme.
  - Implement the findings and recommendations of the NTPF special audit to drive process and performance improvement in scheduled care.
  - Further develop GP referral guidelines and standardised pathways, supported by efficient electronic referral systems.
  - Roll out the national validation project for inpatient, day case and outpatient waiting lists.
- Increase acute hospital capacity
  - Open additional beds and new units to increase capacity and improve access over the winter period.
    - Our Lady of Lourdes Hospital, Drogheda
    - University Hospital Galway
    - University Hospital Limerick
    - St. Vincent's University Hospital, Dublin
    - University Hospital Waterford
    - Cork University Hospital
    - St. Luke's Hospital, Kilkenny
    - Commence project to provide modular build at South Tipperary General Hospital
    - Expand medical assessment services at Roscommon University Hospital.
- Continue to oversee the new children's hospital development including the Paediatric Outpatient and Urgent Care Centre in the context of the HSE CHP&P Steering Group in directing the overall integration programme of work within agreed parameters
  - Support the on-going implementation of the new Children's Hospital Integration Programme.
  - Support the development of the all-island paediatric cardiology service.

- Continue to improve access to paediatric orthopaedics including surgery for scoliosis in conjunction with the Children's Hospital Group to achieve clinically appropriate waiting times. This will be underpinned by the development of a standardised pathway of care for children and adolescents with scoliosis which will be evidence-based and patient-centred.
- Continue the development of a service for young adults with scoliosis in the Mater Misericordiae University Hospital, Dublin, and Cappagh Orthopaedic Hospital for patients transferring from paediatric services.
- Continue the development of urology services for children with spina bifida.

- Develop and improve national specialties
  - Commence development of the National Genetics and Genomic Network including recruitment of a Clinical Director.
  - Implement a range of service and capacity improvement actions by the National Endoscopy Programme.
  - Further develop the national narcolepsy service at St. James's Hospital, Dublin.
  - Progress the recruitment of a consultant and the opening of two assessment beds to support the national transplant service in the Mater Misericordiae University Hospital, Dublin.
  - Progress the recruitment of a national clinical lead and the establishment of the National Office for Trauma Services and begin implementation planning for the report of the Trauma Steering Group, once published.
  - Strengthen the role of the NCCP in centralising surgical cancer services.

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

- Ensure quality and patient safety
  - Facilitate initiatives which promote a culture of patient partnership including the next phase of the National Patient Experience Survey.
  - Monitor and control HCAIs.
    - Continue to develop robust governance structures at hospital, group and national level to support management of HCAI / AMR.
    - Collate information on incidence of CPE and associated infection control measures.
- Enhance medicines management
  - Further enhance medicines management, improve equitable access to medicines for patients and continue to optimise pharmaceutical value through the Acute Hospitals Drugs Management Programme.
  - Commence implementation of the *Report on the Review of Hospital Pharmacy, 2011* (McLoughlin Report) with a focus on the development of pharmacist roles to improve and enhance medication safety, and implement HIQA medication safety reports.
- Implement Children First
  - Commence implementation of the *Children First Act 2015.*

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

- Support and progress the policies and initiatives of the Office of the Chief Nursing Officer, DoH
  - Extend and roll out nationally the Phase 1 Framework for Staffing and Skill Mix for Nursing in General and Specialist Medical and Surgical Care in acute hospitals within the allocated resources.
  - Implement a pilot for the Phase 2 Framework for Staffing and Skill Mix for Nursing in emergency care settings.

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

- On-going monitoring and performance management of financial allocations in line with the Performance and Accountability Framework
  - Monitor and control hospital budgets and expenditure in line with allocations.
  - Continue to focus on initiatives that will drive quality of care and value for money.
  - Continue the next phase of ABF including the incentivised scheme for elective laparoscopic cholecystectomy.
  - Ensure compliance with the memorandum of understanding between the HSE and VHI in conjunction with National Finance.

Cancer Services

The population aged over 65 years is estimated to more than double in the 25 years between 2011 and 2036. This ageing of the population will drive a large increase in the number of new cancer cases, with the number of new patients receiving chemotherapy expected to increase by between 42% and 48% in the period from 2010 to 2025.

Services provided

Services for the treatment of cancer include surgery, radiotherapy and systemic anti-cancer therapy (SACT). The majority of, but not all, cancer surgery now takes place in the designated cancer centres. Eight hospitals were designated as cancer centres (with a satellite unit in Letterkenny University Hospital). A further 18 public hospitals provide SACT (chemotherapy, immunotherapy, etc.) and an additional two centres provide radiotherapy services.

The national programme for radiation oncology (NPRO) phase 2 capital developments (St. Luke's Hospital, Rathgar, Cork University Hospital and Galway University Hospitals) will proceed and assist with meeting the current level of demand, along with continuing and developing the cross-border radiotherapy initiative.

As part of the new *National Cancer Strategy 2017-2026*, initiatives will be set up across the continuum of care, from diagnosis and treatment, to appropriate follow-up and support, in both the hospital and community setting across the four strategy goals:

- Reduce the cancer burden through cancer prevention and early detection.
- Provide optimal care in the most appropriate setting and in a timely manner.
- Maximise patient involvement and quality of life, especially for those living with and beyond cancer, through psycho-oncology services, survivorship care plans and cancer care guidelines and initiatives.
- Enable and assure change, aligned with desired outcomes.

Issues and opportunities

Realising the huge importance of cancer prevention and early detection is key to reducing the cancer burden on people and on the health service, as is providing acute services to meet the estimated increase in cancer incidence. Preventative efforts will be particularly directed at more deprived populations. The National Cancer Control Programme (NCCP) will continue to develop integrated care pathways in collaboration with GPs and with specialist colleagues. To meet the expected growth in the number of people living with and beyond cancer, a new model of care for survivorship will be developed.

Managing increased demand as a result of growth expected in the number of cancer patients, and particularly in those in receipt of SACT, is a significant challenge. Improvements are required in facilities, including SACT day wards, to improve access, safety and patient experience, and in aseptic compounding units, to improve efficiency and reduce drug expenditure.

A key focus in ensuring patients have access to the best possible treatment is access to appropriate drug treatments, but this must be managed against the realities of new drug costs and growth in the cost of existing drugs.

Control and validation of direct payment for cancer drugs through the Oncology Drug Management System is managed by PCRS on behalf of the NCCP to facilitate a reimbursement process utilising ABF, which results in direct payments to the treating hospitals.

To ensure services are underpinned by evidence and best practice, services are monitored against agreed performance parameters. Development of further national clinical guidelines is also on-going.

Support for the implementation of the recommendations of the *National Cancer Strategy 2017-2026* will address some of the current deficits in cancer services nationally.

Priorities 2018

- Develop cancer survivorship and psycho-oncology services.
- Develop a cancer prevention and early detection function in the NCCP.
- Implement the new *National Cancer Strategy 2017-2026*.
- Support the expansion of the NPRO including NPRO phase 2 developments and the cross-border radiotherapy initiative.
- Improve the quality of cancer services.
- Support the development of workforce planning, in line with the *National Cancer Strategy 2017-2026*.
- Support the enhancement of funding programmes for the best available cancer drug treatments, and support hospitals in meeting the continuing burden of drug costs and in implementing quality initiatives in cancer care.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Develop cancer survivorship and psycho-oncology services
  - Ensure appropriate clinical and non-clinical staff are in place.
  - Complete a national needs assessment.
  - Link with other stakeholder agencies to implement a survivorship model across the cancer centres.
  - Develop and implement a national plan for cancer survivorship.
- Develop a cancer prevention and early detection function in the NCCP
  - Ensure appropriate staff are in place to progress this function.
  - Link with other stakeholder agencies to implement cancer prevention and early detection projects.
  - Develop and implement a national plan for cancer prevention and early detection.

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

- Implement the new *National Cancer Strategy 2017-2026*
  - Work with the DoH and other stakeholders on the implementation of the *National Cancer Strategy 2017-2026.*

- Support integrated care between GPs and clinical colleagues.
- Continue the implementation of the centralisation of cancer surgery in line with the *National Cancer Strategy 2017-2026*.
- Lead on service developments including cancer prevention, early diagnosis, treatment and survivorship within a performance monitoring framework.
- Implement a molecular testing framework for tests that are predictive for drug treatment.
- Continue to ensure that cross-border collaboration at the North West cancer radiation centre at Altnagelvin is progressing to full capacity, allowing patients in the North West to receive radiotherapy closer to home.

- Expand the NPRO
  - Support the expansion of the NPRO including NPRO phase 2 developments and the cross-border radiotherapy initiative.

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

- Improve the quality of cancer services
  - Work with Hospital Groups to implement the recommendations of the performance improvement plan for breast, prostate and lung cancer rapid access clinics and other rapid access cancer services.
  - Commence the roll-out of the medical oncology clinical information system (including multi-disciplinary meeting module) on a phased basis across the 26 SACT hospital sites.
  - Improve care in relation to patient / family psychological impact after a diagnosis of cancer, supported by the appointment of a psycho-oncology lead and implementation of the model of care.
  - Further develop cancer clinical guidelines, GP referral guidelines, follow-up protocols and national chemotherapy regimens.
  - Look after the needs of people who are living with and beyond cancer.

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

- Support the development of workforce planning, in line with the *National Cancer Strategy 2017-2026*
  - Commence workforce planning requirements as set out in the *National Cancer Strategy 2017-2026*.
  - Support development of national leads and sub-specialisation as identified in the *National Cancer Strategy 2017-2026*.

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

- Support the enhancement of funding programmes for the best available cancer drug treatments, and support hospitals in meeting the continuing burden of drug costs and implementing quality initiatives in cancer care
  - Undertake and review quarterly activity data submissions.

- Review trends for cancer drug spending in hospitals.
- Monitor and evaluate the provision of private radiotherapy providers in University Hospital Limerick and University Hospital Waterford.

Women and Infants' Health

Population served

The National Women and Infants' Health Programme (NWIHP) was established in January 2017 to lead the management, organisation and delivery of maternity, benign gynaecology and neonatal services, strengthening these services by bringing together work that is currently undertaken across primary, community and acute care. It aims to ensure equity of access for women and their families to high quality, nationally consistent, woman-centred maternity care.

Services provided

The NWIHP has developed an implementation plan for the *National Maternity Strategy 2016-2026* (NMS) which was launched in October 2017. The implementation plan sets out over 230 actions to achieve the strategic priorities of the NMS. The NMS is a 10-year strategy and, while all the actions are important, the programme is prioritising anomaly scanning, the commencement of implementing the new model of care, and quality and safety for 2018.

The new model of integrated, multi-disciplinary care, introduced by the NMS, comprises three care pathways – supported, assisted and specialised. Developing teams of community midwives will ensure that women who have a normal risk pregnancy can avail of the supported care pathway in their own community.

Issues and opportunities

In parallel with the implementation of the model of care, the NWIHP will focus on the quality and safety of patients. Currently, only seven maternity hospitals / units offer all women access to anomaly scans. This current inequitable issue needs to be addressed and the programme has identified the need to recruit additional sonographers to ensure that all pregnant women are offered an anomaly scan (20-22 weeks). Pending the necessary recruitment and training processes, the programme will continue to work with maternity networks to improve access to anomaly scans. The recruitment of additional staff in 2018 will have a positive impact and will assist in mitigating the risk in this area.

Critical adverse incidents, where they occur, have a devastating impact on families. The programme will implement a new framework for the management of maternity related incidents, which will include the recruitment of quality and safety resources for each of the six maternity networks. The focus will be on the most devastating adverse incidents, as the Each Baby Counts model is rolled out.

NCEC national clinical guidelines relating to maternity care and risk stratification for the model of care have been commissioned and are in development. In line with the NMS, these will support the model of care when complete. Pending the completion of the guidelines, core principles to underpin the model of care will be developed and implemented.

Priorities 2018

- Quality and safety: Establish a Serious Incident Management Forum in each Hospital Group.
- Model of care: Establish the community midwifery model.
- Anomaly scanning: Ensure anomaly scanning is available to all women attending ante-natal services.

- Health and wellbeing: Develop a bespoke Make Every Contact Count programme.
- Obstetric anaesthetics: Pilot the anaesthetics model of care.
- Maternal and Newborn Clinical Management System (MN CMS): Roll out MN CMS.
- Online resource: Develop an online resource for maternity services.
- Benign gynaecology services: Develop a national plan for benign gynaecology.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Develop a bespoke Make Every Contact Count programme
  - Support social work and dietetics at maternity network level to create appropriate clinical pathways for women.
- Develop an online resource for maternity services
  - Develop an online resource to act as a one-stop shop for all maternity related information.

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

- Ensure anomaly scanning is available to all women attending ante-natal services
  - Provide resources to improve access to anomaly scanning in those units that do not currently offer any woman access to anomaly scanning (five units) and to the seven units where less than 100% of women are offered a service.
- Establish the community midwifery model
  - Ensure appropriate staff are in place to establish a community midwifery model in a minimum of one maternity hospital / unit in each hospital network.
- Develop a national plan for benign gynaecology
  - Improve outpatient, inpatient, day case and emergency out of hours access to benign gynaecology services.
- Pilot the anaesthetics model of care
  - Work with the clinical care programme in anaesthetics to commence the roll-out of an anaesthetics model of care for maternity services.
  - Develop and implement principles to underpin the model of care pending completion of the NCEC guidelines.

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

- Establish a Serious Incident Management Forum in each Hospital Group
  - Allocate a quality and safety resource to each Hospital Group, specifically for maternity services.

- Support professionals and promote inclusiveness.
  - Host an annual national multi-disciplinary conference, bringing professionals from across the country, and with international speakers, to support professionals and promote a culture of inclusiveness.

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

- Roll out MN CMS
  - Complete phase 1 of the roll-out of MN CMS and commence phase 2 in five maternity sites.

Pre-Hospital Emergency Care Services

Population served

The National Ambulance Service (NAS) is a demand-led service serving the whole population. An ageing population and an increase in the number of people living with chronic disease drive a corresponding increase in the demand for pre-hospital emergency care.

The population density and distribution in Ireland is significantly different from that of many other countries. With the exception of Dublin, the population is widely dispersed around the country with a relatively large proportion distributed throughout rural Ireland. As a result of the distribution of the population, the NAS has a far higher percentage of activity in rural areas than, for example, a typical English service.

Services provided

The NAS is the statutory pre-hospital emergency and intermediate care provider for the State. In the Dublin metropolitan area, ambulance services are provided by both the NAS and by agreement with the Dublin Fire Brigade. National aeromedical services are provided by the Irish Air Corps and the Irish Coast Guard by agreement with each organisation. At a local level, the NAS is also supported by Community First Responder schemes, responding to particular types of medical emergencies (i.e. cardiac arrest, respiratory arrest, chest pain, choking and stroke) where it is essential for the patient to receive immediate life-saving care whilst an emergency response vehicle is en route to the patient. A memorandum of understanding is also in place with the Northern Ireland Ambulance Service to support working for the benefit of the population on both sides of the border.

Currently, the NAS operates from over 100 locations throughout Ireland, responding yearly to over 300,000 emergency and urgent calls, transporting approximately 30,000 intermediate care patients, co-ordinating and dispatching over 850 air ambulance calls, and completing approximately 700 paediatric and neonatal retrievals.

Issues and opportunities

A particular challenge faced by the NAS is the recruitment and retention of a highly skilled and qualified workforce due to increasing competition in the labour market internationally, age profile and increasing competition between the public and private sectors. There will be on-going challenges in meeting compliance with response time targets, particularly for calls in rural areas rather than urban areas because of the longer travel distances, and in the continued implementation of the recommendations of the HIQA review of pre-hospital emergency care services. Performance in ambulance turnaround times (at ED) also represents a key challenge to the NAS.

We will continue to address these challenges through on-going implementation of the NAS Strategic Plan, *National Ambulance Service Vision 2020 Patient Centred Care 2016-2020*.

Through NSP 2018 and the on-going implementation of the strategic plan, the NAS will strive to avail of opportunities for service improvements. These include the opportunity to progress the development and implementation of alternative care pathways, move towards a multi-dimensional urgent and emergency

care provision model, expansion of Community First Responder schemes, and service improvements underpinned by the development of additional clinical performance indicators.

In cases where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved, the available funding level and planning assumptions provided by the DoH, the HSE is required to manage within the available resources while seeking to prioritise services to those in greatest need. Within pre-hospital emergency care, this primarily applies to increases in service demand.

Priorities 2018

- Continue to improve operational performance and access.
- Progress the development and implementation of alternative care pathways.
- Support the expansion of aeromedical services.
- Continue to improve clinical outcome.
- Enhance clinical competencies to improve quality of care and patient safety.
- Continue to deploy the most appropriate resources safely, quickly and efficiently.

Implementing priorities 2018 in line with Corporate Plan goals

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

- Continue to improve operational performance and access
  - Improve response times in targeted areas with the recruitment and training of additional staff.
  - Expand the intermediate care service to support Hospital Groups in inter-hospital transfers.
  - Progress the development of the National Transport Medicine Programme.
- Progress the development and implementation of alternative care pathways
  - Progress Hear and Treat as an alternative care pathway.
  - Expand the number of Community First Responder schemes in line with the *National Ambulance Service of Ireland, Emergency Service Baseline and Capacity Review, 2015*.
- Support the expansion of aeromedical services
  - Support the expansion of aeromedical services, in particular the potential development of a second base.

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

- Continue to improve clinical outcomes
  - Pilot a new set of clinical key performance indicators for pre-hospital emergency care services.
  - Improve engagement with patients and families.

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

- Enhance clinical competencies to improve quality of care and patient safety
  - Support the additional education and competency assurance capacity of the NAS College, including on-going progression of the Road Safety Authority Emergency Services Driving Standards.
  - Introduce a community paramedic (pilot) scheme, in partnership with the Northern Ireland Ambulance Service and the Scottish Ambulance Service – a cross-border Co-operation and Working Together initiative.
  - Progress the introduction of a clinical support capacity.

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

- Continue to deploy the most appropriate resources safely, quickly and efficiently
  - Strengthen and embed effective fleet management and maintenance.

Section 6: Finance

Section 6: Finance

Summary

The headline 2018 budget level of €14,556m is set out in the Letter of Determination (LoD) received from the DoH and is a €608m / 4.4% year on year budget increase.

This is €238m / 1.6% above the cost of delivering services in 2017, estimated at approximately €14,318m, including activity related and other cost variances. Included within this amount is also €196m provided under the heading of 'development monies' which will be allocated in line with DoH direction so as to maintain and expand existing services while also driving new developments and other improvements.

The HSE acknowledges its legal requirement to protect and promote the health and wellbeing of the population, having regard to the resources available to it and by making the most efficient and effective use of those resources.

The DoH has provided the HSE, by letter dated 8th December 2017, with a set of planning assumptions to be utilised in the finalisation of this plan.

Taking account of these assumptions, the HSE estimates that there will be a financial challenge within the operational service areas of approximately €346m / 2.4% excluding what the HSE refers to as pensions and demand-led areas. This is after significant measures have been taken to avoid unfunded cost growths and on-going routine efforts to operate services within available resources. The pension and demand-led areas above are made up primarily of the areas covered by the DoH provided assumptions along with local demand-led schemes and overseas treatment.

Approach to addressing financial challenge 2018

The HSE is establishing an overall Value Improvement Programme at the beginning of 2018 which will have three priority themes. Please see detail in Section 7.

Data caveats and other assumptions

The financial information underpinning the plan is subject to the specific limitations of the HSE's financial systems, currently available within the overall finance operating model, which are well documented and are being addressed via a major improvement programme. This includes the HSE's reliance on the receipt of financial and other information from a large number of voluntary organisations which are separate legal entities with their own separate financial systems. Every effort has been made within the time and resources available to ensure that the information provided in the plan is as accurate as possible. However, it must be read in the above context and it is noted that a margin of error of as little as 0.1% (one tenth of 1%) equates to €14.5m in net expenditure terms for the HSE as a whole.

It is stressed that, as outlined in previous NSPs, the HSE is not in a position to set aside a general contingency fund in 2018. A 1% to 2% contingency would not be unusual in many organisations and in the case of the HSE this would equate to €145m to €290m. In addition, it is not expected that overruns in one area can be offset against surpluses in other areas to any great extent beyond what has already been factored in, coupled with the need to respond to regulatory / legal requirements as required, and the plan is

prepared and approved on that basis. It is also noted that pandemic vaccines and emergency management scenarios were previously covered by contingency funding held by the HSE. These contingency funds are no longer available to the HSE, and accordingly, in the event that such costs arise they fall outside of what has been provided for the plan and will need to be the subject of separate engagement with the DoH at the time.

There is no capacity within the plan for the HSE to respond in 2018 to further pay or other pressures, beyond those already specifically funded. In the event that additional pressures emerge, for example, via the industrial relations machinery of the state, regulatory processes, government decisions or the courts etc., the HSE will need to engage with the DoH as to how to proceed.

It is noted that the HSE's capacity to respond to new drugs and new indications for existing drugs is limited. In this context the HSE will continue to monitor these areas closely and correspond appropriately with the DoH to seek any necessary direction before incurring any costs that may be outside of the available level of funding.

Budget 2018 versus budget 2017

The total net revenue budget available to the HSE in 2018 will be €14,556m.This 2018 budget level represents an overall increase of €413m (2.9%) on the final 2017 budget. The increase can be stated as €608.1m (4.4%), if the expected supplementary 2017 funding of €195m is excluded.

The amounts above include a sum of €143.5m (see Appendix 1, table 3) which is being held by the DoH for additional service initiatives which will be released during the year as specific implementation plans are agreed. In addition, a further €2.45m in relation to dormant accounts funding is subject to a separate approval arrangement with Pobal and will be drawn down following approval by Pobal in relation to the funding, leaving a total of €145.9m held by the DoH.

Budget summary 2018 (See Table A)

Existing level of service

The cost of maintaining existing services increases each year due to a variety of factors including:

- Incremental costs of developments commenced during 2017.
- Impact of national pay agreements (primarily public sector-wide).
- Increases in drugs and other clinical non-pay costs including health technology innovations.
- Inflation-related price increases.
- Additional costs associated with demographic factors.

Full year effect of 2017 developments - €47.6m

The incremental cost of developments and commitments approved in 2017 is €47.6m. This includes the cost of providing services which commenced part way through 2017, over a full year in 2018.

Pay rate funding (including *Lansdowne Road Agreement*) - €278.1m

This funding is provided in respect of the growth in pay costs associated with the *Lansdowne Road Agreement* (LRA), Labour Relations Commission recommendations and other pay pressures. It is provided to offset the increased cost of employing existing levels of staff and does not allow for an increase in staff numbers.

It is noted that some unavoidable pay-related costs, identified as part of the estimates process, were not funded within the overall allocation. The most significant of these relate to the net cost of increments, which must be paid in line with approved public pay policy, which has been estimated at €27.4m for 2018.

A breakdown of the pay rate funding allocation by division is provided in Appendix 1, table 3, column F.

Demographic and inflation - €59.2m

Additional funding of €59.2m has been received to offset inflationary costs and the impact of demographics on maintaining services in 2018. Demographic pressures include the age of the population and other trends within the population such as births.

Other ELS funding (including adjustments) - €27.1m

Additional funding of €68.7m has been received for areas such as SCA (€50m), NHSS (€9.7m) and disability services (€9m). In addition, reductions have been applied to the PCRS (€33.6m), primary care (€5m) and health and wellbeing (€3m) giving a net increase under this heading of €27.1m. The funding provided to SCA relates to the cost of managing and settling claims which arose in previous years which is a statutory function of the agency. The SCA is a demand-led area and therefore cannot be directly controlled by the HSE.

Expanding existing services / developing new services - €196.1m of which €143.5m held by the DoH

Within the total allocation of €14,556m, funding of €196.1m will be applied to enhance or expand existing services, including responding to demographic pressures, and to commence new approved service developments. Of this amount, €153.5m (78%) is allocated to operational service areas performance managed by the HSE and €42.6m (22%) is allocated to pensions and other demand-led areas. Costs in these areas are primarily driven by eligibility, legislation and similar factors and therefore cannot be directly controlled by the HSE.

As indicated above, €143.5m of this €196.1m is being held by the DoH. This funding will be released to the HSE on approval of implementation plans and commencement of specific developments. Funding is being held to support the following:

- Primary care services – €25m for service developments including lease costs of new primary care centres, GP training and diagnostics, therapies and nursing.
- Social inclusion – €6.5m for the drug strategy.
- Mental health services – €15m to initiate new developments in 2018 with a recurring full year value of up to €35m. (In addition, there will be €35m allocated to mental health services in 2019, bringing the total increase for 2019 to €55m and resulting in an increase of €105m over the three years 2017 – 2019).
- NAS – €2.75m to invest in areas such as the intermediate care service, clinical hub, national transport medicine and aeromedical services.
- Acute hospital services – €40.2m to invest in areas such as scheduled and unscheduled care (access), strategies, the new children's hospital, all-island cardiology and foetal anomaly screening.
- NCCP – €5.5m for cancer services.
- Disability services – €25m for school leavers, respite and HIQA related costs.

- Older persons' services – €32m for home support in the community and access: scheduled and unscheduled care – home support.
- Health and wellbeing – €0.3m for influenza campaign.
- PCRS – €42.6m for new drugs, reductions in the prescription and drug payment scheme (DPS) threshold, provision of GP visit cards to full time carers.
- National services – €1.25m for exceptional measures.

As indicated previously, given the extent of the financial challenges the plan assumes that development funding will be allocated in order to maintain and expand existing services while also driving new developments and other improvements.

The effect of the funding held at the DoH on the opening 2018 divisional budgets is illustrated in Appendix 1, table 3, column I.

Table A: Budget framework 2018

	€m	€m	€m
2017 Budget brought forward to 2018			13,948.5
(€13,948.5m NSP 2017 - See Table 2 on pages 95-96 for increases during 2017)			
Full year impact of 2017 new developments			
Acute Hospitals	9.0		
National Ambulance Service	3.0		
Health and Wellbeing	4.1		
Social Inclusion	1.5		
Mental Health	20.0		
Disability Services	10.0	47.6	
Demographics and Inflation			
Acute Hospitals	18.8		
National Ambulance Service	1.5		
Health and Wellbeing	1.8		
Primary Care	4.6		
Social Inclusion	0.6		
Palliative Care	0.4		
Disability Services	18.2		
Older Persons' Services	8.6		
National Cancer Control Programme	1.0		
Local Demand-Led Schemes	3.5	59.2	
Other ELS Funding (including Adjustments)			
Nursing Homes Support Scheme (NHSS)	9.7		
State Claims Agency	50.0		
Primary Care Reimbursement Service	(33.6)		
Health and Wellbeing	(3.0)		
Primary Care	(5.0)		
Disability Services	9.0	27.1	
2018 Total ELS Funding (excluding Pay Rate Funding)			133.9

	€m	€m	€m
2018 Pay Rate Funding (supports existing staff levels)			
Acute Hospitals	160.6		
National Ambulance Service	3.4		
Health and Wellbeing	3.3		
Primary Care	21.4		
Social Inclusion	1.3		
Palliative Care	1.3		
Mental Health	22.5		
Disability Services	29.7		
Nursing Homes Support Scheme (NHSS)	12.0		
Older Persons' Services	8.0		
National Cancer Control Programme	0.1		
Clinical Strategy and Programmes	8.4		
Quality Assurance and Verification	0.1		
Quality Improvement	0.0		
Emergency Management	0.0		
National Services	5.3		
Primary Care Reimbursement Service	0.6		
2018 Total Pay Rate Funding			278.1
2018 New Developments (see Table 4)			
Acute Hospitals		40.2	
National Ambulance Service		2.8	
Health and Wellbeing		0.3	
Primary Care		25.0	
Social Inclusion		6.5	
Mental Health		15.0	
Disability Services		25.0	
Older Persons' Services		32.0	
Primary Care Reimbursement Service		42.6	
National Services		1.3	
National Cancer Control Programme		5.5	
2018 Total Development Funding			196.1
Total 2018 Additional Funding (Note 1)			608.1
2018 Budget			14,556.5

Key risk areas

The HSE has modelled the theoretical level of activity that the 2018 funding will pay for and identified service areas where the HSE is expected to address service demands, even where these exceed the available funding. It has also assessed the costs that cannot be avoided or are fixed, and formed an estimate of the likely scale of financial challenge facing our health and social care services in 2018, before cost mitigation measures.

Management of cash risk

Given the level of planning assumptions and the scale of the financial challenge to be dealt with as outlined above, it is expected that the management of the cash position will be challenging in 2018. Any 2017 deficit or accumulated deficits from prior years within the statutory or larger voluntary providers will add to this challenge.

Operational service areas

Acute hospital services

Where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved, the available funding level and planning assumptions provided by the DoH, the HSE is required to manage within the available resources, while seeking to prioritise services to those in greatest need. This primarily applies to elective services.

In the case of some services, given that the HSE is the statutory public provider and the realities around the relatively fixed nature of certain costs, there is a requirement to respond to need even if this exceeds what can be supported by any level of realistic efficiencies coupled with the available funding. This primarily applies to emergency and maternity services.

The headline 2018 net budget level of €4,696m is a €222m / 5% year on year budget increase and this is to be welcomed.

The estimated cost of acute services in 2017 is €4,702m or €6m / 0.1% above the 2018 budget level.

In looking forward to 2018, including the key risk areas, the financial challenge within acute hospitals, before cost mitigation, is estimated to be €245m / 5.2% after application of the DoH provided planning assumptions and significant cost avoidance. Further context is provided within the Acute Hospital Services section of the plan. Through the Value Improvement Programme, we will target improvement opportunities to address the acute hospital financial challenge while maintaining levels of activity. See Section 7 for details.

Disability services

In the case of some services, given that the HSE is the statutory provider of last resort and the realities around the relatively fixed nature of certain costs, there is a requirement to respond to need even if this exceeds what can be supported by the available funding level. Within disability services this primarily relates to residential places and emergency cases.

In looking forward to 2018, including the key risk areas, the financial challenge within disability services, before cost mitigation, is estimated to be €72.5m / 4.1% after application of the DoH provided planning

assumptions and significant cost avoidance. This relates primarily to the unfunded costs of providing residential care to people with an intellectual disability, including emergency provision and cost of responding to unfunded regulatory requirements notified by HIQA or the courts. Through the Value Improvement Programme, we will target improvement opportunities to address the disability services financial challenge while maintaining levels of activity. See Section 7 for details. Further context is provided within the Disability Services section of the plan.

Primary care services – core services (excluding PCRS and local demand-led schemes)

The likely financial challenge for core primary care services in 2018 is €15m / 1.4% after application of the DoH provided planning assumptions and significant cost avoidance. This principally relates to the provision of support for complex paediatric discharges and virus reference laboratory services. It is before cost mitigation. Through the Value Improvement Programme, we will target improvement opportunities to address the primary care services financial challenge while maintaining levels of activity. See Section 7 for details.

Older persons' services

Managing the year on year growth in demand for community-based social services is one of the key challenges for older person's services in 2017. The additional funding received, while welcome, does not allow the services to keep pace with the increasing demand and demographic pressures within the community. Specific pressures are evident in the areas of the NHSS, home support, and short stay and transitional care beds, where the level of provision is directly determined by the funding available.

The financial challenge within older persons' services, before cost mitigation, can be reduced to €10.2m / 1.2% after application of the DoH provided planning assumptions and cost avoidance.

To part address this financial challenge, the HSE, in partnership with the DoH, our staff and suppliers, will during 2018, seek to implement realistic and achievable measures to improve efficiency and effectiveness. Our current best estimate is that the first phase of these measures can, with the support of the DoH, deliver up to €6m / 0.7% and therefore reduce the overall financial challenge to €4.2m / 0.5%. Subject to satisfactory progress early in the year in relation to this first phase, a second phase of measures, again focusing on a safe and sustainable level and mix of staff in our public units and other measures, has the potential to deliver up to a further €3m leaving a residual financial challenge of €1.2m which we will seek to mitigate.

Separately, the NHSS budget for 2018 has been set at €961.7m, in accordance with the LoD received by the HSE. This represents an increase of €21.7m from Budget 2017. The DoH has advised the HSE to operate on the overriding assumption that the waiting time is to be limited to no more than four weeks. In the event that actual expenditure, driven by maintaining this four week limit, emerges in 2018 at a level higher than the notified budget level, the DoH and HSE will engage to seek solutions which do not adversely impact services.

Further context is provided within the Older Persons' Services section of the plan. Through the Value Improvement Programme, we will target improvement opportunities to address the older persons' services financial challenge while maintaining levels of activity. See Section 7 for details.

Health and wellbeing

The budget allocation for health and wellbeing in 2018 has two distinct financial risks relating to the National Screening Service performance and related activity targets, in addition to anticipated costs within the Environmental Health Service arising as a result of the full recovery cost model of Irish Water in 2018. These risks have been the subject of discussion with the DoH and will also be subject to on-going engagement with other relevant departments and state bodies. Should any risks manifest themselves in relation to the funding of the National Screening Services, these will fall to be met from within the overall allocation.

Pensions and demand-led areas

Primary Care Reimbursement Service

The PCRS continues to face significant financial challenges and increased demand for services. The budget has been set at the minimum level prescribed by the LoD received.

In summary, the various schemes, including the medical card scheme, are operated by the HSE (PCRS) on the basis of legislation as well as policy and direction provided by the DoH.

Eligibility under these schemes is administered by PCRS. Its key task in this regard is to ensure that those who have eligibility can have their eligibility confirmed and access their entitlements under the schemes in as efficient and as responsive a way as practical. PCRS also has a role in ensuring appropriate application of the various scheme rules. This includes ensuring probity in claims processing and payments to primary care contractors and PCRS will pursue the targets set under this heading.

Thereafter demographic, economic and other variable factors, given the demand-led nature of the schemes, will dictate the actual numbers of eligible persons and the cost of their entitlements to be paid by PCRS in 2018 under each scheme. The PCRS plan for 2018 is based on a number of assumptions around demographics, economic growth and those other factors which have been prescribed by the DoH following an extensive series of engagements.

Pensions

Pensions provided within the HSE and HSE funded agencies (section 38) cannot readily be controlled in terms of financial performance and are difficult to predict. The LoD prescribes the minimum funding level to be allocated to pensions which is the same level as in 2017.There is a strict requirement on the health service, as is the case across the public sector, to ring fence public pension related funding and costs and keep them separate from mainstream service costs. The plan has been prepared on the basis that, as in prior years, pension related funding issues will be dealt with separately from the general resource available for service provision.

Pension costs and income will be monitored carefully and reported on regularly. In the event that actual expenditure emerges in 2018 at a level higher than the notified budget level, the DoH and HSE will engage to seek solutions which do not adversely impact services.

State Claims Agency

This funding relates to the cost of managing and settling claims which arose in previous years which is a statutory function of the SCA. As part of NSP 2018 and in line with the LoD received, an additional €50m

has been assigned to SCA bringing the prescribed minimum budget available in 2018 to €274m. It is noted that the cost growths in this area in recent years are driven primarily by the operation of the legal system and not by factors under the control of the HSE and its services. In the event that actual expenditure emerges in 2018 at a level higher than the notified budget level, the DoH and HSE will engage to seek solutions which do not adversely impact services.

Local demand-led schemes

The budget has been set in accordance with funding levels received. This will allow the HSE to fund a maximum of €251.5m for these services. The costs within these schemes are largely demand-led, including drug costs in relation to HIV and statutory allowances such as Blind Welfare allowance, and are therefore not amenable to normal budgetary control measures.

Programme for Health Service Improvement

The HSE will continue to support the PHSI in 2018 through a continuation of the commitment to make approximately €15m available from within existing resources, subject to any considerations that emerge under the Value Improvement Programme. Programme resources will assist with the establishment of that programme, including building measurement and reporting on productivity and value into all PHSI initiatives.

Capital funding 2018

Separately, a provision of €478m in capital funding will be made available to the HSE in 2018, comprising €418m for building, equipping and furnishing of health facilities, and €60m for ICT.

It is noted that there are significant risks to the revenue budget caused by the pressure related to backlog maintenance and essential equipment replacement.

Section 7: Improving Value and Services

Section 7: Improving Value and Services

Health and social care systems around the world are under increasing pressure due to growing and ageing populations, increases in chronic disease, rising costs of specialist drugs and therapies, and slow funding recovery from the 2008 global financial crisis. Given wider competing pressures on Government funding, there is an onus on the health and social care system to drive efficiencies, productivity and value from its existing funding base, informed by national policy and in line with our *Corporate Plan* Goal 5: managing resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money. Value will be judged in terms of improvement of services and service user experience alongside evidence of economy, efficiency and effectiveness.

While there are a number of opportunities to secure improved value that are within the remit and role of the HSE to deliver, there are others that will require wider consideration of policy, legislation and regulatory issues and therefore will benefit from the involvement and support of the DoH and other stakeholders.

Recognising the necessity to secure improved value, the HSE is taking forward a systematic review of its existing activities to drive value with a view to taking forward, from the beginning of 2018, a comprehensive Value Improvement Programme.

Scope and key themes

The Value Improvement Programme will be a single over-arching programme, but with three broad priority themes:

Priority theme 1: Improving value within existing services

Within this theme, we will identify realistic and achievable opportunities to improve economy, efficiency and effectiveness prioritised within, but not restricted to, the specific service areas that have the greatest financial challenges in 2018 i.e. acute hospitals, disability services, older persons' services and primary care. Our aim will be to secure reductions in the costs and / or improvements in the efficiency of the services we are currently providing to patients in these and other areas. Working with CHOs, Hospital Groups and other stakeholders, we will systematically assess existing service delivery arrangements across providers, informed by appropriate national and international benchmarking, with a view to maximising value. As far as possible the value improvements secured will be recurrent but there will be elements of savings in 2018 that will be once-off in nature.

Priority theme 2: Improving value within non-direct service areas

Within this theme, we will identify realistic and achievable opportunities to reduce the costs of corporate and other overhead-type costs that exist at national and local level across our health and social care services. Working with CHOs, Hospital Groups and other stakeholders we will systematically assess the full range of overhead activities across the organisation to identify opportunities to reduce expenditure, thereby maximising the resources available for direct service user activities. As far as possible, the value improvements secured will be recurrent but there will be elements of savings in 2018 that will be once-off in nature.

Priority theme 3: Strategic value improvement

Within this theme, we will identify the strategic changes that are required to ensure that, from 2018 and thereafter, the resources available to health and social care in Ireland are prioritised and committed to in a way that will ensure the best outcomes for service users. Working with key stakeholders, including the DoH and other relevant external stakeholders, we will seek to identify and take forward the fundamental changes that are required, including how services are delivered to maximise value from the resources made available to health and social care. Our aim will be to identify the key strategic changes required to ensure alignment between funding and the costs of service delivery. The value improvements secured within this theme will include very large initiatives which may, by their nature, require a multi-annual approach.

The Programme, under these themes will seek to improve services while also seeking to mitigate the €346m operational financial challenge for 2018. This should only be delivered via realistic and achievable measures that do not adversely impact services. The main financial challenges across service areas and targeted value improvement are as follows:

Service Area	VIP Priority Theme 1	VIP Priority Theme 2	VIP Priority Theme 3
Acute Hospitals	€46m		
Disability	€15m		
Older Persons	€9m		
Primary Care	€7m		
Other / whole of system (to be identified)		€119m	€150m
Total	€ 77m	€119m	€150m

Work streams

Across the three priority themes that make up the Value Improvement Programme, all realistic and achievable changes to service delivery – both operationally and strategically – will be considered. This will encompass the full continuum of services, to include those directly provided by the HSE, as well as those provided through section 38 and 39 providers and other voluntary and private contractors.

Initial proposed work streams will include:

- Service redesign
- Workforce
- Pharmacy and procurement
- Unscheduled care and integration
- Health Business Services and other corporate expenditure
- Effective care
- Operational and clinical efficiency.

These work streams will be added to over the course of the programme.

Delivering the programme

For each priority theme and the associated projects, appropriate governance arrangements will be established, with national leads appointed from within the HSE Leadership Team, and from CHO Chief Officers and Hospital Group CEOs. In relation to the strategic value improvement theme, the involvement of the DoH and other key stakeholders will be essential. Across the entirety of the Value Improvement Programme, appropriate clinical involvement and leadership will be critical to success.

Within the Office of the Chief Operations Officer, a dedicated Performance Management Unit, as outlined in the Building a Better Health Service section, will be established. This unit will be the prime source of support to the Value Improvement Programme and will be appropriately prioritised and resourced consistent with the significance of this role.

The Value Improvement Programme will be linked to the PHSI to ensure that the transformation is aligned with the changes and improvements being driven through the operational improvement projects. Both programmes will use the PHSI programme management office to support implementation locally.

Performance will be benchmarked with services from other jurisdictions, where appropriate, and across our own services. Where an operational unit demonstrates excellence, appropriate arrangements will be in place to ensure the learning, processes, tools and techniques used to achieve the improvement are scaled and rolled out across the wider system.

Key objectives and outputs

It is expected that the Value Improvement Programme will ensure a rigorous, consistent, national, multi-year approach to:

- The identification of existing areas of cost / expenditure that are of limited benefit to delivering core DoH / HSE objectives, with a view to ending or significantly reducing same.
- The identification of existing areas of activity that are of value but which could be delivered for lower total cost (economy).
- The identification of existing areas of activity that are of value but could deliver higher throughput from existing resources (efficiency).
- The identification of existing areas of activity that are of value but could deliver greater value (e.g. better outcomes for patients) from existing resources (effectiveness).

In practice, there will be opportunities to improve value across each of the domains outlined above. While the scale of annual improvement that can be consistently and reliably delivered over time will be relatively small in percentage terms, this will nonetheless be significant in the context of the overall budget for health and social care.

The projects under this programme will have annual targets and will be measured under a consistent, robust national methodology. Progress in meeting these targets will be reviewed and reported on a quarterly basis.

The benefit of this programme will be that all of the resources available to the HSE, both existing and new, will be used more effectively each year to deliver on population health needs.

Section 8: Workforce

Section 8: Workforce

The Health Services People Strategy 2015-2018

We are committed to putting people at the heart of everything we do, delivering high quality safe healthcare to our service users, communities and wider population. The *Health Services People Strategy 2015-2018* was developed in recognition of the vital role our workforce plays in delivering safer better healthcare. We recognise the vital role of staff at all levels in addressing the many challenges in delivering health services and the strategy, which extends to the entire health sector workforce, is underpinned by the commitment to engage, develop, value and support the workforce. The strategy provides the anchor to support HR developments throughout the system. Key priorities in 2018 include:

- Implementation of strategy:
  - Progress to the next phase of implementation of the strategy, building on progress to date.
  - Build on evidence of what is working well and use this data to inform future developments.
  - Enhance connections and foster collaboration.
- Change management:
  - Deliver the *Health Services Change Model 2nd Edition* and accompanying literature review.
  - Put in place a range of accessible supports to further enhance organisational and change management capacity.
- HR operating model: Work with HR business partners, national HR services and HR shared services in an integrated manner to support people managers across the service delivery areas.
- Collective leadership: Continue to build and enhance leadership development, capacity and capability through the Health Service Leadership Academy.
- Empowerment and engagement: Undertake the third staff survey and further develop and implement staff engagement and staff health and wellbeing programmes in response to what staff are telling us.
- Team working: Prioritise developing a team-working action plan in line with the strategy, in recognition of the importance of teams in the delivery of health and social care interventions.
- Diversity, equality and inclusion (DEI): Ensure a planned, systematic approach to the mainstreaming of DEI in employment in the HSE.
- Performance and outcomes: Introduce performance management systems in areas of the public health sector where these are not already in place.
- Recognising performance and achievement: Continue the annual HSE Achievement Awards to recognise, celebrate, and share endeavours and examples of excellence across the health services.
- Workforce planning: Operationalise the *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning, 2017* across the health services.
- Upgrade and further enhance the capability of HSELanD.
- Support the planning, development and implementation of the National Integrated Staff Records and Payroll Programme.
- Monitor and support the implementation of the Pay and Staffing Strategy 2018.
- Implement and operationalise the Staff Health and Wellbeing Strategy that was launched in 2017.

- Occupational Health and Safety Management: Improve organisational compliance by increasing capacity and capability of health and safety functions, at national level and across the service delivery organisations.

The workforce position

Government policy on public service numbers and costs is focused on ensuring that the health workforce operates within the pay budgets available. It is estimated that the number of whole time equivalent (WTE) posts in place at the end of 2017 will be 110,633 WTEs. Current health service staff numbers, by CHO, Hospital Group, and national service (as of September 2017) are set out in Appendix 2.

Pay and Staffing Strategy 2018 and Funded Workforce Plans

The 2018 Pay and Staffing Strategy is a continuation of the 2017 strategy, central to which is compliance with allocated pay expenditure budgets. Overall pay expenditure, which is made up of direct employment costs, overtime and agency, will continue to be robustly monitored, managed and controlled to ensure compliance with allocated pay budgets as set out in annual funded workforce plans at divisional and service delivery organisation level. These plans are required to:

- Operate strictly within allocated pay frameworks, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed.
- Comply strictly with public sector pay policy and public sector appointments.
- Identify further opportunities for pay savings to allow for reinvestment purposes in the health sector workforce and to address any unfunded pay cost pressures.
- Ensure CHO Chief Officers and Hospital Group CEOs have delegated authority to manage their pay and staffing requirements.

Pay and staff monitoring, management and control, at all levels, will be further enhanced in 2018 in line with the Performance and Accountability Framework. Early intervention and effective plans to address any deviation from the approved funded workforce plans will be central to ensuring full pay budget adherence at the end of 2018.

An integrated approach, with service managers being supported by HR and Finance, will focus on reducing and / or controlling pay costs, including agency and overtime, and implementing cost containment plans, in addition to maximising the performance and productivity of the health workforce.

Public Service Stability Agreement 2018 - 2020

The Public Service Stability Agreement, which represents an extension of the Lansdowne Road Agreement, was negotiated between government and unions in 2017 and will continue until December 2020. It provides for the continuation of the phased approach towards pay restoration, targeted primarily at low-paid personnel, as well as providing a number of general pay adjustments in the course of the Agreement. The Agreement builds on the provisions of previous agreements to support reform and change in the health services. The HSE will support the work of the Public Service Pay Commission as established under the Agreement.

Workforce planning

The DoH published *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning* in 2017, providing an integrated, dynamic and multi-disciplinary approach to workforce planning at all levels of the health service. The HSE will support work to commence the operationalisation of the framework for the health sector in 2018. The implementation will be guided by the relevant work streams of the *Health Services People Strategy 2015-2018*, in conjunction with the PHSI.

Particular attention will be directed to the further development of measures to support the sourcing, recruitment, and retention of nursing and midwifery staff in light of identified shortages.

As part of overall workforce planning, workforce plans for the new Children's Hospital and Paediatric Outpatient and Urgent Care Centre will be progressed.

Strategic Review of Medical Training and Career Structure (MacCraith Report)

The outstanding recommendations of this report will continue to be implemented and, in particular, the issue of friendly flexible working arrangements will, service dependent, be supported. The negotiations on the task transfer initiative will be concluded and implementation of revised work practices prioritised.

Further action will be taken to advance streamlined training, protected training time and measures to support recruitment and retention. Remedial and risk mitigation actions will be taken in respect of consultants that do not hold registration on the 'Specialist Division'.

The HSE will consider findings of the report, when published, concerning public health physicians, arising from recommendation 3.5 as set out in the MacCraith Report.

Enhancing Nursing and Midwifery Services

Strategic leadership and workforce development for nursing and midwifery to meet the health and wellbeing needs of the population is supported by education and training, safe clinical evidence-based practice, a consistent and standardised approach and avoidance of duplication of effort, while supporting legal and regulatory requirements at all levels. Key priorities in 2018 include:

- Develop and test innovative approaches to leadership, professional development and advancing nursing and midwifery professional practice.
- Expand implementation of the Caring Behaviours System for Ireland to additional sites.
- Support and progress initiatives through engagement with the Chief Nursing Officer's Office, DoH, including the roll-out of the Framework for Staffing and Skill Mix for Nursing (phase 1 and 2) and the advanced nurse practitioner and community nursing projects.
- Progress the development of nursing and midwifery performance indicators in line with the DoH framework. This includes implementing the Nursing and Midwifery Quality Care-Metrics system nationally on an incremental basis.
- Provision of:
  - A minimum of 1,500 postgraduate education programmes for nurses and midwives.
  - Education to increase to 1,030 the number of nurses and midwives with authority to prescribe medicines.

  - Education to increase to 340 the number of nurses and midwives with authority to prescribe ionising radiation (x-ray).
- Implement the Nursing and Midwifery Agreement.
  - Provide six national foundation education programmes for nurses in critical care, surgical pre-assessment, acute medicine unscheduled care, frailty, emergency care and anaesthetic recovery room nursing.
  - Commission a national education programme to prepare 130 nurses for advanced practitioner roles.
  - Expand the public health nurse (PHN) sponsorship programme to 150 nurses.
  - Expand the sponsorship for healthcare workers to train as nurses to 30 places, incorporating both academic fees and salaries.
  - Develop a national framework and establish an online resource to support and guide professional development planning for all nurses and midwives.
  - Expand education provision by centres of nursing and midwifery.
  - Establish a nursing postgraduate entry programme.

Health and Social Care Professions

Health and Social Care Professions (HSCP) refers to approximately 25 professions who provide services and interventions in diagnosis, therapy and social care, impacting on the health, wellbeing and quality of life of people. HSCP accounts for approximately 17,000 of the health service workforce and includes therapists, social workers, psychologists, radiographers, medical scientists and dietitians among others. The services in which they work include acute hospital, community and primary care, mental health, older persons', disability and residential services. Key priorities in 2018 include:

- Continue to implement the priority actions outlined in the *HSCP Education and Development Strategy 2016-2019*.
- Strengthen and support evidence-based, integrated HSCP practice, including input to clinical and integrated care programmes.
- Drive quality improvement and efficiencies by extending HSCP scope of practice as appropriate.

European Working Time Directive

The HSE is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for both non-consultant hospital doctors (NCHDs) and staff in the social care sector. Key indicators of performance agreed with the European Commission include a maximum 24 hour shift, maximum average 48 hour week, 30 minute breaks every six hours, 11 hour daily rest / equivalent compensatory rest and 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest.

Code of Conduct for Health and Social Care Providers

The application and adherence to the Code of Conduct remains a key priority for the health services. It continues to be an important driver in the delivery of the patient safety agenda, both in terms of policy and service delivery.

Section 9: Enabling Healthcare Delivery

Technology and Information

A modern health service depends on high quality information and digital technology. *eHealth Strategy for Ireland, 2013* is a business change programme across the health services supported by digital technology and enhanced information. The technology is based on patient and clinical benefit and implemented through measurable cultural change. Implementation of *eHealth Strategy for Ireland, 2013* will allow us to better connect patients and service users and their care teams, and to put data into action to improve outcomes, manage demand and optimise service delivery.

Priorities 2018

Improve our eHealth capacity

- Implement the new operational model.
- Address General Data Protection Regulation requirements as it pertains to digital services.
- Renew and refresh the focus on cyber security to protect essential health service systems and patient data.
- Make individual health identifiers available to four national systems, two patient administration systems, all general practice systems and a pharmacy system, thereby reducing fragmentation of data and patient records, and increasing the integration of patient information.
- Continue to build the foundations for the implementation and integration capability of an electronic health record for Ireland, in line with the recommendations of *Sláintecare* and the forthcoming *Sláintecare* implementation plan.
- Further develop the digital programme for the new Children's Hospital Outpatient and Paediatric Urgent Care Centres.
- Complete a digital infrastructural strategy.
- Procure strategic partners for implementation of the Ireland Health Cloud to enable the migration of legacy systems to the cloud.
- Maintain progress towards making data sources available on the eHealth Ireland Open Data Portal, making it easier to find and access data from across the Irish health sector.
- Complete the implementation of the HSELanD training programme on Good Information Practices to help staff ensure information is kept safe, confidential, available and accurate.
- Enable the digital workplace through the continued implementation of the ONE Programme, which will deliver digital identities to an additional 20,000 staff who currently have no access to digital services such as email or file sharing.
- Develop and deliver a patient reminder technology solution to underpin the aim of reducing waiting lists.
- Deliver capability through an inpatient journey solution to help improve bed management and, therefore, the potential to reduce waiting lists.

Deliver key national solutions

- Deliver phase 1 of the national patient portal including diagnostic results.

- Progress towards a fully-integrated information services capability for health.
- Increase the deployment footprint for major national solutions including:
  - the national laboratory information system
  - the national imaging and diagnostics system
  - electronic document management
  - Waiting List Management Protocol 2017
  - the national MN CNS
  - national medical oncology information systems
  - ePharmacy including ePrescriptions in primary care
  - summary care records
  - the integrated finance and HR ERP system, as recommended by *Sláintecare*
  - support for the eRostering solutions currently being deployed
  - expand the usage and footprint of eReferrals and work with NTPF to ensure implementation of the minimum national dataset for the purposes of implementation of the *National Inpatient, Day Case and Planned Procedure (IDPP) Waiting List Management Protocol.*

Health Business Services

Capital infrastructure

The HSE requires healthcare facilities that create and sustain a physical environment that enhances wellness in patients and clients, empowers staff and allows the delivery of services in an efficient and effective manner. The upkeep and maintenance of current buildings, and planning appropriate new facilities, are key supports to the delivery of services. The five year Capital Plan is reviewed and refreshed each year, taking into account current work underway, changing needs and the budget available.

In 2018, the construction capital allocation is €418m and this will be managed to achieve the best value for the funding available.

Priorities 2018

- Implement the Capital Plan including progression of the:
  - new children's hospital
  - National Rehabilitation Hospital
  - radiation oncology programme
  - National Forensic Mental Health Service
  - National Maternity Hospital
  - primary care centres, and the
  - social care residential programme for older people and people with disabilities.
- Develop a strategic plan for healthcare physical infrastructure.

Further information in relation to the progression of capital projects can be found in Appendix 4 including an update on projects that are:

- Completed in 2016 / 2017 and will be operational in 2018
- Due to be completed and operational in 2018, and
- Due to be completed in 2018 and due to be operational in 2019.

Business services

The maximisation of shared services across the public service remains a key priority for Government and developing a shared service capability that supports the delivery of common business processes and functions is also recognised as an essential part of the wider health reform agenda. Alongside managing the Capital Plan, Health Business Services (HBS) provides a range of national common business services. Maximising a business partnering approach with corporate partners and customers, HBS supports the evolving health structures as they mature.

A number of important strategic enabling projects will be progressed in 2018 to continue the programme of work set out in the *HBS Strategy 2017-2019*.

Priorities 2018

- Progress the implementation of a National Integrated Staff Records and Payroll Programme.
- Work in partnership with national finance and other stakeholders on the National Finance Reform Programme, including implementing stabilisation projects.
- Implement the three-year procurement sourcing plan, roll out the national logistics service and expand point of use.
- Implement the Pensions Improvement Plan and work towards full implementation of the Single Public Service Pension Scheme.
- Implement the central governance structure for HBS HR and implement the HSE Recruitment Strategy.
- Enhance the HBS Customer Business Intelligence products (HR / Payroll Systems and Analytics).
- Implement the HBS Digital Programme (eBusiness) solutions for a number of projects including phase 1 of Customer Relationship Management Technology (recruitment, procurement and payroll helpdesk in the eastern region).

Enablers in Delivering our Services

It is recognised that there are key enablers behind the scenes in any health service which support service delivery. Activities to enable this include using communications to support people to manage their health and use the best health services for them, improving transactional automation and accuracy, increasing control of contracts and driving value for money, focusing on audit to oversee governance and drive change, improving compliance, ensuring financial management and emergency management.

Priorities 2018

- Develop our digital assets and capabilities to deliver better user experiences online, including the multi-channel public information and signposting service *@HSELive*.
- Conduct and complete a comprehensive programme of audits, including tracking the implementation of recommendations.
- Conduct special investigations including fraud related topics as required.
- Increase our compliance through:
  - Ensuring that service arrangements and grant aid agreements are in place with all section 38 and 39 service providers.
  - Completing the 2017 annual compliance statement process for all section 38 and 39 service providers that receive annual funding over €3m.
  - Rolling out the internal inspection / review process, commenced in 2017, to ensure that the HSE Governance Framework is being implemented.
- Increase the capacity for contract management support in relation to provider governance arrangements at community healthcare level.

Finance

- Implement the National Finance Reform Programme, including interim stabilisation of legacy financial systems – Mid West live October 2016, North West November 2017.
- Upgrade national corporate reporting solution – first phase completed August 2017.
- Plan the design and implementation of a single national finance and procurement system (Integrated Financial Management System (IFMS)) – contract signed June 2017 for a software platform (SAP).
- Implement a single national integrated HR and staff records programme which will link to the finance system.
- Continue development of ABF within acute hospital services (patient level costing live in 18 larger hospital sites and Hospital Inpatient Enquiry (HIPE) activity data incorporated into the performance process).
- Further develop capacity and expertise to analyse pay in line with the Pay and Staffing Strategy.
- Progress the implementation of the community costing programme, building on work underway in disability and mental health services.
- Commence implementation of the Pay Foundation Programme, to improve and accurately cost, report, forecast and plan pay across the health service.

Emergency Management

The HSE has a set of emergency management governance arrangements, processes and support functions that enable it to respond alongside other government agencies to major emergencies. The governance arrangements are independent of the type of emergency but are underpinned by specific emergency plans relative to the nature of the emergency, e.g. severe weather plan or mass casualty incident plan.

These plans require constant review, updating and testing. Recent international events such as the severe weather and terrorism attacks highlight the importance of a system-wide response being in place within the

health and social care system, and with other government agencies. In 2018, a number of strategic priorities have been identified to ensure the HSE is as well prepared as possible:

- Facilitate the on-going refinement of major emergency plans and pursue capability development, where necessary, so that HSE preparedness and response can be optimised.
- Implement management commitments under the National Framework for Emergency Management and meet all requirements under relevant legislation.
- Address gaps in our emergency management preparedness in specific geographic areas and in specific services to improve the HSE's ability to respond to mass casualty incidents in the State.

Appendices

Appendix 1: Financial Tables

Table 1: Finance 2017

Division / Service Area	2017 NSP Budget	2017 Movements	2017 Closing Recurring Budget
	€m	€m	€m
Operational Service Areas			
Acute Hospitals	4,367.0	4.8	4,371.8
National Ambulance Service	155.0	(0.1)	154.9
Health and Wellbeing	233.3	1.2	234.6
Primary Care			
Primary Care	808.1	2.7	810.8
Social Inclusion	133.3	1.3	134.6
Palliative Care	76.5	0.0	76.5
Primary Care Total	1,017.8	4.1	1,021.8
Mental Health	853.1	7.2	860.3
Disability Services	1,688.6	(8.2)	1,680.4
Older Persons' Services			
Nursing Homes Support Scheme (NHSS)	940.0	-	940.0
Older Persons' Services	765.4	(2.8)	762.6
Older Persons' Services Total	1,705.4	(2.8)	1,702.6
National Cancer Control Programme	78.4	0.4	78.8
Clinical Strategy and Programmes	63.6	1.6	65.2
Quality Assurance and Verification	4.0	1.6	5.6
Quality Improvement	9.1	(0.8)	8.3
Emergency Management	1.5	-	1.5
National Services	313.8	1.4	315.3
Total Operational Service Areas	10,490.7	10.4	10,501.0
Pensions and Demand-Led Services			
Pensions	565.4	74.0	639.4
Pension Levy	(156.0)	(80.3)	(236.3)
Total Pensions	409.4	(6.3)	403.1
State Claims Agency	224.0	-	224.0
Primary Care Reimbursement Service	2,560.7	(2.5)	2,558.3
Local Demand-Led Schemes	249.6	(1.6)	248.0
Overseas Treatment	14.1	0.0	14.1
Total Pensions and Demand-Led Services	3,457.8	(10.4)	3,447.4
Total Budget	13,948.5	(0.0)	13,948.5

Note 1: Excludes once-off supplementary funding of €195m.

Note 2: This table illustrates the movement in recurring budgetary allocation, in respect of agreed service movements and also the centralisation of pensions funding, from the published NSP 2017 budget to the final 2017 closing recurring budget. The 2017 closing recurring budget is then referenced in tables 2 and 3.

Table 2: Income and Expenditure 2018 Allocation

Division / Service Area	2017 Budget €m	2018 Budget €m	Increase €m	Increase %	Total Increase Excl Pay Rate Funding €m	Increase Excl Pay Rate Funding %	*Gross Budget €m*	*Income €m*	*Net Budget €m*
Operational Service Areas	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
Acute Hospitals	4,371.8	4,600.5	228.7	5.2%	68.1	1.6%	*5,505.0*	*(904.5)*	*4,600.5*
National Ambulance Service	154.9	165.6	10.6	6.9%	7.3	4.7%	*165.7*	*(0.2)*	*165.6*
Health and Wellbeing	234.6	241.0	6.5	2.8%	3.2	1.4%	*246.9*	*(5.8)*	*241.0*
Primary Care									
Primary Care	810.8	856.8	46.0	5.7%	24.6	3.0%	*874.4*	*(17.6)*	*856.8*
Social Inclusion	134.6	144.5	9.9	7.4%	8.6	6.4%	*144.8*	*(0.3)*	*144.5*
Palliative Care	76.5	78.2	1.7	2.3%	0.4	0.5%	*86.4*	*(8.1)*	*78.2*
Primary Care Total	1,021.8	1,079.5	57.7	5.6%	33.6	3.3%	*1,105.6*	*(26.0)*	*1,079.5*
Mental Health	860.3	917.8	57.5	6.7%	35.0	4.1%	*937.1*	*(19.2)*	*917.8*
Disability Services	1,680.4	1,772.3	91.9	5.5%	62.2	3.7%	*1,821.7*	*(49.4)*	*1,772.3*
Older Persons' Services									
Nursing Homes Support Scheme (NHSS)	940.0	961.7	21.7	2.3%	9.7	1.0%	*1,029.9*	*(68.2)*	*961.7*
Older Persons' Services	762.6	811.3	48.7	6.4%	40.6	5.3%	*1,125.6*	*(314.3)*	*811.3*
Older Persons' Services Total	1,702.6	1,772.9	70.4	4.1%	50.3	3.0%	*2,155.5*	*(382.5)*	*1,772.9*
National Cancer Control Programme	78.8	85.3	6.5	8.3%	6.5	8.2%	*85.6*	*(0.2)*	*85.3*
Clinical Strategy and Programmes	65.2	73.5	8.4	12.8%	-	0.0%	*74.0*	*(0.5)*	*73.5*
Quality Assurance and Verification	5.6	5.7	0.1	2.3%	-	0.0%	*5.7*	*-*	*5.7*
Quality Improvement	8.3	8.3	0.0	0.5%	0.0	0.0%	*8.3*	*(0.0)*	*8.3*
Emergency Management	1.5	1.5	0.0	3.1%	-	0.0%	*1.7*	*(0.2)*	*1.5*
National Services	315.3	321.9	6.6	2.1%	1.3	0.4%	*325.4*	*(3.6)*	*321.9*
Total Operational Service Areas	10,501.0	11,046.0	545.0	5.2%	267.5	2.5%	*12,438.1*	*(1,392.1)*	*11,046.0*

Division / Service Area	2017 Budget €m	2018 Budget €m	Increase €m	Increase %	Total Increase Excl Pay Rate Funding €m	Increase Excl Pay Rate Funding %	*Gross Budget €m*	*Income €m*	*Net Budget €m*
Pensions and Demand-Led Services	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
Pensions	639.4	639.4	0.0	0.0%	0.0	0.0%	*868.3*	*(229.0)*	*639.4*
Pension Levy	(236.3)	(236.3)	-	0.0%	-	0.0%	*(0.1)*	*(236.2)*	*(236.3)*
Total Pensions	403.1	403.1	0.0	0.0%	0.0	0.0%	*868.2*	*(465.1)*	*403.1*
State Claims Agency	224.0	274.0	50.0	22.3%	50.0	22.3%	*274.0*	*-*	*274.0*
Primary Care Reimbursement Service	2,558.3	2,567.8	9.6	0.4%	9.0	0.4%	*2,681.3*	*(113.4)*	*2,567.8*
Local Demand-Led Schemes	248.0	251.5	3.5	1.4%	3.5	1.4%	*251.5*	*(0.0)*	*251.5*
Overseas Treatment	14.1	14.1	0.0	0.0%	0.0	0.0%	*14.1*	*-*	*14.1*
Total Pensions and Demand-Led Services	3,447.4	3,510.6	63.1	1.8%	62.5	1.8%	*4,089.1*	*(578.6)*	*3,510.6*
Total Budget	13,948.5	14,556.5	608.1	4.4%	330.0	2.4%	*16,527.3*	*(1,970.7)*	*14,556.5*

Note 1: €14,410m is the amount notified to the HSE by the DoH of the net non-capital determination for 2018. The letter also notifies a further €143.5m which will initially be held by the DoH pending agreement of the relevant implementation details and €2.450m of dormant accounts funding, bringing the total held funding by the DoH to €145.9m. The total funding available in 2018 is €14,556m.

Note 2: The gross and income split of the 2018 budget is illustrative and should not be considered as final. This relative weighting between gross and income will change once the detailed operational planning process has been completed. In finalising the income budget for the acute division in 2018, other than to account for any specific minor adjustments, the budget will be set at the planned level of 2017 less €44m.

Table 3: Finance Allocation 2018

Division / Service Area	2017 Budget €m	Full Year Impact of 2017 New Develop-ments €m	Demo-graphics and Inflation €m	Other ELS Funding €m	2018 Total ELS Funding €m	2018 Pay Rate Funding (supports existing staffing levels) €m	2018 New Develop-ments €m	2018 NSP Budget €m	2018 NSP Budget held at DoH €m	2018 Opening Budget €m	2018 Once off Funding to be applied €m	2018 Available Funding €m
Operational Service Areas	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L
Acute Hospitals	4,371.8	9.0	18.8	-	27.9	160.6	40.2	4,600.5	40.2	4,560.3	95.9	4,656.2
National Ambulance Service	154.9	3.0	1.5	-	4.5	3.4	2.8	165.6	2.8	162.8	-	162.8
Health and Wellbeing	234.6	4.1	1.8	(3.0)	2.9	3.3	0.3	241.0	0.3	240.7	(18.2)	222.5
Primary Care												
Primary Care	810.8	-	4.6	(5.0)	(0.4)	21.4	25.0	856.8	25.0	831.8	-	831.8
Social Inclusion	134.6	1.5	0.6	-	2.1	1.3	6.5	144.5	6.5	138.0	-	138.0
Palliative Care	76.5	-	0.4	-	0.4	1.3	-	78.2	-	78.2	-	78.2
Primary Care Total	1,021.8	1.5	5.6	(5.0)	2.1	24.1	31.5	1,079.5	31.5	1,048.0	-	1,048.0
Mental Health	860.3	20.0	-	-	20.0	22.5	15.0	917.8	15.0	902.8	-	902.8
Disability Services	1,680.4	10.0	18.2	9.0	37.2	29.7	25.0	1,772.3	15.0	1,757.3	-	1,757.3
Older Persons' Services												
Nursing Homes Support Scheme (NHSS)	940.0	-	-	9.7	9.7	12.0	-	961.7	-	961.7	-	961.7
Older Persons' Services	762.6	-	8.6	-	8.6	8.0	32.0	811.3	32.0	779.3	-	779.3
Older Persons' Services Total	1,702.6	-	8.6	9.7	18.3	20.0	32.0	1,772.9	32.0	1,740.9	-	1,740.9
National Cancer Control Programme	78.8	-	1.0	-	1.0	0.1	5.5	85.3	5.5	79.9	(72.2)	7.7
Clinical Strategy and Programmes	65.2	-	-	-	-	8.4	-	73.5	-	73.5	(11.0)	62.5
Quality Assurance and Verification	5.6	-	-	-	-	0.1	-	5.7	-	5.7	-	5.7
Quality Improvement	8.3	-	-	-	-	0.0	-	8.3	-	8.3	-	8.3
Emergency Management	1.5	-	-	-	-	0.0	-	1.5	-	1.5	-	1.5
National Services	315.3	-	-	-	-	5.3	1.3	321.9	3.7	318.2	-	318.2
Total Operational Service Areas	10,501.0	47.6	55.6	10.7	113.9	277.5	153.5	11,046.0	145.9	10,900.1	(5.5)	10,894.6

Division / Service Area	2017 Budget €m	Full Year Impact of 2017 New Develop-ments €m	Demo-graphics and Inflation €m	Other ELS Funding €m	2018 Total ELS Funding €m	2018 Pay Rate Funding (supports existing staffing levels) €m	2018 New Develop-ments €m	2018 NSP Budget €m	2018 NSP Budget held at DoH €m	2018 Opening Budget €m	2018 Once off Funding to be applied €m	2018 Available Funding €m
Pensions and Demand-Led Services	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L
Pensions	639.4	-	-	-	-	0.0	-	639.4	-	639.4	-	639.4
Pension Levy	(236.3)	-	-	-	-	-	-	(236.3)	-	(236.3)	-	(236.3)
Total Pensions	403.1	-	-	-	-	0.0	-	403.1	-	403.1	-	403.1
State Claims Agency	224.0	-	-	50.0	50.0	-	-	274.0	-	274.0	-	274.0
Primary Care Reimbursement Service	2,558.3	-	-	(33.6)	(33.6)	0.6	42.6	2,567.8	-	2,567.8	5.5	2,573.3
Local Demand-Led Schemes	248.0	-	3.5	-	3.5	-	-	251.5	-	251.5	-	251.5
Overseas Treatment	14.1	-	-	-	-	0.0	-	14.1	-	14.1	-	14.1
Total Pensions and Demand-Led Services	3,447.4	-	3.5	16.4	19.9	0.6	42.6	3,510.6	-	3,510.6	5.5	3,516.1
Total Budget	13,948.5	47.6	59.2	27.1	133.9	278.1	196.1	14,556.5	145.9	14,410.6	-	14,410.6

Note 1: A number of HSE divisions, including National Cancer Control Programme, Health and Wellbeing (screening services) and Clinical Strategy and Programmes, utilise their budgets to 'commission' services internally from the Acute Hospitals Division and other Community Divisions. As part of our detailed operational planning work over the coming weeks, and subject to agreement between the relevant divisions, an element of these budgets may be reflected within the budget profile for both the Acute Hospitals and other National Divisions as part of the overall profiles. These allocations are illustrative and should not be considered as final.

Note 2: €278.1m Pay Rate Funding including funding for the Nursing Agreement.

Note 3: As per the Letter of Determination, €145.9m will be held by the DoH: €143.5m of development funding and €2.450m of dormant accounts funding.

Note 4: The total HSE additional budget of €608.1m consists of the totals of columns E - €133.9m, F - €278.1m and G - €196.1m = €608.1m.

Note 5: The budgets indicated in column L will be subject to the strategic value opportunities initiatives (see Section 7). These initiatives will begin to look at strategic value opportunities including larger scale initiatives and consideration of any expected savings in 2018 will be taken into consideration when setting operational budgets.

Table 4: 2019 Full Year Costs related to NSP 2018

Division / Service Area	Cost in 2018 €m	Cost in 2019 (Note 1) €m	2019 Incremental funding requirement €m
Acute Hospitals			
- Access: Scheduled and unscheduled care	25.3	59.6	34.4
- National Women and Infants' Health Programme	4.6	7.6	3.1
- New children's hospital	7.7	13.7	6.0
- New units / developments, excluding covered in access	1.8	3.9	2.1
- All-island cardiology	0.9	1.8	0.9
Total – Acute Hospitals	40.2	86.7	46.5
National Ambulance Service	2.8	4.4	1.7
Health and Wellbeing	0.3	-	-
Primary Care			
- GP contract (including chronic disease management), GP training, diagnostics, therapies, nursing, ANP and community nursing and integrated care	25.0	32.5	7.5
- Drug strategy / Social inclusion	6.5	6.8	0.2
Total – Primary Care	31.5	39.3	7.7
Mental Health	15.0	35.0	20.0
Disability Services			
- School leavers, therapy and HIQA	15.0	27.5	12.5
- Respite care	10.0	10.0	-
Total – Disability Services	25.0	37.5	12.5
Older Persons' Services			
- Home support in the community	7.0	7.0	-
- Access: Scheduled and unscheduled care (home support)	25.0	30.0	5.0
Total – Older Persons' Services	32.0	37.0	5.0
NCCP	5.5	9.4	3.9
National Services			
- Exceptional measures	1.3	1.3	-
Primary Care Reimbursement Service			
- Drugs	14.0	14.0	-
- Reduction in prescription charges	12.6	13.0	0.4
- Reduction in DPS threshold	5.0	5.5	0.5
- GP visit: Provision of GP visit card to full time carers	11.0	15.0	4.0
Total – Primary Care Reimbursement Service	42.6	47.5	4.9
Total Funding available for existing / developing new services in 2018	196.1	297.9	102.2

Note 1: There are outstanding decisions on what assumptions can be made relating to the extra full year cost in 2019 of each of the developments detailed above. These incremental funding requirements are subject to these assumptions being finalised and are therefore subject to change.

Appendix 2: HR Information

Direct Workforce Numbers by service area and staff category

	Medical / Dental	Nursing	Health and Social Care	Manage-ment / Admin	General Support	Patient and Client Care	WTE Sep 2017	Projected Dec 2017
Total Health Service	10,038	36,170	15,632	17,479	9,500	20,519	109,338	110,633
Health and Wellbeing	169	39	671	487	12	53	1,431	1,448
Primary Care	955	2,859	2,507	2,959	447	922	10,649	10,775
Mental Health	812	4,748	1,305	919	792	1,168	9,744	9,859
Disabilities	84	3,771	3,687	1,266	963	7,622	17,394	17,600
Older People	122	3,336	395	638	1,010	4,259	9,761	9,877
Acute Services	7,861	21,268	7,041	8,669	5,948	4,763	55,550	56,208
National Ambulance Service	1	-	-	85	16	1,724	1,826	1,848
Health Business Services	-	8	5	1,129	302	5	1,449	1,466
Corporate	34	140	20	1,327	9	5	1,534	1,552

Direct Workforce Numbers by CHO, Hospital Group, national service and staff category

	Medical / Dental	Nursing	Health and Social Care	Manage-ment / Admin	General Support	Patient and Client Care	WTE Sep 2017	Projected Dec 2017
Total Health Service	10,038	36,170	15,632	17,479	9,500	20,519	109,338	110,633
Health and Wellbeing	169	39	671	487	12	53	1,431	1,448
Community Services	1,973	14,715	7,895	5,782	3,212	13,970	47,548	48,111
CHO 1	174	1,649	482	601	366	1,544	4,818	4,875
CHO 2	202	1,506	728	622	246	1,554	4,857	4,915
CHO 3	141	1,204	650	471	251	1,255	3,972	4,019
CHO 4	293	2,266	963	638	402	2,179	6,741	6,821
CHO 5	162	1,497	651	457	405	1,219	4,392	4,444
CHO 6	186	1,006	839	528	261	888	3,708	3,752
CHO 7	268	1,714	1,062	613	503	2,111	6,271	6,345
CHO 8	243	1,707	977	726	216	1,782	5,652	5,719
CHO 9	279	1,953	1,489	656	546	1,407	6,330	6,405
PCRS	-	-	16	358	3	-	377	381
Other Non-Acute	25	211	37	112	13	32	430	435
Acute Services	7,861	21,268	7,041	8,669	5,948	4,763	55,550	56,208
Dublin Midlands Hospital Group	1,281	3,743	1,594	1,561	896	1,152	10,227	10,348
Ireland East Hospital Group	1,641	4,256	1,325	1,687	1,395	893	11,196	11,329
Children's Hospital Group	437	1,191	498	585	204	139	3,054	3,090
RCSI Hospital Group	1,273	3,287	1,048	1,350	1,012	716	8,687	8,790
Saolta University Health Care Group	1,290	3,376	1,008	1,321	902	739	8,638	8,740
South / South West Hospital Group	1,427	3,918	1,185	1,486	1,230	591	9,836	9,952
UL Hospitals Group	507	1,488	374	616	309	533	3,826	3,871

	Medical / Dental	Nursing	Health and Social Care	Manage-ment / Admin	General Support	Patient and Client Care	WTE Sep 2017	Projected Dec 2017
Other Acute Services	6	9	7	64	-	-	85	86
National Ambulance Service	1	-	-	85	16	1,724	1,826	1,848
Health Business Services	-	8	5	1,129	302	5	1,449	1,466
Corporate	34	140	20	1,327	9	5	1,534	1,552

HSE / Section 38 Agencies Workforce Numbers

	Medical / Dental	Nursing	Health and Social Care	Manage-ment / Admin	General Support	Patient and Client Care	WTE Sep 2017	Projected Dec 2017
Total Health Service	10,038	36,170	15,632	17,479	9,500	20,519	109,338	110,633
HSE	6,454	23,701	8,768	12,237	5,780	12,253	69,194	70,014
Voluntary Hospitals	3,417	9,238	3,538	4,071	2,621	1,777	24,661	24,953
Voluntary Agencies (Non-Acute)	168	3,231	3,326	1,170	1,099	6,489	15,483	15,666
Section 38	3,584	12,469	6,863	5,241	3,720	8,265	40,144	40,619

Source: Health Service Personnel Census. Projected figures for end of 2017 extracted from 2017 Funded Workforce plan profile for year-end

Note: All figures expressed as whole time equivalents and exclude home helps. Rounding may result in minor variances.

Appendix 3: National Scorecard and National Performance Indicator Suite

National Scorecard		
Scorecard Quadrant	Priority Area	Key Performance Indicator
Quality and Safety	Complaints investigated within 30 days	% of complaints investigated within 30 working days of being acknowledged by complaints officer
	Serious Incidents	% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident
	Child Health	% of newborn babies visited by a PHN within 72 hours of discharge from maternity services
		% of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age
		% of children aged 24 months who have received the measles, mumps, rubella (MMR) vaccine
	CAMHs Bed Days Used	% of bed days used in HSE child and adolescent acute inpatient units as a total of bed days used by children in mental health acute inpatient units
	HIQA Inspection Compliance	% compliance with regulations following HIQA inspection of disability residential services
	HCAI Rates	Rate of new cases of hospital acquired Staph. Aureus bloodstream infection (<1 per 10,000 bed days used)
		Rate of new cases of hospital acquired C. difficile infection (<2 per 10,000 bed days used)
		No. of new cases of CPE
	Urgent Colonoscopy within four weeks	No. of people waiting > four weeks for access to an urgent colonoscopy
	Surgery	% of emergency hip fracture surgery carried out within 48 hours
	Healthy Ireland	% of smokers on cessation programmes who were quit at one month
Access and Integration	Therapy Waiting Lists	Speech and Language: % on waiting list for assessment ≤52 weeks
		Physiotherapy: % on waiting list for assessment ≤52 weeks
		Occupational Therapy: % on waiting list for assessment ≤52 weeks
	CAMHs Access to First Appointment	% of accepted referrals / re-referrals seen within 12 months by Child and Adolescent Community Mental Health Teams excluding DNAs
	Delayed Discharges	No. of beds subject to delayed discharges
	Disability Act Compliance	% of assessments completed within the timelines as provided for in the regulations

National Scorecard		
Scorecard Quadrant	Priority Area	Key Performance Indicator
	Ambulance Response Times	% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less
		% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less
	Emergency Department Patient Experience Time	% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration
		% of all attendees at ED who are discharged or admitted within six hours of registration
	Waiting times for procedures	% of adults waiting <15 months for an elective procedure (inpatient)
		% of adults waiting <15 months for an elective procedure (day case)
		% of children waiting <15 months for an elective procedure (inpatient)
		% of children waiting <15 months for an elective procedure (day case)
		% of people waiting <52 weeks for first access to OPD services
	Cancer	Breast cancer: % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of two weeks for urgent referrals
		Lung Cancer: % of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres
		Prostate cancer: % of patients attending prostate rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres
		% 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)
	Older Persons	No. of home support hours provided (excluding provision of hours from Intensive Home Care Packages (IHCPs))
Finance, Governance and Compliance	Financial Management	Net expenditure variance from plan (total expenditure)
		Gross expenditure variance from plan (pay + non-pay)
		% of the monetary value of service arrangements signed
	Governance and Compliance	Procurement - expenditure (non-pay) under management
		% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received
Workforce	EWTD	<48 hour working week
	Attendance Management	% absence rates by staff category
	Funded Workforce Plan	Pay expenditure variance from plan

National Performance Indicator Suite

Note: 2017 and 2018 expected activity and targets are assumed to be judged on a performance that is equal or greater than (≥) unless otherwise stated (i.e. if less than (<) or, less than or equal to symbol (≤) is included in the target).

System-Wide					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Finance Net expenditure variance from plan (total expenditure)	Finance, Governance and Compliance	M	≤0.1%	To be reported in Annual Financial Statements 2017	≤0.1%
Gross expenditure variance from plan (pay + non-pay)			≤0.1%		≤0.1%
Non-pay expenditure variance from plan			≤0.1%		≤0.1%
Capital Capital expenditure versus expenditure profile		Q	100%	100%	100%
Governance and Compliance Procurement - expenditure (non-pay) under management		Q (1 Qtr in arrears)	New NSP PI 2018	New NSP PI 2018	25% increase
Audit % of internal audit recommendations implemented within six months of the report being received		Q	75%	65%	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received			95%	78%	95%
Service Arrangements / Annual Compliance Statement % of number of service arrangements signed		M	100%	100%	100%
% of the monetary value of service arrangements signed			100%	100%	100%
% annual compliance statements signed		Annual	100%	100%	100%
Workforce **Staff Engagement** % of staff who complete staff engagement survey annually	Workforce		New NSP PI 2018	New NSP PI 2018	20%
Attendance Management % absence rates by staff category		M (1 Mth in arrears)	≤3.5%	4.4%	≤3.5%
Pay and Staffing Strategy / Funded Workforce Plan Pay expenditure variance from plan		M	New NSP PI 2018	New NSP PI 2018	≤0.1%
EWTD <24 hour shift (acute – NCHDs)			100%	98%	100%
<24 hour shift (mental health – NCHDs)			100%	92.7%	100%

System-Wide					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
<24 hour shift (disability services – social care workers)	Workforce	M	New NSP PI 2018	New NSP PI 2018	95%
<48 hour working week (acute – NCHDs)			95%	82%	95%
<48 hour working week (mental health – NCHDs)			95%	90.2%	95%
<48 hour working week (disability services – social care workers)			New NSP PI 2018	New NSP PI 2018	90%
Quality and Safety Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	Quality and Safety	Q	75%	74%	75%
Serious Incidents % of serious incidents being notified within 24 hours of occurrence to the senior accountable officer		M	New NSP PI 2018	New NSP PI 2018	99%
% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident			New NSP PI 2018	New NSP PI 2018	90%
Incident Reporting % of reported incidents entered onto NIMS within 30 days of occurrence by CHO / Hospital Group / NAS		Q	90%	48%	90%
Extreme and major incidents as a % of all incidents reported as occurring			<1%	0.8%	<1%
% of claims received by State Claims Agency that were not reported previously as an incident		Annual	40%	38%	<30%

Health and Wellbeing					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
National Screening Service BreastCheck No. of women in the eligible population who have had a complete mammogram	Access and Integration	M	155,000	155,000	170,000
% BreastCheck screening uptake rate		Q (1 Qtr in arrears)	70%	70%	70%
% of women offered hospital admission for treatment within three weeks of diagnosis of breast cancer		Bi-annual (1 Qtr in arrears)	90%	90%	90%
CervicalCheck No. of unique women who have had one or more smear tests in a primary care setting		M	242,000	255,000	255,000

Health and Wellbeing					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
% of eligible women with at least one satisfactory CervicalCheck screening in a five year period	Access and Integration	Q (1 Qtr in arrears)	80%	79.7%	80%
BowelScreen No. of clients who have completed a satisfactory BowelScreen FIT test		M	106,875	118,000	125,000
% of client uptake rate in the BowelScreen programme		Q (1 Qtr in arrears)	45%	41%	45%
Diabetic RetinaScreen No. of Diabetic RetinaScreen clients screened with final grading result		M	87,000	91,000	93,000
% Diabetic RetinaScreen uptake rate		Q (1 Qtr in arrears)	56%	65%	65%
Environmental Health No. of initial tobacco sales to minors test purchase inspections carried out		Q	384	324	384
No. of test purchases carried out under the *Public Health (Sunbeds) Act 2014*		Bi-annual	32	32	32
No. of mystery shopper inspections carried out under the *Public Health (Sunbeds) Act 2014*			32	32	32
No. of establishments receiving a planned inspection under the *Public Health (Sunbeds) Act 2014*		Q	New NSP PI 2018	New NSP PI 2018	225
No. of official food control planned, and planned surveillance, inspections of food businesses.			33,000	32,210	33,000
No. of inspections of e-cigarette and refill container manufacturers, importers, distributors and retailers under *E.U. (Manufacture, Presentation and Sale of Tobacco and Related Products) Regulations 2016*			New NSP PI 2018	New NSP PI 2018	40
Tobacco No. of smokers who received intensive cessation support from a cessation counsellor		M	13,000	13,476	13,000
% of smokers on cessation programmes who were quit at one month	Quality and Safety	Q (1 Qtr in arrears)	45%	50.7%	45%
Chronic Disease Management No. of people who have completed a structured patient education programme for diabetes		M	2,440	2,055	4,500
Immunisations and Vaccines % of children aged 24 months who have received three doses of the 6 in 1 vaccine		Q (1 Qtr in arrears)	95%	94.8%	95%
% of children aged 24 months who have received the measles, mumps, rubella (MMR) vaccine			95%	92.4%	95%
% of first year girls who have received two doses of HPV vaccine		Annual	85%	49.4%	85%

Health and Wellbeing					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
% of healthcare workers who have received seasonal Flu vaccine in the 2017-2018 influenza season (acute hospitals)	Quality and Safety	Annual	40%	33.7%	65%
% of healthcare workers who have received seasonal Flu vaccine in the 2017-2018 influenza season (long term care facilities in the community)			40%	27.1%	65%
% uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card			75%	56%	75%
Public Health No. of infectious disease (ID) outbreaks notified under the national ID reporting schedule		Q	500	573	500
Making Every Contact Count No. of frontline staff to complete the online Making Every Contact Count training in brief intervention	Access and Integration		New NSP PI 2018	New NSP PI 2018	7,523
No. of frontline staff to complete the face to face module of Making Every Contact Count training in brief intervention			New NSP PI 2018	New NSP PI 2018	1,505

Primary Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Primary Care Services					
Community Intervention Teams No. of referrals	Quality and Safety	M	32,861	36,500	38,180
Health Amendment Act: Services to persons with State Acquired Hepatitis C No. of *Health Amendment Act* card holders who were reviewed		Q	586	127	459
Healthcare Associated Infections: Medication Management Consumption of antibiotics in community settings (defined daily doses per 1,000 population)			<21.7	21.5	<21.7
GP Activity No. of contacts with GP Out of Hours Service	Access and Integration	M	1,055,388	1,024,151	1,105,151
Nursing No. of patients seen			898,944	743,605	743,605
% of new patients accepted onto the nursing caseload and seen within 12 weeks			100%	96%	96%
Therapies / Community Healthcare Network Services Total no. of patients seen			1,549,256	1,517,489	1,524,864

Primary Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Physiotherapy No. of patients seen	Access and Integration	M	613,320	581,661	581,661
% of new patients seen for assessment within 12 weeks			81%	80%	80%
% on waiting list for assessment ≤52 weeks			98%	93%	93%
Occupational Therapy No. of patients seen			338,705	334,139	336,836
% of new service users seen for assessment within 12 weeks			72%	68%	68%
% on waiting list for assessment ≤52 weeks			92%	77%	85%
Speech and Language Therapy No. of patients seen			265,182	278,862	279,803
% on waiting list for assessment ≤52 weeks			100%	96%	100%
% on waiting list for treatment ≤52 weeks			100%	94%	100%
Podiatry No. of patients seen			74,952	74,206	74,206
% on waiting list for treatment ≤12 weeks			44%	26%	26%
% on waiting list for treatment ≤52 weeks			88%	77%	77%
Ophthalmology No. of patients seen			97,150	96,404	96,404
% on waiting list for treatment ≤12 weeks			50%	26%	26%
% on waiting list for treatment ≤52 weeks			81%	66%	66%
Audiology No. of patients seen			56,834	52,548	52,548
% on waiting list for treatment ≤12 weeks			50%	41%	41%
% on waiting list for treatment ≤52 weeks			95%	88%	88%
Dietetics No. of patients seen			65,217	63,382	63,382
% on waiting list for treatment ≤12 weeks			48%	37%	37%
% on waiting list for treatment ≤52 weeks			96%	79%	79%
Psychology No. of patients seen			37,896	36,287	40,024
% on waiting list for treatment ≤12 weeks			60%	26%	36%
% on waiting list for treatment ≤52 weeks			100%	71%	81%
Oral Health % of new patients who commenced treatment within three months of scheduled oral health assessment			88%	92%	92%
Orthodontics No. and % of patients seen for assessment within six months		Q	2,632 75%	2,483 46%	2,483 46%

Primary Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Reduce the proportion of patients (grades 4 and 5) on the treatment waiting list waiting longer than four years	Access and Integration	Q	<5%	4%	<1%
Paediatric Homecare Packages No. of packages		M	514	524	584
GP Trainees No. of trainees		Annual	187	170	198
National Virus Reference Laboratory No. of tests		M (1 Mth in arrears)	627,684	855,288	855,288
Child Health % of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age	Quality and Safety		95%	93%	95%
% of newborn babies visited by a PHN within 72 hours of discharge from maternity services		Q	98%	98%	98%
% of babies breastfed (exclusively and not exclusively) at first PHN visit		Q (1 Qtr in arrears)	58%	55%	58%
% of babies breastfed exclusively at first PHN visit			New NSP PI 2018	New NSP PI 2018	48%
% of babies breastfed (exclusively and not exclusively) at three month PHN visit			40%	39%	40%
% of babies breastfed exclusively at three month PHN visit			New NSP PI 2018	New NSP PI 2018	30%
Social Inclusion Services					
Opioid Substitution No. of clients in receipt of opioid substitution treatment (outside prisons)	Access and Integration	M (1 Mth in arrears)	9,700	9,748	10,028
Average waiting time from referral to assessment for opioid substitution treatment			4 days	3 days	3 days
Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced			28 days	16 days	28 days
Needle Exchange No. of unique individuals attending pharmacy needle exchange		Q (1 Qtr in arrears)	1,647	1,628	1,628
Homeless Services No. of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed within two weeks of admission	Quality and Safety	Q	1,272	1,035	1,035
% of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed within two weeks of admission			85%	73%	73%

Primary Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Traveller Health No. of people who received information on type 2 diabetes or participated in related initiatives	Quality and Safety	Q (1 Qtr in arrears)	New NSP PI 2018	New NSP PI 2018	3,735
No. of people who received information on cardiovascular health or participated in related initiatives			New NSP PI 2018	New NSP PI 2018	3,735
Substance Misuse No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	Access and Integration		 100%	4,298 98%	4,946 100%
No. and % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment			100%	326 98%	333 100%
Palliative Care Services					
Inpatient Palliative Care Services No. accessing specialist inpatient beds	Access and Integration	M	3,555	3,379	3,595
Access to specialist inpatient bed within seven days			98%	98%	98%
% of patients triaged within one working day of referral (inpatient unit)	Quality and Safety		90%	95%	95%
% of patients with a multi-disciplinary care plan documented within five working days of initial assessment (inpatient unit)			90%	52%	90%
Community Palliative Care Services No. of patients who received specialist palliative care treatment in their normal place of residence in the month	Access and Integration		3,620	3,349	3,376
Access to specialist palliative care services in the community provided within seven days (normal place of residence)			95%	93%	95%
% of patients triaged within one working day of referral (community)	Quality and Safety		90%	94%	94%
Children's Palliative Care Services No. of children in the care of the Clinical Nurse Co-ordinator for Children with Life Limiting Conditions (children's outreach nurse)	Access and Integration		269	292	280
No. of children in the care of the acute specialist paediatric palliative care team (during the reporting month)			20	97	97
Primary Care Reimbursement Service					
Medical Cards No. of persons covered by medical cards as at 31st December	Access and Integration	M	1,672,654	1,612,020	1,564,230
No. of persons covered by GP visit cards as at 31st December			528,593	484,344	492,293
Total			2,201,247	2,096,364	2,056,523

Primary Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
% of completed medical card / GP visit card applications processed within 15 days	Access and Integration	M	96%	70%	96%
% of medical card / GP visit card applications, assigned for medical officer review, processed within five days	Quality and Safety		91%	85%	91%
% of medical card / GP visit card applications which are accurately processed from a financial perspective by National Medical Card Unit staff			95%	95%	95%
General Medical Services Scheme Total no. of items prescribed	Access and Integration		57,821,617	58,224,900	56,854,793
No. of prescriptions			18,811,508	18,860,700	18,721,471
Long Term Illness Scheme Total no. of items prescribed			8,657,750	8,237,342	8,241,730
No. of claims			2,407,912	2,309,099	2,342,248
Drug Payment Scheme Total no. of items prescribed			8,305,797	7,203,504	7,872,735
No. of claims			2,411,929	2,211,362	2,389,599
Other Schemes No. of high tech drugs scheme claims			660,125	645,579	650,150
No. of dental treatment services scheme treatments			1,256,417	1,236,648	1,261,381
No. of community ophthalmic services scheme treatments			857,617	852,834	869,891

Mental Health Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
General Adult Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks / three months by General Adult Community Mental Health Team	Access and Integration	M	90%	94.2%	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / three months by General Adult Community Mental Health Team			75%	75.3%	75%
% of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month			20%	21.1%	<20%
No. of adult referrals seen by mental health services			39,321	29,107	29,135
No. of admissions to adult acute inpatient units		Q (1 Qtr in arrears)	13,104	12,133	12,692

Mental Health Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Psychiatry of Later Life Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks / three months by Psychiatry of Later Life Community Mental Health Teams	Access and Integration	M	98%	97.8%	98%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / three months by Psychiatry of Later Life Community Mental Health Teams			95%	95.8%	95%
% of new (including re-referred) Psychiatry of Later Life Psychiatry Team cases offered appointment and DNA in the current month			3%	2.1%	<3%
No. of Psychiatry of Later Life referrals seen by mental health services			10,013	8,683	9,045
Child and Adolescent Mental Health Services Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total no. of admissions of children to mental health acute inpatient units			95%	73.7%	95%
% of bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of bed days used by children in mental health acute inpatient units			95%	97.1%	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / three months by Child and Adolescent Community Mental Health Teams			78%	79.1%	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / three months by Child and Adolescent Community Mental Health Teams			72%	71.4%	72%
% of new (including re-referred) child / adolescent referrals offered appointment and DNA in the current month			10%	10.4%	<10%
% of accepted referrals / re-referrals seen within 12 months by Child and Adolescent Community Mental Health Teams excluding DNAs			New NSP PI 2018	New NSP PI 2018	100%
No. of CAMHs referrals received by mental health services			18,496	18,892	18,831
No. of CAMHs referrals seen by mental health services			14,365	11,286	14,365

Disability and Older Persons' Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Safeguarding % of preliminary screenings for adults aged 65 years and over with an outcome of reasonable grounds for concern that are submitted to the safeguarding and protection teams accompanied by an interim safeguarding plan	Quality and Safety	Q (1 Mth in arrears)	100%	88.6%	100%
% of preliminary screenings for adults under 65 years with an outcome of reasonable grounds for concern that are submitted to the safeguarding and protection teams accompanied by an interim safeguarding plan			100%	90.7%	100%

Disability Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Quality % of compliance with regulations following HIQA inspection of disability residential services	Quality and Safety	Q (2 Qtrs in arrears)	80%	78.4%	80%
% of CHO quality and safety committees in place with responsibilities to include governance of the quality and safety of HSE provided Disability Services who have met in this reporting month		M (1 Mth in arrears)	New NSP PI 2018	New NSP PI 2018	100%
% of CHOs who have established a Residents' Council / Family Forum / Service User Panel or equivalent for Disability Services		Q	100%	33.3%	100%
Residential Places No. of residential places for people with a disability	Access and Integration	M	8,371	8,371	8,399[(i)]
New Emergency Places and Supports Provided to People with a Disability No. of new emergency places provided to people with a disability			185	128	130
No. of new home supports for emergency cases			210	75	135
No. of in home respite supports for emergency cases					120
Total no. of new Emergency and Support Places			395	203	385
Transforming Lives – VfM Policy Review Deliver on VfM implementation priorities	Access and Integration	Bi-annual	100%	100%	100%
Congregated Settings Facilitate the movement of people from congregated to community settings		Q	223	161	170

Disability Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Day Services including School Leavers No. of people with a disability in receipt of work / work-like activity services (ID / autism and physical and sensory disability)	Access and Integration	Bi-annual	3,253	2,752	2,752
No. of people (all disabilities) in receipt of rehabilitation training (RT)		M	2,870	2,368	2,432
No. of people with a disability in receipt of other day services (excl. RT and work / work-like activities) (adult) (ID / autism and physical and sensory disability)		Bi-annual	18,672	18,772	19,672
% of school leavers and rehabilitation training (RT) graduates who have been provided with a placement		Annual	100%	100%	100%
Respite Services No. of day only respite sessions accessed by people with a disability		Q (1 Mth in arrears)	41,100	42,552	42,552
No. of overnights (with or without day respite) accessed by people with a disability			182,506	161,262	182,506
No. of people with a disability in receipt of respite services (ID / autism and physical and sensory disability)			6,320	5,720	6,320
One additional respite house in each of the nine CHO areas - no. of individuals supported		M	New NSP PI 2018	New NSP PI 2018	251
Three additional respite houses in the greater Dublin Region - no. of individuals supported			New NSP PI 2018	New NSP PI 2018	143
Alternative models of respite provision including Home Sharing, Saturday Club, Extended Day – no. of individuals supported			New NSP PI 2018	New NSP PI 2018	250
Personal Assistance (PA) No. of PA service hours delivered to adults with a physical and / or sensory disability		Q (1 Mth in arrears)	1.4m	1.462m	1.46m
No. of adults with a physical and / or sensory disability in receipt of a PA service			2,357	2,255	2,357
Home Support Service No. of home support hours delivered to persons with a disability			2.75m	2.93m	2.93m
No. of people with a disability in receipt of home support services (ID / autism and physical and sensory disability)			7,447	7,126	7,447
Disability Act Compliance No. of requests for assessments of need received		Q	6,234	6,548	6,548
% of assessments completed within the timelines as provided for in the regulations			100%	26%	100%
Progressing Disability Services for Children and Young People (0-18s) Programme No. of Children's Disability Network Teams established		M	129	56	129

Disability Services

Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
% of Children's Disability Network Teams established	Access and Integration	M	100%	43%	100%
Service Improvement Team Process Deliver on service improvement priorities		Bi-annual	100%	100%	100%
(i) The residential placements take account of an increase of 128 emergency places during 2017 together with a reduction of 100 places in congregated settings due to vacancies in congregated settings not being replaced to improve compliance with HIQA standards					

Older Persons' Services

Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Quality % of compliance with regulations following HIQA inspection of HSE direct-provided Older Persons' Residential Services	Quality and Safety	Q (2 Qtrs in arrears)	New NSP PI 2018	83.2%	80%
% of CHO quality and safety committees, with responsibilities to include governance of the quality and safety of Older Persons' Services who have met in this reporting month		M (1 Mth in arrears)	New NSP PI 2018	New NSP PI 2018	100%
% of CHOs who have established a Residents' Council / Family Forum / Service User Panel or equivalent for Older Persons' Services		Q	100%	77.7%	100%
Home Support No. of home support hours provided (excluding provision of hours from Intensive Home Care Packages (IHCPs))	Access and Integration	M	New NSP PI 2018(ii)	16.340m	17.094m
No. of people in receipt of home support (excluding provision from Intensive Home Care Packages (IHCPs)) – each person counted once only			New NSP PI 2018(ii)	New NSP PI 2018	50,500
Intensive Homecare Packages (IHCPs) Total no. of persons in receipt of an Intensive Home Care Package			190	235	235
No. of home support hours provided from Intensive Home Care Packages			New NSP PI 2018(ii)	New NSP PI 2018	360,000
% of clients in receipt of an IHCP with a key worker assigned			100%	75.9%	100%
Transitional Care No. of people at any given time being supported through transitional care in alternative care settings		M (1 Mth in arrears)	600	879	879
No. of persons in acute hospitals approved for transitional care to move to alternative care settings			7,820	9,160	9,160

Older Persons' Services

Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Nursing Homes Support Scheme (NHSS) No. of persons funded under NHSS in long term residential care during the reporting month	Access and Integration	M	23,292[iii]	23,292	23,334
No. of NHSS beds in public long stay units			5,088	5,016	5,096
No. of short stay beds in public long stay units			1,918	2,053	2,053
% of population over 65 years in NHSS funded beds (based on 2016 Census figures)			4%	4%	≤4%
% of clients with NHSS who are in receipt of ancillary state support			10%	12%	10%
% of clients who have Common Summary Assessment Reports (CSARs) processed within six weeks			90%	88.8%	90%
Service Improvement Team Process Deliver on service improvement priorities		Bi-annual	100%	100%	100%

(ii) The new home support measures with a target delivery of 17.094m hours for 50,500 people is the equivalent of the combination of home help target of 10.57m hours plus home care package recipient target of 20,175. This assumes the numbers receiving the home support measures will be 50,500 people with each person counted once.

(iii) Previous figure of 23,603 amended in agreement with the DoH in October 2017

Acute Hospital Services

Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Discharge Activity Inpatient	Access and Integration	M (1 Mth in arrears)	635,414	634,815	634,815
Day case (includes dialysis)			1,056,792	1,049,851	1,055,851
Total inpatient and day cases			1,692,206	1,684,666	1,690,666
Emergency inpatient discharges	Access and Integration	M (1 Mth in arrears)	424,659	430,995	430,995
Elective inpatient discharges			94,587	92,172	92,172
Maternity inpatient discharges			116,168	111,648	111,648
Inpatient discharges ≥75 years			New NSP PI 2018	119,146	119,146
Day case discharges ≥75 years			New NSP PI 2018	183,625	183,625
Emergency Care New ED attendances		M	1,168,318	1,177,362	1,178,977
Return ED attendances			94,225	97,238	97,371
Injury unit attendances			81,919	91,463	91,588
Other emergency presentations			48,895	48,642	48,709
Births Total no. of births			63,247	61,720	61,720
Outpatients No. of new and return outpatient attendances			3,440,981	3,324,615	3,337,967

Acute Hospital Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Outpatient attendances New: Return Ratio (excluding obstetrics, warfarin and haematology clinics)	Access and Integration	M	1:2	1: 2.5	1:2
Activity Based Funding (MFTP) model HIPE Completeness – Prior month: % of cases entered into HIPE	Quality and Safety	M (1 Mth in arrears)	100%	93%	100%
Inpatient, Day Case and Outpatient Waiting Times % of adults waiting <15 months for an elective procedure (inpatient)	Access and Integration	M	90%	82.7%	90%
% of adults waiting <15 months for an elective procedure (day case)			95%	89.3%	95%
% of children waiting <15 months for an elective procedure (inpatient)			95%	82.5%	90%
% of children waiting <15 months for an elective procedure (day case)			97%	85.3%	90%
% of people waiting <52 weeks for first access to OPD services			85%	74.3%	80%
Colonoscopy / Gastrointestinal Service No. of people waiting > four weeks for access to an urgent colonoscopy	Quality and Safety		0	0	0
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD			70%	51.9%	70%
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within six hours of registration	Access and Integration		75%	66.8%	75%
% of all attendees at ED who are discharged or admitted within nine hours of registration			100%	81.3%	100%
% of ED patients who leave before completion of treatment			<5%	5%	<5%
% of all attendees at ED who are in ED <24 hours			100%	96.9%	100%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration			95%	44.3%	95%
% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration			100%	63%	100%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration			100%	92.5%	100%
Ambulance Turnaround Times % of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	Quality and Safety		95%	92.6%	95%

Acute Hospital Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Length of Stay ALOS for all inpatient discharges excluding LOS over 30 days	Quality and Safety	M (1 Mth in arrears)	4.3	4.7	4.3
Medical Medical patient average length of stay			6.3	6.8	≤6.3
% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration	Access and Integration		75%	63.8%	75%
% of all medical admissions via AMAU	Quality and Safety		45%	33.7%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge			11.1%	11%	≤11.1%
Surgery Surgical patient average length of stay			5.0	5.3	≤5.0
% of elective surgical inpatients who had principal procedure conducted on day of admission	Access and Integration		82%	74.7%	82%
% day case rate for Elective Laparoscopic Cholecystectomy	Quality and Safety		60%	45.7%	60%
% of emergency hip fracture surgery carried out within 48 hours			95%	84.9%	95%
% of surgical re-admissions to the same hospital within 30 days of discharge			<3%	2%	≤3%
Delayed Discharges No. of bed days lost through delayed discharges	Access and Integration	M	<182,500	193,661	182,500
No. of beds subject to delayed discharges			<500	563	500
Healthcare Associated Infections (HCAI) Rate of new cases of hospital acquired Staph. Aureus bloodstream infection	Quality and Safety		<1/10,000 bed days used	0.7	<1/10,000 bed days used
Rate of new cases of hospital acquired C. difficile infection			<2/10,000 bed days used	2.4	<2/10,000 bed days used
No. of new cases of CPE			New NSP PI 2018	New NSP PI 2018	Reporting to commence in 2018
% of acute hospitals implementing the requirements for screening of patients with CPE guidelines		Q	New NSP PI 2018	New NSP PI 2018	100%
% of acute hospitals implementing the national policy on restricted anti-microbial agents			New NSP PI 2018	New NSP PI 2018	100%
Mortality Standardised Mortality Ratio (SMR) for inpatient deaths by hospital and defined clinical condition		Annual	New NSP PI 2018	New NSP PI 2018	-
Quality Rate of slip, trip or fall incidents as reported to NIMS that were classified as major or extreme		M	Reporting to commence in 2017	0.01	-

Acute Hospital Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Medication Safety Rate of medication incidents as reported to NIMS that were classified as major or extreme	Quality and Safety	M	Reporting to commence in 2017	0.01	-
Patient Experience % of Hospital Groups conducting annual patient experience surveys amongst representative samples of their patient population		Annual	100%	To be reported in January 2018	100%
National Early Warning Score (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals		Q	100%	98%	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning System)			New NSP PI 2018	New NSP PI 2018	100%
Clinical Guidelines % of acute hospitals with an implementation plan for the guideline for clinical handover			100%	Data not available	100%
National Standards % of hospitals who have completed second assessment against the NSSBH			100%	26.5%	100%
% of acute hospitals which have completed and published monthly hospital patient safety indicator report		M	New NSP PI 2018	New NSP PI 2018	100%
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Access and Integration	Q (2 Qtrs in arrears)	New NSP PI 2018	New NSP PI 2018	90%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis			9%	11.9%	12%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit			90%	65%	90%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI		Q	90%	Not reported in 2017	90%
% of reperfused STEMI patients (or LBBB) who get timely PPCI			80%	Not reported in 2017	80%
National Women and Infants Health Programme Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with full implementation of IMEWS	Quality and Safety		100%	100%	100%
% of hospitals with implementation of IMEWS			100%	94.3%	100%
Clinical Guidelines % of maternity units / hospitals with an implementation plan for the guideline for clinical handover in maternity services			100%	Data not available	100%

Acute Hospital Services

Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
% maternity hospitals / units which have completed and published Maternity Patient Safety Statement and discussed same at hospital management team / Hospital Group / NWIHP meetings each month	Quality and Safety	M (2 Mths in arrears)	100%	100%	100%

Cancer Services

Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Symptomatic Breast Cancer Services Urgent No. of patients triaged as urgent presenting to symptomatic breast clinics	Access and Integration	M	18,000	19,000	19,600
No. of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of two weeks for urgent referrals			New NSP PI 2018	14,060	18,620
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of two weeks for urgent referrals			95%	74%	95%
Symptomatic Breast Cancer Services Non-urgent No. of non-urgent attendances presenting to symptomatic breast clinics			New NSP PI 2018	22,500	22,500
No. of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (No. offered an appointment that falls within 12 weeks)			New NSP PI 2018	16,200	21,375
% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)			95%	72%	95%
Clinical Detection Rate No. of new attendances to clinic, triaged as urgent, which have a subsequent primary diagnosis of breast cancer			New NSP PI 2018	1,960	1,176
% of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer	Quality and Safety	M	6%	10%	6%
Lung Cancers No. of patients attending the rapid access lung clinic in designated cancer centres	Access and Integration		3,300	3,600	3,700

Cancer Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
No. of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	Access and Integration	M	New NSP PI 2018	2,880	3,515
% of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres			95%	80%	95%
Clinical Detection Rate No. of new attendances to clinic that have a subsequent primary diagnosis of lung cancer	Quality and Safety		New NSP PI 2018	1,160	925
% of new attendances to clinic that have a subsequent primary diagnosis of lung cancer			25%	32%	25%
Prostate Cancer No. of patients attending the rapid access clinic in cancer centres	Access and Integration		2,600	3,000	3,100
No. of patients attending prostate rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres			New NSP PI 2018	1,800	2,790
% of patients attending prostate rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres			90%	60%	90%
Clinical Detection Rate No. of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer	Quality and Safety		New NSP PI 2018	1,100	930
% of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer			30%	37%	30%
Radiotherapy No. of patients who completed radical radiotherapy treatment (palliative care patients not included)	Access and Integration		New NSP PI 2018	5,200	5,200
No. of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)			New NSP PI 2018	3,900	4,680
% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)			90%	75%	90%

Pre-Hospital Emergency Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Total no. of AS1 and AS2 (emergency ambulance) calls	Access and Integration	M	315,000	312,127	318,370
Total no. of AS3 calls (inter-hospital transfers)			30,503	30,156	31,100
No. of clinical status 1 ECHO calls activated			5,589	5,674	5,787
No. of clinical status 1 ECHO calls arrived at scene (excludes those stood down en route)			5,290	5,386	5,494
No. of clinical status 1 DELTA calls activated			125,985	126,506	129,036
No. of clinical status 1 DELTA calls arrived at scene (excludes those stood down en route)			122,159	122,650	125,103
Aeromedical Service - Hours (Department of Defence)			480	480	480
Irish Coast Guard - Calls (Department of Transport, Tourism and Sport)			144	316	200
Clinical Outcome Return of spontaneous circulation (ROSC) at hospital in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using Utstein comparator group calculation	Quality and Safety	Q (1 Qtr in arrears)	40%	40%	40%
Audit National Emergency Operations Centre (NEOC) Tallaght and Ballyshannon - % of control centres that carry out Advanced Quality Assurance Audits (AQuA)		M	100%	100%	100%
National Emergency Operations Centre (NEOC) Tallaght and Ballyshannon - % medical priority dispatch system (MPDS) protocol compliance			90%	93%	90%
Emergency Response Times % of clinical status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	Access and Integration		80%	80%	80%
% of ECHO calls which had a resource allocated within 90 seconds of call start			85%	98%	95%
% of clinical status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less			80%	65%	80%
% of DELTA calls which have a resource allocated within 90 seconds of call start			85%	92%	90%
Intermediate Care Service No. of intermediate care vehicle (ICV) transfer calls			26,846	26,578	28,000
% of all transfers provided through the intermediate care service			80%	89%	90%

Pre-Hospital Emergency Care Services					
Indicator	Performance Area	Reporting Period	NSP 2017 Expected Activity / Target	Projected Outturn 2017	Expected Activity / Target 2018
Ambulance Turnaround % of ambulance turnaround delays escalated where ambulance crews were not cleared nationally (from ambulance arrival time through clinical handover in ED or specialist unit to when the ambulance crew declares readiness of the ambulance to accept another call) in line with the process / flow path in the ambulance turnaround framework within: • 30 minutes • 60 minutes	Access and Integration	M	100%	100%	100%

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that: 1) were completed in 2016 / 2017 and will be operational in 2018; 2) are due to be completed and operational in 2018; or 3) are due to be completed in 2018 and will be operational in 2019

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
Primary Care Services									
CHO 1: Donegal, Sligo, Leitrim, Cavan, Monaghan									
Killybegs CNU, Co. Donegal Carndonagh CNU, Co. Donegal, Dungloe CNU, Co. Donegal, Donegal CNU	Purchase of radiology and diagnostic equipment for the primary care service in Donegal including installation	Q1 2018	Q2 2018	0	0	0.60	1.60	0	0
CHO 2: Galway, Roscommon, Mayo									
Westport, Co. Mayo	Primary Care Centre by PPP	Q1 2018	Q1 2018	0	0	0.00	0.00	0	0
CHO 4: Cork, Kerry									
Knocknaheeny, Fairhill, Gurranebraher, Cork City	Primary Care Centre	Q1 2018	Q1 2018	0	0	3.00	18.35	0	0
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
Wexford	Primary Care Centre by PPP	Q2 2018	Q2 2018	0	0	0.00	0.00	0	0
Carrick on Suir, Co. Tipperary	Primary Care Centre by PPP	Q1 2018	Q1 2018	0	0	0.00	0.00	0	0
Dungarvan, Co. Waterford	Primary Care Centre by PPP	Q1 2018	Q1 2018	0	0	0.00	0.00	0	0
Waterford City East	Primary Care Centre by PPP	Q2 2018	Q2 2018	0	0	0.00	0.00	0	0
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Simms Building, Tallaght, Dublin	Purchase and fit-out of the building to provide accommodation for orthodontic services (currently in St. James's Hospital)	Q4 2017	Q1 2018	0	0	0.10	6.50	0	0
Churchtown / Nutgrove, Dublin	Extension to Primary Care Centre, by lease agreement	Q3 2018	Q4 2018	0	0	0.10	0.10	0	0
Royal Hospital, Donnybrook, Dublin	Primary Care Centre, by lease agreement	Q3 2018	Q3 2018	0	0	0.10	0.10	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
CHO 7: Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West									
Kilnamanagh / Tymon (Junction House), Dublin	Primary Care Centre, by lease agreement	Q2 2018	Q3 2018	0	0	0.45	0.45	0	0
Cashel Road / Walkinstown (Crumlin), Dublin	Primary Care Centre, by lease agreement	Q2 2018	Q2 2018	0	0	0.30	0.30	0	0
Kilcock, Co. Kildare	Primary Care Centre by PPP	Q1 2018	Q2 2018	0	0	0.00	0.00	0	0
Our Lady's Hospice, Harold's Cross, Dublin	Equipping of new hospice.	Q1 2018	Q1 2018	0	0	0.20	1.20	0	0
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
Drogheda North, Co. Louth	Primary Care Centre, by lease agreement	Q2 2018	Q2 2018	0	0	0.30	0.30	0	0
Tullamore, Co. Offaly	Primary Care Centre, by lease agreement	Q2 2018	Q3 2018	0	0	0.30	0.30	0	0
St. Fintan's Campus, Portlaoise, Co. Laois	Community addiction services unit - new facility for counselling and support services	Q4 2018	Q1 2019	0	0	2.40	2.95	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Coolock (Coolock South combined with Coolock North Darndale), Dublin	Primary Care Centre by PPP	Q1 2018	Q1 2018	0	0	0.00	0.00	0	0
Dublin North East Inner City (Summerhill), Dublin	Primary Care Centre by PPP	Q2 2018	Q2 2018	0	0	0.00	0.00	0	0
Mental Health Services									
CHO 1: Donegal, Sligo, Leitrim, Cavan, Monaghan									
St. Conal's Hospital, Letterkenny, Co. Donegal	Phased upgrade of building fabric	Q2 2018	Q2 2018	0	0	0.40	1.72	0	0
CHO 3: Clare, Limerick, North Tipperary									
St. Joseph's Hospital, Ennis, Co. Clare	Refurbishment of Gort Glas (at front of St. Joseph's) to provide a Mental Health Day Centre	Q4 2017	Q1 2018	0	0	0.14	1.50	0	0
CHO 4: Cork, Kerry									
University Hospital Kerry	Refurbishment and upgrade of the acute mental health unit, phase 2.	Q4 2018	Q4 2018	0	0	1.40	2.10	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
University Hospital Waterford	Further upgrade acute mental health unit to comply with recommendations of the Mental Health Commission Report	Q4 2017	Q1 2018	0	0	0.05	0.60	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Stanhope Terrace, Dublin North Central	Refurbishment of Stanhope Terrace to provide accommodation for 13 people currently in Weir Home	Q4 2018	Q1 2019	0	0	2.50	2.20	0	0
Disability Services									
CHO 1: Donegal, Sligo, Leitrim, Cavan, Monaghan									
Cregg House and Cloonamahon, Co. Sligo	Nine units at varying stages of purchase / new build / refurbishment to meet housing requirements for 28 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	28	0.50	3.50	0	0
CHO 2: Galway, Roscommon, Mayo									
Aras Attracta, Swinford, Co Mayo	11 units at varying stages of purchase / new build / refurbishment to meet housing requirements for 39 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	39	2.00	6.00	0	0
	Fire safety and infrastructural upgrade	Q1 2018	Q1 2018	0	0	0.15	0.40	0	0
Brothers of Charity, Galway	One unit for purchase / new build to meet housing requirements for four people transitioning from a congregated setting	Q3 2018	Q4 2018	0	4	0.70	0.78	0	0
CHO 3: Clare, Limerick, North Tipperary									
Daughters of Charity, Co. Limerick Daughters of Charity, Roscrea, Co. Tipperary Brothers of Charity, Co. Limerick	Seven units at varying stages of purchase / new build / refurbishment to meet housing requirements for 26 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	26	2.00	4.00	0	0
CHO 4: Cork, Kerry									
Cluain Fhionnain, Co. Kerry St. Raphael's, Youghal, Co. Cork COPE Foundation, Ashville, Co. Cork St. John of God, Beaufort Campus, Killarney, Co Kerry Brothers of Charity, Co. Cork	Eight units at varying stages of purchase / new build / refurbishment to meet housing requirements for 24 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	24	1.20	5.00	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
St. Patrick's Centre, Co. Kilkenny	Four units at varying stages of purchase / new build / refurbishment to meet housing requirements for 15 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	15	1.30	2.40	0	0
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Sunbeam, Rosanna, Bray, Co. Wicklow	Two units at varying stages of purchase / new build / refurbishment to meet housing requirements for eight people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	8	0.02	1.30	0	0
Southside Intellectual Disability Service: Hawthorns, Stillorgan, Co. Dublin and Aishling House, Newtown Grove, Maynooth, Co. Kildare	Two units at varying stages of purchase / new build / refurbishment to meet housing requirements for seven people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	7	0.50	1.20	0	0
CHO 7: Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West									
St. John of God, St. Raphael's Centre, Celbridge, Co. Kildare	Five units at varying stages of purchase / new build / refurbishment to meet housing requirements for 17 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	17	0.25	2.50	0	0
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
St. John of God, St. Mary's Campus, Drumcar, Co. Louth Muiriosa, Delvin, Co. Westmeath	Eight units at varying stages of purchase / new build / refurbishment to meet housing requirements for 19 people transitioning from congregated settings	Phased 2018 / 2019	Phased 2018 / 2019	0	19	1.20	3.70	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Daughters of Charity, Rosalie, Portmarnock, Dublin	Two units at varying stages of purchase / new build / refurbishment to meet housing requirements for eight people transitioning from congregated settings	Q4 2017	Q1 2018	0	8	0.06	0.93	0	0
Grangegorman, Dublin	Relocation of Eve Holdings to 1-5 Grangegorman Villas to facilitate development of Grangegorman PCC	Q4 2018	Q1 2019	0	0	1.17	1.97	0	0
Older Persons' Services									
CHO 3: Clare, Limerick, North Tipperary									
St. Camillus, Co. Limerick	Refurbishment of unit 5 to relocate the children and family service from the main building to facilitate the development of a new CNU	Q1 2018	Q1 2018	0	0	0.10	0.50	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
CHO 7: Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West									
Tymon North, Tallaght, Dublin	100 bed CNU to address capacity deficit	Q4 2018	Q1 2019	45	55	17.82	22.68	0	0
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
St. Joseph's CNU, Trim, Co. Meath	HIQA compliance (including 12 bed dementia unit)	Q4 2018	Q4 2018	0	50	2.66	6.67	0	0
St. Loman's, Mullingar, Co. Westmeath	Refurbishment of former Children and Family Unit to facilitate removal of staff from the main building	Q4 2017	Q1 2018	0	0	0.10	0.60	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Sean Cara and Clarehaven, Glasnevin, Dublin	Refurbishment and upgrade (to achieve HIQA compliance)	Q3 2018	Q4 2018	0	25	2.20	3.48	0	0
Acute Hospital Services									
RCSI Hospital Group									
Our Lady of Lourdes Hospital, Drogheda, Co. Louth	Phase 3: Fit-out and equipping of theatres	Q4 2018	Q4 2018	0	0	8.16	10.94	0	0
	Phase 4: Fit-out and equipping of ED expansion at ground floor of ward block - including reconfiguration of existing ED and equipping of surgical ward	Q2 2018	Q2 2018	28	25	3.97	9.09	110	4.0
	Upgrade of hospital-wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q4 2017	Q1 2018	0	0	0.55	1.30	0	0
Connolly Hospital, Dublin	Phased upgrade of the existing radiology department - phase 1 in 2015 (Interventional Suite) includes equipment	Q1 2018	Q2 2018	0	0	1.00	8.32	0	0
	Upgrade of hospital-wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q1 2017	Q1 2018	0	0	0.22	1.02	0	0
Beaumont Hospital, Dublin	Provision of accommodation for the cochlear implant programme - refurbishment of existing St. Martin's ward after decant to renal dialysis unit	Q4 2018	Q4 2018	0	0	0.90	1.61	0	0
Dublin Midlands Hospital Group									
Simms Building, Tallaght, Dublin	Purchase and fit out of the building to provide accommodation for chronic care / day services from Tallaght Hospital	Q4 2017	Q1 2018	0	0	0.10	3.43	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
Midland Regional Hospital, Portlaoise, Co. Laois	New hospital street extension linking ED and AMAU	Q3 2018	Q3 2018	0	0	0.80	1.00	0	0
Ireland East Hospital Group									
St. Vincent's University Hospital, Dublin	The provision of a PET-CT facility. (PET-CT being donated by UCD)	Q4 2017	Q1 2018	0	0	0.00	0.89	0	0
Saolta University Health Care Group									
Sligo University Hospital	Upgrade of boiler plant and boiler room	Q3 2018	Q3 2018	0	0	1.20	2.30	0	0
University Hospital Galway	Medium temp hot water system upgrade / replacement Phase 1	Q1 2018	Q1 2018	0	0	0.20	0.50	0	0
	Provision of a new IT room for the hospital	Q2 2018	Q2 2018	0	0	0.35	0.50	0	0
Letterkenny University Hospital, Co. Donegal	Refurbish / upgrade CSSD	Q4 2017	Q1 2018	0	0	0.05	0.70	0	0
Mayo University Hospital	Replacement of lifts in main concourse.	Q4 2017	Q1 2018	0	0	0.08	0.70	0	0
UL Hospitals Group									
St. John's Hospital, Co. Limerick	Upgrade of hospital-wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q4 2017	Q1 2018	0	0	0.08	0.88	0	0
University Hospital Limerick	Reconfiguration of recently vacated ED to create a medical short stay unit	Q4 2018	Q1 2019	17	0	0.60	1.00	30	1.4
Ennis Hospital, Co. Clare	Phase 1a of the redevelopment of Ennis General Hospital - consists of the fit out of vacated areas in the existing building to accommodate physiotherapy and pharmacy (complete) and the reconfiguration of layouts and the provision of a viewing room.	Q4 2017	Q1 2018	0	0	0.05	1.32	0	0
Nenagh Hospital, Co. Tipperary	Part 2 - Refurbishment of vacated space, support accommodation for 16 single rooms and 4 double rooms (part funded by the Friends of Nenagh Hospital)	Q3 2018	Q4 2018	0	0	0.90	4.79	0	0
South / South West Hospital Group									
Cork University Hospital	Blood Science Project - extension and refurbishment of existing pathology laboratory to facilitate management services tender	Q4 2018	Q1 2019	0	0	1.10	2.20	0	0
	Radiation oncology	Q4 2018	Q4 2019	0	0	20.00	56.00	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
	Provision of a helipad	Q3 2018	Q3 2018	0	0	1.00	1.70	0	0
South Tipperary General Hospital	Upgrade of hospital wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q1 2018	Q1 2018	0	0	0.22	1.02	0	0
Children's Hospital Group									
Our Lady's Children's Hospital (Crumlin), Dublin	Upgrade of services to the existing PICU	Q1 2018	Q1 2018	0	0	0.25	0.50	0	0
Pre-Hospital Emergency Care Services									
Edenderry Ambulance Station, Co. Offaly	New ambulance station	Q1 2018	Q3 2018	0	0	0.41	1.22	0	0.05
Carlow Ambulance Station	New ambulance station	Q1 2018	Q1 2018	0	0	0.10	0.30	0	0
St. Joseph's Hospital, Stranorlar, Co. Donegal	The provision of an ambulance restroom at St. Joseph's Hospital, Stranorlar	Q2 2018	Q2 2018	0	0	0.15	0.30	0	0
Health Business Services									
St. Joseph's Hospital, Co. Limerick	Refurbish existing vacant space for Pension Management	Q3 2018	Q4 2018	0	0	0.38	0.43	0	0
Ballycummin, Raheen, Co. Limerick	Refurbish existing vacant space for Finance	Q1 2018	Q2 2018	0	0	0.20	0.35	0	0

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