National Service Plan **2019**

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

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Foreword from the Director General

While 2018 was a challenging year for the HSE in many ways, we have made some progress in key areas, which is of real benefit to patients and service users.

Inpatient and day case waiting lists have decreased to 72,718 in September 2018 from a high of over 85,000 in July 2017, while several major initiatives such as the five fundamentals programme have been launched to improve unscheduled care.

In our community services, Health Information and Quality Authority (HIQA) has advised the HSE that all 1,149 disability centres are now registered as of 31st October 2018 under the national standards for residential services for children and adults with disabilities. This has been a substantial achievement for the sector. This is a very positive indication regarding our investment in quality improvement through dedicated professional programmes and additional financial resources for providers.

Despite the progress made across our health service in these areas, there is still significant pressure on acute, community and social care services. This service pressure, coupled with the costs of the level of services already in place by the end of 2018, and the current models of care, will again place significant financial pressure on the system in 2019 that will need to be tightly managed.

A key priority for 2019 will be to maintain appropriate capacity in services, mindful of the increasingly complex health needs of a growing, ageing and increasingly diverse population and to focus relentlessly on quality improvement and innovation within a patient-centred culture. This has to be balanced with our responsibility to deliver safe services within the resources available to us and we will prioritise appropriately to ensure that we get the best care and outcomes for the investment made in public health services.

Throughout the year, day to day decisions will need to be made to ensure that we use the totality of our resources to meet the greatest need in the most effective way.

We are preparing also for the introduction of a Board to the HSE in early 2019. This is welcome and necessary for the appropriate governance of the largest organisation in Ireland. I have welcomed the appointment of Mr. Ciarán Devane to the post of Chairman as a significant first step in that regard.

I know from my early discussions with Mr. Devane that a focus on patient safety and quality and culture and values will be early agenda items for the Board. The HSE welcomed the publication of the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* in September and consideration of how the HSE responds to the recommendations on Audit, Risk and Governance and Accountability arising from the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* will be the most important aspects of the early work of the Board.

This year also saw the publication of the *Sláintecare Implementation Strategy*, which has provided a framework within which the HSE will focus on transforming health services over the coming decade. I very

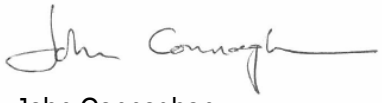
much welcome the appointment of Ms. Laura Magahy, as Executive Director of *Sláintecare*, and of the *Sláintecare* Advisory Council led by Prof. Tom Keane. We have already begun to work together on the planning to meet the challenges of delivering new models of care while meeting the increasing current needs of patients and service users using the existing system.

There are a number of key organisational objectives that the HSE will have a focus on in 2019. These include, for example, the progress on the implementation of the Trauma Strategy (*A Trauma System for Ireland: Report of the Trauma Steering Group*) designation of the major trauma centre and trauma units in Dublin and commencement of the nine learning sites focused on a new network operating model for community healthcare networks that will lead to full scale national implementation.

New services will be progressed in line with new development funding notified. Care closer to home will be improved by further investment in primary care services through general practitioner (GP) services, extension of eligibility, reduction in prescription charges and drug payment scheme limits. We will introduce new services including termination of pregnancy and the extension of the human papillomavirus (HPV) vaccine to boys in line with government policy. Funding will also be made available to reduce waiting times for assessment of need under the *Disability Act 2005*.

As the Introduction and Finance sections of this Plan set out, there are a number of overarching risks to the delivery of the NSP in 2019. The preparation of a plan that is financially balanced and at the same time seeks to respond to the most pressing service quality and safety issues in 2019 has presented a very significant challenge. It has been necessary for us to consider carefully how the entirety of funding made available to the HSE is being used and whether there is scope to reshape or reprioritise activities where this can deliver better outcomes. Dealing with and responding to increased demand for a whole range of services, in addition to delivering programmes of work to improve service efficiency and meet the goals and objectives of key government strategies to improve patient care, were overriding objectives in allocating resources in 2019. Responding adequately within available funding to support the delivery of all key service developments and augmentations is not possible. Instead we have sought, as far as possible, to respond to the most pressing patient and service user needs while also prioritising some small investments in critical transformation and reform programmes of work.

I should not let 2018 pass without reflecting on the immense contribution of staff over the past year, particularly in relation to the continuation of services through the worst of the snow and the storms of last winter. At the time of writing I am also pleased to see that the latest staff survey results show significant increases in motivation, engagement and enthusiasm for the job. Our National Patient Experience Survey also shows that 85% of patients rated their experience on the wards of our hospitals as good or very good. We will wish to build on these results as we move into 2019.



John Connaghan
Director General
Chairman of the Directorate
14th December 2018

Section 1:
Introduction

Introduction

The National Service Plan 2019 (NSP2019) has been prepared in response to the funding allocation and associated requirements and conditions set out in the Department of Health's (DoH) Letter of Determination of 17th October 2018. The Plan sets out the type and volume of health and social care services to be provided by the Health Service Executive (HSE) in 2019 having regard to the funding made available and the level of staff to be deployed.

NSP 2019 reflects a comprehensive review of service activity and has been prepared following extensive engagement with the DoH. The Plan seeks to balance the many priorities across all of our services, including those of the Minister for Health and the Government. It also seeks to plan and respond, as effectively as possible, to the predictable increases in demand for services in 2019.

The overall non-capital allocation to the HSE for 2019 is just over €16 billion; this represents a *maximum* amount of expenditure that may be incurred by the Executive during the forthcoming financial year. The services, levels of activity and performance detailed in NSP2019 are consistent with this level of funding.

For 2019, a key priority is to ensure that the resources which have been made 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. It is more important than ever that we secure value for money, achieving maximum benefit from the available financial, staffing and infrastructure resources.

This Plan provides a view of our population and healthcare need in addition to our reform and transformation priorities. The Plan sets out our overarching priorities and specific actions to be progressed by the HSE during 2019 to deliver improved population health, and health and social care services within a defined financial framework. New services are described in line with the Letter of Determination and government policy, including services which will be delivered as part of the GP contract, termination of pregnancy and the HPV vaccine for boys.

Service Quality and Improvement

The health service has committed itself to continuous learning and as such, we recognise that there are significant opportunities for improvement in some of our services and we are striving to secure these. We know from surveys of patient experience that, while many people are happy with the service they receive, others unfortunately have difficulties in accessing services, or have a poor experience when they do. A priority in 2019 is to continue to build capacity within each service delivery entity, to anticipate and respond to risks and challenges effectively and to strive for a culture that genuinely focuses on continuously improving quality of service for patients and service users, and values innovation. Section 4 outlines the emphasis that is being placed on a range of existing and new quality and safety programmes in 2019.

Findings from the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* and other HSE reports have highlighted areas which need immediate attention. Ensuring real and meaningful involvement and engagement between patients, service users, families, health professionals and organisations across our services will receive a renewed focus in 2019. We are committed to implementing a revised Open Disclosure policy to provide transparency and assurance to those who use our services when things go wrong.

Service Redesign

The way in which we plan our services and how and where we provide them needs to change. We know that the current service delivery model is unsustainable. Given what we know about the growing numbers of people who live in Ireland, their age and health needs, we have been investing at a small scale in different types of services that are more needed into the future and we have been examining the benefits to patients in delivering them.

In line with *Sláintecare,* we are committed in 2019 to exploring and demonstrating how these new models of care can be expanded in a sustainable manner and that will deliver a demonstrable impact in patient care, patient experience and patient outcomes. This will involve a greater focus on planning and increased investment over a number of years, to ensure the foundations for these service changes and improvements are in place, are sustainable, monitored and are effective.

The longer-term vision continues to be on providing improved access to services, the provision of an expanded range of primary care services, appropriately targeted investment in acute services to improve access in times of emergency and for planned procedures.

To deliver this, our principal challenge is to transform the way we deliver services, while in parallel continuing to meet the current needs of patients and service users under the existing system. Dealing with and responding to increased demand across a whole range of health and social care services and delivering programmes of work to improve service efficiency and meet the goals and objectives of key government strategies, is an on-going feature of health service management and delivery. Section 3 on reform and transformation describes 2019 priorities in this regard.

Service Challenges

The funding of €16,050 million (m) made available to the HSE in 2019 represents an increase of €848m (5.6%) over the final budget for 2018. This funding is required to meet the costs of new service developments set out by the DoH (€198m), the higher costs in 2019 of delivering 2018 levels of service activity as a result of centrally agreed pay rate and pension changes as well as other price increases, and the costs in 2019 of additional service activity to meet demographic changes and other service pressures.

In this context, endeavouring to prepare a plan that is financially balanced and, at the same time, seeks to respond to the most pressing service quality and safety issues in 2019 has presented a very significant challenge. It has been necessary for us to consider carefully how the entirety of funding made available to the HSE is being used and whether there is scope to reshape or reprioritise activities where this can deliver better outcomes.

Where there is scope to reduce costs or improve value for money in how and / or where services are delivered, we have reflected this within our planning considerations. Details in this regard are provided in the subsequent sections of the Plan. However, even with cost reductions and improved efficiency, it is not possible to respond fully to the level of health and social care needs expected in 2019. Inevitably, difficult choices have had to be made, in order that we continue as far as possible to respond to the most pressing patient and client needs while operating within the resources available.

NSP2019 has been prepared on the basis of a range of assumptions and with careful consideration of risks to delivery. These are outlined below. Further details are provided in the subsequent sections of the Plan.

- Delivering a volume of activity in 2019, consistent with available funding and reflecting improved efficiency, which fails to respond adequately to need. It is assumed that, as far as possible, levels of service will be maintained at 2018 outturn levels.
- Delivering a volume of activity in 2019 in demand-led service areas (e.g. emergency hospital services, emergency placements for people with a disability) – which are not usually amenable to normal budgetary control measures – which exceeds budgeted levels of activity and available funding.
- Ensuring an adequate response to the additional service pressures which will arise during the winter period in relation to hospital, community and primary care services. In preparing for winter, we have prioritised funding to anticipate and manage critical demand pressures, within the funding envelope available.
- Ensuring that service delivery entities – Community Healthcare Organisations (CHOs), Hospital Groups and the myriad associated delivery organisations – operate within notified financial and staffing budget levels for 2019, and also ensure appropriate balancing of quality and risk issues at local level during a period of potential structural change, with escalation regionally and nationally as appropriate.
- Effectively managing our workforce, including recruitment and retention of a highly skilled and qualified workforce, delivering a reduction in overtime and the use of agency personnel and staying within our pay budget.
- Working within the constraints posed by limitations to clinical, business, financial and HR information systems.
- Progressing at scale and pace the required transformation agenda, in the context of the resources available.
- Responding adequately to urgent safety concerns and emergencies such as Carbapenemase-Producing Enterobacteriaceae (CPE), in the context of the resources available.
- Responding adequately to the impact of the Brexit process, in the context of the resources available.
- Responding adequately to unplanned and unforeseen events (e.g. further storms), in the absence of a contingency fund in 2019.
- Meeting public expectations in terms of access to services, new therapies, drugs and interventions, in the context of the resources available.
- Ensuring that levels of activity and costs in screening services, as a result of laboratory demands and requirements, remain within budgeted levels.
- Responding adequately to recommendations in new and existing reviews and reports, in the context of the resources available.
- Meeting the regulatory requirements in the disability sector, long-stay facilities and mental health and hospital services, within the limits of funding available without impacting on service levels.
- Responding adequately within available funding to support the delivery of key service developments and augmentations, including in relation to: sexual assault treatment units; children's palliative care services; disability services; and older persons' services.
- Complying with the General Data Protection Regulation requirements.

We will keep these and other risks under on-going review to ensure that they are mitigated as far as possible.

Performance and Accountability

A key principle of *Sláintecare* and enhanced operational management and oversight is the need for strengthened governance and accountability, at all levels.

The enactment of the *Health Service Executive (Governance) Bill 2018* will provide for the re-establishment of a HSE Board to strengthen independent oversight and performance of the HSE. The establishment of a HSE Board is an important step in strengthening governance arrangements. Once established, the Board will have a number of immediate priorities including to provide oversight of actions necessary to ensure improved service delivery, corporate and clinical governance, and financial control and accountability within the HSE. The HSE executive will work proactively with the new Chair and the new Board to ensure it can work effectively and respond efficiently and productively to a range of new governance requirements stemming from these new arrangements.

Our Performance and Accountability Framework will be reviewed to reflect new Board governance and accountability arrangements, in line with legislation being developed by the DoH. An enhanced system of performance appraisal is being introduced in 2019 for senior managers at Assistant National Director level or equivalent and above. This will set out business and personal objectives and provide the opportunity to align personal, service and organisational goals in a way that supports the strategic and reform objectives of the organisation.

During 2019, we will work with our new Board, the DoH and relevant stakeholders to progress the development of new health service structures in line with *Sláintecare*. The performance and accountability arrangements for these new organisations will be scoped and agreed, in addition to the respective roles of the DoH, the Board of the HSE and the range of voluntary, statutory, community and private providers. Work will be undertaken to ensure that all structural changes will be focused on and ultimately lead to improved services and outcomes for patients and service users. The intention is that new structures will provide a better balance between central decision-making, and flexibility and responsiveness at local level. This will facilitate more effective planning across the full range of services and at regional level to respond to defined needs of local populations.

Structure

The remainder of this document is structured as follows:

- Section 2: Our Population
- Section 3: Reform and Transformation
- Section 4: Clinical, Quality and Patient Safety
- Section 5: Population Health and Wellbeing
- Section 6: Health and Social Care Delivery including Community Healthcare, Acute Hospital Care and the National Ambulance Service
- Section 7: Finance
- Section 8: Value Improvement Programme
- Section 9: Workforce
- Section 10: Enhancing EU and North South Co-operation and Preparing for Brexit
- Section 11: National Services
- Section 12: Enabling Healthcare Delivery.

Section 2:
Our Population

Our Population

Over 4.8m people live in Ireland (Central Statistics Office (CSO), 2018). An overall increase in the population of 64,500 was experienced from April 2017 to April 2018, the largest annual increase since 2008 (*Population and Migration Estimates April 2018*).

The greatest change in population structure over the last ten years is the growth in both the proportion and the number of people aged 65 years and over, increasing in the intercensal period from 11.6% in 2011 to 13.3% in 2016. It is projected that people aged 65 years and over will increase by 22,935 (3.5%) in 2018 and 21,969 (3.3%) in 2019 (*Population and Labour Force Projections 2017-2051*). Similarly, adults aged 85 years and over will increase by 2,505 (3.6%) in 2018 and by 3,116 (4.3%) in 2019. Notwithstanding this growth in the older population, in 2016 a quarter of our population are children aged 0-17 years.

There were 62,053 births in 2017, 1,844 fewer births compared with 2016. The death rate has remained static from 2016 to 2017 with a rate of 6.4 per 1,000 population. The infant mortality rate in 2017 was 2.8 per 1,000 live births (or 174 infant deaths). The average maternal age for all births registered in 2017 was 32.8 years, with teenage births reducing to 1,041 births in 2017 from 1,098 in 2016 (*Vital Statistics Yearly Summary, 2017*).

These statistics provide a brief profile of the size, growth and distribution of our population – the demographic changes which have implications for future planning and health service delivery.

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 living to, on average, 83.4 years and men 79.6 years. The greatest gains in life expectancy have been achieved in the older age groups reflecting decreasing mortality rates from major diseases (*Health in Ireland – Key Trends 2017,* DoH). People living longer demonstrates that we are managing to prevent and treat diseases more effectively. Mortality rates from circulatory system diseases decreased by 31.5% between 2007 and 2017, and cancer death rates decreased by 11.3% over the same period. Transport accident mortality rates have fallen by 44.5% in the past decade, and suicide rates by 26% in the same period (provisional figures provided by the DoH for *Health in Ireland – Key Trends 2018*).

Chronic Disease

The three most common chronic diseases are cancer, cardiovascular disease and respiratory disease. These diseases give rise to three quarters of deaths in Ireland. It is estimated that over 1.07m people over the age of 18 years currently have one or more chronic diseases (based on analysis of *The Irish Longitudinal Study on Ageing (TILDA), wave1, 2017* and *Quarterly National Household Survey, special module on health, 2010*). However, chronic disease increases with age, the highest prevalence observed in the population aged 50 years and over. The number of people in this age cohort, living with one or more chronic disease, is estimated to increase by 40% from 2016 levels, to 1.09m in 2030 (based on analysis of *TILDA data, 2018*). Multi-morbidity is common in older people with 45.3% of adults aged 65 years and over affected by arthritis, 44.4% by high blood pressure, 11.8% by diabetes and 3.7% by stroke (*TILDA wave 3, 2014-2015*).

Increasing Lifestyle Risk Factors for Poor Health

Many diseases and premature deaths are preventable. Increased morbidity and mortality are strongly related to lifestyle-based health determinants such as smoking, alcohol consumption, exercise and healthy eating.

The prevalence of smoking has declined from 23% in 2015 to 20% in 2018, with 44% of all smokers reporting they have made an attempt to quit in the past 12 months.

Three-quarters of the population reported drinking alcohol in the past year, with over half (55%) of drinkers drinking at least once a week (*Healthy Ireland Survey 2018*). Binge drinking is drinking six or more standard drinks on a typical drinking occasion, 37% of the population report binge drinking.

Almost two thirds (65%) of the population are aware that people should be active for at least 150 minutes each week (*Healthy Ireland Survey 2016*). The initial wave of this survey identified that 32% undertake a sufficient level of physical activity. The average amount of time spent sitting each day is 396 minutes.

Over a third (37%) of the population report that they consume at least five portions of fruit and vegetables daily (including juices) (*Healthy Ireland Survey 2018*). Of the five types of unhealthy foods measured by the survey, in 2018 34% of the population consumed at least one of them on a daily basis; this is down by 1% since the 2017 report. In 2018, 9% drink sugar-sweetened drinks on a daily basis; this is highest amongst those aged 15-24 (15%).

Wider Social Determinants of Health in Ireland

There is a strong link between poverty, socio-economic status and health. In 2016, the consistent poverty rate in Ireland was 8.3%, with 11.1% of children experiencing consistent poverty (*Survey on Income and Living Conditions 2016*).

Our social environment plays a key role in determining health status. In Ireland, certain groups, due largely to their socioeconomic status, are at greater risk of poor health outcomes. '*The social conditions in which people live powerfully influence their chances to be healthy. Indeed factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most diseases, deaths and health inequalities between and within countries*' (World Health Organization, 2004). Since the 1990s, a pattern showing that life expectancy is lower among unskilled workers compared to professional workers has emerged in Ireland (*Socioeconomic differentials in mortality by cause of death in the Republic of Ireland, 1984-2008*; European Journal of Public Health, 2016).

Healthy Ireland, our national policy, promotes a reduction in health inequalities through improved lifestyle and health behaviours. This is an inter-sectoral whole of government approach to ensuring an improvement of the wider determinants of health. The *Healthy Ireland* / HSE policy priority programmes focus particularly on population health issues such as overweight and obesity, child health, mental health, smoking, alcohol and drugs, and positive ageing. *Healthy Ireland* provides people and communities with accurate information on how to improve their health and wellbeing and seeks to empower and motivate them by making the healthy choice the easier choice.

Health Inequalities among Socially Excluded Groups

Socially excluded groups have complex health needs, experience very poor health outcomes across a range of indicators like chronic disease, morbidity, mortality and self-reported health. Socially excluded groups include people who are homeless, people with substance use disorders, Travellers, asylum-seekers, prisoners and survivors of institutional abuse. These populations require a lot of support across a range of healthcare areas. The health inequalities experienced differ in their severity and their complexity, compared to those for the wider population.

People who are homeless

People who are homeless often experience complex and chronic health conditions. Of particular concern are adults who are persistently homeless and rough sleepers. There is a high risk of a combination of physical ill-health with dual diagnosis (co-existing mental ill-health and substance misuse) and consequent high healthcare needs. The average life expectancy for a homeless person is just over 40 years. In August 2018 there were 5,834 adults who were in Ireland – 2,547 were female and 3,287 were male, 60% were aged between 25 and 44 years. The number of children who were homeless was 3,693. Compared with July 2017, these figures have increased by 12.5% for adults (5,187) and 24.2% for children (2,973) nationally. The Dublin region accounts for 68% of all homelessness *(Department of Housing, Planning and Local Government, Homelessness Report, July 2018*).

People with substance use disorders

People with substance use disorders can often have complex health needs. These include mental health problems and the combined effect of drug and alcohol misuse. Of particular concern are the needs of older people availing of treatment for heroin use, which is in excess of 4,000 (of a total of over 10,000 people on opioid substitution treatment) (*Drugnet Ireland, Issue 64, Winter 2018,* Health Research Board). They are vulnerable to a range of health problems, including poor dental health, liver damage, chronic lung and circulation disease, poor mental health, as well as the effects of long-term drug and alcohol use.

Travellers and Roma

Severe health inequalities experienced by Traveller and Roma communities lead to poorer health outcomes, including lower life expectancy and higher infant mortality, compared to the general population. These outcomes are documented in the All Ireland Traveller Health Study. 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 (*National Traveller and Roma Inclusion Strategy 2017-2021*).

Section 3:
Reform and Transformation

Reform and Transformation

Over the last five years, the HSE has had programmes of work focusing on four pillars of healthcare reform. Significant work has been delivered under the health and wellbeing pillar, the financial reform pillar, the service reforms pillar and Hospital Groups and CHOs were established under the 'structural reform' pillar. During this time, the HSE advocated the need for a whole of government, cross-party vision for health and this was made possible by Government and delivered with the publication of the *Sláintecare Report* in May 2017.

Figure 3: Principles set out in the *Sláintecare Report*

Implementation of *Sláintecare*

The *Sláintecare Report* (2017) and *Sláintecare Implementation Strategy* (2018) signal a new direction for the delivery of health and social care services in Ireland. The opportunity that will come with implementation cannot be overestimated, as it has the potential to create a far more sustainable, equitable, cost effective system and one that delivers better value for patients and service users. It creates a more sustainable opportunity to transform the health and wellbeing of the population and how and where they access services.

At its core, the strategy focuses on establishing programmes of work to move to a community-led model, providing local populations with access to a comprehensive range of non-acute services at every stage of their lives. This will enable our healthcare system to provide care closer to home for patients and service users, to be more responsive to needs and deliver better outcomes, with a strong focus on prevention and population health improvement.

The *Sláintecare Implementation Strategy* sets out four over-arching goals, ten high-level strategic actions and eight principles (see Fig 3.). These underpin the first three years of the reform programme, and represent a mix of legislative, policy and service-level actions.

We identified in the last HSE National Service Plan that 2018 provided a powerful opportunity to create strategic certainty for the health service. As noted above, 2018 saw the publication of the *Sláintecare Implementation Strategy* and the appointment of an Executive Director of the *Sláintecare* Programme Office and a Chair of the *Sláintecare* Implementation Advisory Council in September 2018. A detailed action plan is in development, led by the Executive Director of the *Sláintecare* Programme Office that will set out a series of work streams and designated actions, with associated measures to be delivered in 2019.

The HSE is committed to working with the *Sláintecare* Programme Office and all stakeholders to play our part in successfully bridging the gap between the vision for health service transformation in Ireland and delivery of that change at the frontline. Changes will result in more positive experiences and better outcomes for patients, service users and their families.

The context for reform and transformation in the HSE is extremely challenging. As set out in the *Sláintecare Report* and *Sláintecare Implementation Strategy*, services across all areas of our health system are stretched – with demand far outstripping supply. Hospitals are operating at maximum capacity, with occupancy rates across the country well in excess of safe and internationally benchmarked standards of 85% as defined by the DoH's recent capacity review. Waiting lists for surgery and other planned hospital services, and for community services are unacceptably high. Similarly, demands in other social care services for older people and people with disabilities are growing steadily. Changes in the demographic and morbidity profile in our population, in addition to regulatory and care requirements are driving this increase. The system has also under-invested in the necessary data, information and ICT systems that are needed to more effectively manage services, routinely share information and respond to patients' needs. Meeting both current and future challenges with the current service design of the HSE is not sustainable. *Sláintecare* recognises that we are 'facing extraordinary challenges, we need an extraordinary response' (*Sláintecare Implementation Strategy* pg.13).

Given the need to ensure *Sláintecare* becomes fully embedded in everything we do, in addition to simultaneously being mindful of real service challenges and further structural reconfiguration, five high level reform and transformation priorities have been identified by the HSE for 2019. These include:

- Governance, leadership and corporate strategy.
- Transitional funding to shift the balance of care.
- Managing demand and continuing productivity improvement.
- Delivering programmes of work aligned to the National *Sláintecare* Office Action Plan.
- Transformation support and enablement.

Governance, Leadership and Corporate Strategy

The enactment of the *Health Service Executive (Governance) Act 2018* will provide for the re-establishment of a HSE Board to strengthen independent oversight and performance of the HSE. The HSE executive will work proactively with the new Chair and support the new Board to ensure it can effectively lead, provide strategic clarity in the context of widespread service challenges and most importantly, guide the organisation and work with management, staff and all stakeholders in realising *Sláintecare*'s eight principles and associated actions.

In 2019 we will work with the new Board and Chair to publish a three-year Corporate Plan, aligned to *Sláintecare* and focused on providing a clear medium-term roadmap for staff, patients, service users and all stakeholders.

In 2019 we will also work with the new Board and Chair to publish a more detailed multi-annual transition plan to support the implementation of corporate strategy, aligned to *Sláintecare*. This will focus on *Sláintecare* actions and set out in more detail, the range of enablers and programmes of work that will support sustainable and effective delivery of *Sláintecare* actions in the years ahead.

Transitional Funding to Shift the Balance of Care

Sláintecare requires significant and substantial targeted investment to expand healthcare entitlements, address legacy issues and new eHealth architecture, implement system governance changes, and expand primary and community healthcare services. The publication of the Government's *National Development*

Plan 2018-2027 in 2018 is a significant development creating a funding pipeline for capital developments, aligned to *Sláintecare* in the years ahead. The challenge in 2019 is to prioritise actions, using largely existing resources and incremental funding increases, to continue putting the necessary building blocks in place.

Managing Demand and Continuing Productivity Improvement

The health system and budget is constrained by the rate of growth in real national income. Expenditure demand is rising. The DoH has projected that demographic pressures would increase costs by between 1.4% and 1.6% annually. Responding to rising demand and expectations within available funding is an intractable feature of all healthcare systems. At a system level we need to find ever better ways of managing demand and delivering savings and productivity improvements. This goes hand in glove with transformation and reform as set out in *Sláintecare.*

Through productivity and service redesign work streams, we have opportunities to improve the quality of services for patients and create capacity to respond better to rising demand. It is important to note, however, that the work of service improvement and transformation is dependent on the availability of alternative care pathways to hospital admission. Further restraint of access to these will hinder productivity and benefit for patients. In 2019, therefore, we will ensure a clear, evidence-based and population-focused view is available on current capacity, utilisation and realignment with reform, so as to support planning and decision-making to make best use of existing capacity and ensure that expansion of capacity delivers the best outcomes.

Several improvement initiatives will commence and / or continue in line with existing clinical programmes and international best practice in the area of scheduled and unscheduled care.

During 2019, large scale service redesign programmes will be planned and supported including: community services network model, major trauma centres and trauma networks, elective care delivery model, clinical networks for specialists services (including non-consultant led clinics), and urgent and emergency care networks.

We will establish nine learning sites in CHOs to give effect to the network operating model with a focus on demonstrating how it can more effectively respond to the needs of people with chronic disease and with frailty in community settings.

Community Intervention Teams will be reviewed and will be re-focused to facilitate increased volume of complex hospital avoidance and early discharge cases.

Delivering Programmes of Work aligned to the National *Sláintecare* Office Action Plan

In 2019, we will work closely with the *Sláintecare* Programme Office to ensure we put in place the foundations for *Sláintecare* implementation. We have already undergone a process to ensure that the HSE's NSP will align with the *Sláintecare* Action Plan 2019. This NSP describes across its various sections priority actions that will be reflected in the Action Plan.

A Selection of High-Level Priorities for 2019 include:

Citizen Care Masterplan

- We will work with the *Sláintecare* Programme Office to develop a Citizen Care Masterplan.

Health service structures

- We will work with services, the *Sláintecare* Programme Office and relevant stakeholders to progress the design and development of new Regional Integrated Care Organisations (RICOs) in line with *Sláintecare*. Work will be undertaken to ensure that all structural changes are designed to focus on and lead to improved services and outcomes for patients and service users. The new structures will provide a better balance between central decision-making and flexibility and responsiveness at local level. This will facilitate more effective planning across the full range of services and at regional level to respond to defined needs of local populations.

Staff engagement

- We will map all existing staff engagement programmes of work to ensure one coherent and measurable staff engagement work stream is in place to support *Sláintecare* implementation.

Population Profiling

- We will further develop our information systems and workforce to support a standardised and systemised approach to population needs assessment.
- We will put in place an augmented capability to focus more on the use of information to understand population need and ensure investment and reform decisions deliver best outcomes.
- We will augment our Planning for Health work to publish standardised frameworks and related publications to support regional population needs assessment that will drive local and regional service plans and the work of new RICOs.

eHealth

- We will complete the procurement for an electronic health record (EHR) and re-prioritise existing resources to put a team in place to commence implementation, with an acute service solution in the first instance.
- We will put in place a team to programme manage the Individual Health Identifier.
- We will scope and complete business cases for a number of telehealth solutions.
- Complete the business case and commence procurement process for ePrescribing.

Service design

- We will complete reviews of the existing approved models of care for the four chronic diseases (chronic obstructive pulmonary disease (COPD), asthma, diabetes, cardiovascular disease) and a service gap analysis will be conducted.
- We will develop a plan to respond to the prevention and community healthcare needs of COPD patients.

- We will develop an improvement plan for access to radiology diagnostics in collaboration with the National Clinical Programme for Radiology, Hospital Groups, the National Integrated Medical Imaging System (NIMIS) and the NTPF.

Future Capacity Expansion

- With funding assigned to address winter and other service demand pressures, we will focus on opportunities to sustainably expand capacity by augmenting community services.
- We will complete our work to build an evidence-based and robust model for determining regional capacity requirements (flowing from the DoH's *Health Service Capacity Review 2018*) that when allocated will prescribe a shift to care, and treatment, in community settings in addition to clear targets for capacity to be released via efficiencies in length of stay.

Health and Wellbeing

- We will continue to strengthen all programmes to work on delivering on the *Healthy Ireland* Framework across CHOs, Hospital Groups and with external partners.
- We will develop an operating model for Health and Wellbeing in the new RICOs, building on work to date with the CHOs and the strengths of the current model across both CHOs and Hospital Groups.

Clinical Leadership

- We will strengthen clinical leadership in the development of healthcare strategy and in the planning and management of our services at a time of critical service transformation as signalled by the *Sláintecare Report*.
- We will complete a review of the national clinical programmes to ensure optimum alignment with the new HSE structures and commissioning models re-align the work of the programmes with policy direction in Irish healthcare, in particular that set out by *Sláintecare*.

Transformation Support and Enablement

A dedicated *Sláintecare* Programme Office has been established to drive implementation of the reform programme. This approach needs to be mirrored in the HSE to support full implementation.

- *Sláintecare* recognises that to successfully deliver these transformational reforms, a dedicated implementation structure and an effective project management approach will be required.
- The Programme for Health Service Improvement (PHSI) resource and expertise will be re-directed to establish a HSE Strategic Transformation Office under the remit of Strategic Planning and Transformation. This office, working collaboratively with the *Sláintecare* Programme Office, commissioning teams and the wider organisation, will lead, drive and actively support the delivery of the *Sláintecare* reforms in line with the *Sláintecare* Action Plan, when published, and other key work programmes determined as being critical to the overall HSE transformation programme.
- This office will oversee the change management business planning approach across the organisation and will align the existing PHSI framework to the new established priorities.
- In specific terms the Strategic Transformation Office will:

- Work in partnership with the *Sláintecare* Programme Office and through the *Sláintecare* Executive Committee and *Sláintecare* governance structures to ensure that implementation of reform is delivered as planned.
- Drive and actively support the delivery of the *Sláintecare* reforms and other key programmes determined as being critical to the overall HSE transformation programme.
- Oversee the change management business planning approach across the organisation and align the existing PHSI framework to the new established priorities.
- Provide assurance to the new HSE Board on *Sláintecare* implementation progress, highlight issues of concern and take corrective actions as required to ensure that overall outcomes are delivered and that value for money is achieved.
- Direct available resources and expertise towards the delivery of transformational change in accordance with prioritised projects.
- Build strategic change capability, enabling teams to successfully deliver and achieve the benefits of transformation programmes.
- Support and enable local Programme Management Offices to deliver strategic reforms at frontline service level where it will be experienced by our communities, service users, patients and families.

Section 4:
Clinical, Quality and Patient Safety

Clinical, Quality and Patient Safety

Introduction

We will continue to work to support the delivery of sustainable high-quality, effective, accessible and safe health and social care services to meet the needs of our population. The Office of the Chief Clinical Officer (CCO) supports the advancement of key strategic actions of *Sláintecare.* This will be facilitated by the review and re-orientation of national clinical programmes towards the objectives of *Sláintecare* to include development of new models of care. Prioritisation will be given to delivery of integrated care closer to home and reducing dependency on our hospital system. The experience of patients and leadership of clinicians and frontline staff is essential in designing and improving care, responsive to the needs of patients. Further development of patient safety initiatives, in collaboration with the delivery system, to maintain standards and minimise risk is an essential component of a modern healthcare system.

Against the above background, we will progress actions under three priority areas in 2019:

- Strengthening clinical leadership in the development of healthcare strategy and in the planning and management of our services at a time of critical service transformation signalled by the *Sláintecare Report*.
- Improving patient and service user engagement to ensure that the priorities of patients and service users inform service planning which is designed around their needs, enhancing patient safety and improving overall patient experience.
- Advancing a culture of patient safety, continuous quality improvement and learning.

Issues and Opportunities

There are a number of significant issues and opportunities associated with the three priority areas of the Office of the CCO. These include:

- Challenges in delivering safe, high quality, consistent care in the context of finite financial and staffing resources, an increasing population with an older age profile and increasing prevalence of chronic disease.
- Delays in access to care and the large number of delayed discharges in acute hospitals, particularly for patients who have specific requirements for rehabilitation, disability or residential care, result in increasing demands outside the hospital setting.
- Difficulties in recruiting and retaining staff, and ensuring that statutory, legislative and regulatory requirements are met.
- Opportunities, informed by feedback from staff and service users, to build on existing patient safety and quality improvement work and structures to enhance our services.

Responding to these pressures requires integration of health and social care services through further development of the structures already in place for the national clinical and integrated care programmes (ICPs). This provides the opportunity to have a more multi-disciplinary approach to planning and clinical leadership.

We will seek during 2019 to enhance and greater co-ordinate all functions relating to patient experience. This will also allow us to respond to the recommendations of the *Scoping Inquiry into the CervicalCheck*

Screening Programme, 2018 (*Scally Report)*, with a priority focus aligned to areas such as communication and open disclosure, including mandatory reporting under the forthcoming *Patient Safety Bill*. The completion of a review of clinical audit within the HSE aims to ensure that activity and ownership of clinical audit is clear from design to implementation. The establishment of a co-ordinated programme of work for patient safety, working with and through care delivery organisations, is planned in collaboration with the National Patient Safety Office.

We will, as far as possible within available resources in 2019, support a programme of work to address implementation of measures to control antimicrobial resistance (AMR), including Carbapenemase Producing Enterobacteriaceae (CPE), and to improve infection prevention and control and reduce spread of HCAIs in CHOs and Hospital Groups.

Opportunities exist to build on the foundations laid over the last couple of years through the National Incident Management System (NIMS), updated *Incident Management Framework 2018*, the *Framework for Improving Quality in our Health Service* and the *Improvement Knowledge and Skills Guide – Development Assessment Tool for all Staff* to support and enable our staff to continuously improve the quality and safety of service delivery.

Clinical Leadership

We need to plan for a shift in health service delivery and improvement in line with *Sláintecare*, the *Health Service Capacity Review 2018* and the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* recommendations. The Office of the CCO, incorporating clinical programmes, nursing and midwifery, health and social care professions as well as quality and safety, provides the foundations for enhancing clinical leadership and enabling a multi-disciplinary approach to progressing improvements in care. Work to date in relation to clinical programmes and patient safety initiatives provides strong evidence that significant improvements in the delivery of health and social care services can be achieved when compared to previous models and ways of working.

Priorities and Actions

- Complete a review of the national clinical programmes to ensure maximum alignment with the new HSE structures and commissioning models and to align the work of the programmes with policy direction in Irish healthcare, in particular that set out by *Sláintecare*.
- Design and implement a national communications education model which will provide guidance and support to clinicians in communication with patients to include open disclosure.
- Work with commissioning teams, through the national clinical and ICPs, in the planning of services, piloting and evaluating best practice clinical design which promotes end-to-end care from prevention through self-management, primary care and specialist hospital care.
    - ICP for Older Persons will continue to embed new models of integrated care in 13 existing pioneer sites nationally, including the development of redesigned care pathways and ensuring linkages with other strategic changes (dementia, home care, falls, Single Assessment Tool (SAT)). We will work with the Office of the Chief Information Officer in developing ICT support for integrated care and work towards refining and integrating data collection into the national KPI data suite.
    - Design a range of paediatric integrated care pilot projects through the ICP for Children and support the development of integrated care pathways aligned to the paediatric model of care.

  - ICP for the Prevention and Management of Chronic Disease will work with acute and primary care services to support the design, piloting and evaluation of models of care within a service development framework.
  - Design and publish a number of models of care and pathways to deliver more effective and integrated care.
  - Pilot and evaluate clinical designs to demonstrate the significant improvements in the delivery of health and social care services that can be achieved e.g. early supported discharge initiative for stroke patients, trauma assessment clinics for patients with stable fractures, streamlined referrals for back pain through the use of electronic referral guidelines.
- Support and strengthen capacity within health and social care professions (HSCPs) through strategic leadership, engagement and development of a strategic framework to enable their full potential to deliver improved outcomes for service users.
- Strengthen the capacity and capability within nursing and midwifery by developing and delivering targeted programmes to enhance frontline clinical leadership and practice such as providing specialist courses to support clinical nurse / midwife specialists and advanced nurse / midwife practitioners in key specialty areas and sponsoring health service employees to train as nurses.
- Provide executive clinical leadership training for Clinical Directors and multi-disciplinary teams.
- Working in collaboration with acute operations to design and develop a National Genetics and Genomics Network.

Patient and Service User Engagement

Partnering with patients, service users and families to learn from their experience is an essential component in enabling improvements in care and ensuring a quality, effective and safe service that is responsive to the needs of patients and service users. They will need to be central to the design, planning and commissioning of services.

We need to improve our system to achieve a more open and honest communication with patients and service users in relation to their care. Our priority actions will aim to improve partnering with patients, service users and families and will play a key role in supporting the implementation of relevant learning from the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)*, building on the existing work in the area of open disclosure and communication with patients.

Priorities and Actions

- Co-ordinate all elements and workstreams around patient and service user engagement and experience into one cohesive programme.
- Build engagement and co-design with patients, service users, families and communities to make healthcare safer through the insights and experiences of patients and service users themselves.
- Establish a programme to facilitate learning from the National Patient Experience Survey, Your Service Your Say and complaints mechanisms, Your Voice Matters (Patient Narrative Project) and the *Incident Management Framework 2018*.
- Establish a programme to support compliance with legislation and policies relating to open disclosure, mandatory reporting, assisted decision-making, consent and healthcare records.

- Complete an evaluation and consultation process which will enable the design of key performance indicators for open disclosure.
- Work with the Independent Patient Advocacy Service which will be established shortly by the DoH.

Quality, Patient Safety and Learning

Continual improvement, in the quality of care, learning from patient experience, and systems to manage major threats to sustainability to healthcare systems globally e.g. AMR, is essential in ensuring safer healthcare. This reduces harm to patients and helps create more effective evidence based care which is appropriate to patient needs.

The actions below aim to promote, and support staff to deliver on, a culture of patient safety, quality improvement and learning.

Priorities and Actions

Patient safety strategy

- Complete the national patient safety strategy and commence implementation.
- Implement and further develop specific and targeted patient safety initiatives in areas such as medication safety, pressure ulcers, falls, clinical handover underpinned by robust quality improvement methodologies, education and toolkits.
- Support the review, implementation and evaluation of the National Clinical Effectiveness Committee (NCEC) clinical guidelines; National Early Warning System (NEWS), Irish Maternity Early Warning System (IMEWS), Paediatric Early Warning System (PEWS), Emergency Medicine Early Warning System (EMEWS) and Sepsis Management guideline through the enablement of the National Deteriorating Patient Recognition and Response Improvement Programme.
- Work collaboratively to support the service delivery areas to complete a capacity and capability study for quality and patient safety.

Patient safety governance

- Establish new governance arrangements to oversee implementation of the patient safety strategy, and to strengthen the governance of current patient safety programmes.
- Enhance the capability for governance, for quality and patient safety across our services through the application of the Quality Improvement for Boards Programme, including development and use of quality profiles.
- Progress the establishment of a national repository for policies, procedures, protocols and guidelines.
- Progress the improvement and management of AMR and infection prevention control.
    - Progress structures currently managing CPE to encompass AMR and infection prevention and control in line with the strategic action 1 of *Sláintecare* to implement *Ireland's National Action Plan on Antimicrobial Resistance 2017-2020,* to enhance governance and monitoring at national and local level.

- Improve performance management processes for CPE related KPIs and the implementation and monitoring of CPE screening in all acute hospitals - as per the *Requirements for Screening of Patients for Carbapenemase-Producing Enterobacteriales in the Acute Hospital Sector* (target 25,000 screens per month).

(Priorities and actions in relation to the implementation of AMR and infection prevention and control improvement can also be seen in the Health and Social Care section of this plan).

Learning through feedback systems

- Commission a clinical audit evaluation project to ensure that suitable structures and supports are identified and implemented.
- Support the design and development of clinical guidelines, including NCEC clinical guidelines, incorporating management of adults with COPD, care of the dying adult in the last days of life, and clinical concussion.
- Provide recommendations for service improvement through clinical audits, including those conducted under the National Office for Clinical Audit national healthcare audit and the specialty quality improvement programmes for radiology, endoscopy and histopathology.
- Scale up the new suites of Nursing and Midwifery Quality Care-Metrics on a phased basis in selected healthcare settings.
- Work with the National Cancer Registry of Ireland, the National Screening Service (NSS), the DoH and the National Cancer Control Programme (NCCP) to develop a proposal for the establishment of a National Cancer Screening Registry in Ireland.
- Continue to support the roll-out of the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland 2018* (Phase 1).
- Progress implementation and evaluation of the *Incident Management Framework 2018* in order to report, manage, review, disseminate and implement learning from safety incidents, supported by the work of the National Independent Review Panel, the National Appeals Service Office and Confidential Recipient.

Risk Management

- Review the organisational approach to risk management and reporting.

Build capacity and capability for quality improvement in the services.

- Continue to train frontline teams in quality improvement and build a network of improvers across the system to continuously improve the quality of services in a sustainable way based on proven collaborative quality improvement processes and the *Framework for Improving Quality in our Health Service*.
- Roll out the culture of person-centredness programme across acute hospitals and primary care services to build on work completed in disability services.

Section 5:

Population Health and Wellbeing

Population Health and Wellbeing

Introduction

A fundamental goal of the health service is to support the health of its population. *Sláintecare* recognises the importance of supporting people to look after and protect their own health and wellbeing. *Healthy Ireland* is the national strategy for improved health and wellbeing. This strategy is underpinned by a whole-system philosophy involving cross-government and cross-societal responsibility. The health system will continue to play an important leadership role in driving this whole-system shift towards a culture that places greater emphasis and value on prevention and keeping people well.

There are many positive trends visible within our health service, life expectancy is increasing, mortality rates are declining and survival rates from conditions such as heart disease, stroke and cancer are improving. Despite these encouraging developments, we know changing lifestyles, chronic disease patterns and ageing population trends are altering our population's healthcare needs. This is creating an unsustainable horizon for the future provision of our health and social care services in Ireland.

To address these challenges the health service will continue to prioritise high quality evidence based prevention, early intervention and health protection strategies to help reduce demand on our health and social care services thereby ensuring a sustainable health system for future generations.

Services Provided

Population health is about helping our whole population to stay healthy and well by focusing on prevention, protection, and health promotion and improvement through the work of:

- The National Policy Priority Programmes for tobacco, alcohol, healthy eating and active living, sexual health and crisis pregnancy, and child health which provide expertise, strategic advice and direction to address known preventable lifestyle risk factors by designing and developing evidence based best practice policies, programmes and initiatives.
- Health Promotion and Improvement services which provide a range of education and training programmes focused primarily on building the capacity of staff across the health service and in key external bodies who are ideally placed to positively influence health behaviour. Health and Wellbeing services work with people across a variety of settings in the community, in hospitals, in schools and in workplaces.
- Public Health services which protect our population from threats to their health and wellbeing through the design and oversight of national immunisation and vaccination programmes and actions for the prevention and control of infectious diseases.
- CHOs and Hospital Groups implementing comprehensive *Healthy Ireland* plans to deliver upon the health and wellbeing reform agenda locally, improve the health and wellbeing of the local population by reducing the burden of chronic disease and improving staff health and wellbeing.
- National Screening Services which provide population-based screening programmes for BreastCheck, CervicalCheck, BowelScreen and Diabetic RetinaScreen.
- Environmental Health Services which take preventative actions and enforce legislation in areas such as food safety, tobacco control, cosmetic product safety, sunbed regulation, fluoridation of public water supplies, drinking and bathing water, to improve population health and wellbeing.

Issues and Opportunities

Our demographic profile is changing and is placing substantial pressure on our health and social care services. Demand for healthcare services will increase by between 20% and 30% in the next ten years. Unhealthy lifestyle choices such as those related to diet, exercise, smoking and alcohol use are all driving demand for health services and resulting in an increased level of chronic disease amongst our population.

Individual lifestyle choices are heavily influenced by social and economic circumstances. A whole-system approach involving cross-government and cross-societal actions are required to help our most vulnerable and deprived communities.

Building upon *Sláintecare* and HSE structural reforms and enablers, we will create greater capacity within the organisation to lead and deliver upon the health and wellbeing reform agenda. The development and implementation of comprehensive *Healthy Ireland* plans in CHOs and Hospital Groups will deliver upon the health and wellbeing reform agenda locally, improving the health and wellbeing of the local population by reducing the burden of chronic disease, and improving staff health and wellbeing. The transition of Health Promotion and Improvement to CHOs will significantly augment existing health and wellbeing resources supporting accelerated embedding and integration of health and wellbeing reforms across services locally.

A detailed national framework has been developed which outlines how to progress implementation of Self-Management Support for chronic diseases. With the appointment of nine self-management support co-ordinators, the focus will be on delivering greater efficiency of existing services to meet patient need and deliver measurable improvements in patient experience and outcome in 2019. Through the implementation of the Making Every Contact Count (MECC) Programme, chronic disease prevention and management will be an integral and routine part of clinical care by a greater proportion of healthcare professionals enabling them to capitalise on the opportunities that occur every day to support individuals to make healthier lifestyle choices.

Brexit has potential risk implications for continuity of existing service arrangements and for official controls, in particular, the controls for food imports / exports that the Environmental Health Service has legal responsibility to enforce. As Irish Water continues infrastructural development, a significant budgetary issue for the Environmental Health Service in 2019 will be identifying and agreeing a sustainable funding model to ensure compliance with fluoridation requirements in public water supplies. The introduction of the *Public Health (Alcohol) Act 2018* represents an opportunity for the Environmental Health Service to have a positive impact on reducing alcohol consumption through the enforcement of the Act.

Priorities 2019

- Improve the health and wellbeing of the population by reducing the burden of chronic disease.
- Build upon *Sláintecare* and HSE structural reforms and enablers to create greater capacity within the organisation to lead and deliver upon a cross-sectoral health and wellbeing reform agenda.
- Support the implementation of comprehensive *Healthy Ireland* implementation plans in CHOs and Hospital Groups.
- Progress the Early Years Intervention Programme including the National Healthy Childhood and Nurture Infant Health and Wellbeing Programmes.
- Continue to protect our population from threats to health and wellbeing through infectious disease control, immunisation, and environmental health services.
- Improve staff health and wellbeing.

Health and Wellbeing Services

Priorities and Actions

Improve the health and wellbeing of the population by reducing the burden of chronic disease

Chronic disease prevention and self-management support

- Implement CHO and Hospital Group *Healthy Ireland* plans to deliver actions and embed prevention, early detection and self-management support among their staff and the communities they serve.
  - Continue to implement the MECC Framework including the e-learning training programme for frontline staff in CHOs and Hospital Groups, which is a key enabler in promoting lifestyle behavioural change among service users.
  - Continue to implement *Living Well with a Chronic Condition: Framework for Self-Management Support*.
  - Improve access and uptake of structured patient education programmes for patients with Type 2 Diabetes in the community.
  - Implement the National Policy Priority Programmes through supporting the implementation of comprehensive *Healthy Ireland* plans in CHOs and Hospital Groups.

National Policy Priority Programmes

- Tobacco Free Ireland
  - Commence national roll-out of IT patient management system which will manage timely referral to services and integrated care for smokers trying to quit.
  - Produce national clinical guidelines for healthcare professionals to inform clinical practice in the identification, diagnosis and treatment of patients who smoke.
  - Continue to design, develop and run innovative communication campaigns and tobacco cessation services targeting smokers in high prevalence groups.
  - Support patients and staff to quit and stay quit through improved compliance with HSE Tobacco Free Campus.
  - Integrate the national maternity IT system with Quit Manager to improve referral rates of pregnant women into intensive cessation service.
- Alcohol
  - Review the alcohol drinking guidelines to support the reduction of alcohol consumption.
  - Promote and support the *askaboutalcohol* campaign to increase awareness of the risks associated with alcohol intake.
  - Support the implementation of the *Public Health (Alcohol) Act 2018.*
- Healthy Eating and Active Living
  - Improve nutritional care in hospitals through the implementation of the Food, Nutrition and Hydration Policy for Adult Patients in Acute Hospitals and the National Clinical Guideline for Nutrition Screening and the Use of Oral Nutrition Support for Adults in the Acute Care Setting.
  - Increase access and availability of healthier food for staff and visitors through the implementation of the *Minimum Nutrition Standards* for food and beverage provision for staff and visitors in healthcare settings.

  - Increase families' awareness of healthy lifestyle behaviours to prevent childhood obesity by continuing to deliver the START campaign.
  - Support the public to increase their participation in physical activity working in collaboration with the Local Sports Partnership network.
  - Improve nutrition knowledge, dietary behaviour and cooking skills amongst targeted groups through the delivery of community cooking programmes.
- Sexual Health and Crisis Pregnancy Programme (SHCPP)
  - Continue the provision and expansion of vaccines (HPV, Hepatitis B Vaccine) to at risk groups in line with National Immunisation Advisory Committee recommendations.
  - Continue to plan for the delivery of pre-exposure prophylaxis (PrEP) following the outcome of the HIQA health technology assessment.
  - Provide targeted services and supports for Men who have Sex with Men (MSM).
  - Provide a Freephone counselling and information service to people experiencing an unplanned pregnancy.
- Oireachtas Committee on the Eighth Amendment – Ancillary Recommendations
  - Undertake a review of the delivery of Relationships and Sexuality Education in schools in collaboration with the Department of Education and Skills and subsequent development of curriculum and associated resources.
  - Implement sexual health promotion training for professionals in the youth sector, those working with at risk-groups, and for parents.
  - Deliver targeted outreach programmes and campaigns to at risk groups.
  - Promote sexual health and 'safer sex' public advertising campaigns which will encourage sexually active adults to have safer sex, to include contraceptive advice and prevention of sexually transmitted infections.
  - Expand condom distribution services, with initial focus targeting those most at risk.
  - Repeat the in-depth general population survey on sexual health and crisis pregnancy to provide up-to-date data to support implementation.
- Mental Health and Wellbeing
  - Support volunteers and professionals working with young people in the community to build capacity for youth mental health in collaboration with CHOs.

Build upon *Sláintecare* and HSE structural reforms and enablers to create greater capacity within the organisation to lead and deliver upon a cross-sectoral health and wellbeing reform agenda

- Build operational capacity and prioritise existing resources in operational services to support the implementation of *Healthy Ireland* plans in CHOs and Hospital Groups.
- Provide training to support the CHO *Healthy Ireland* implementation plans.
- Lead the design, development and implementation of an operating model for health and wellbeing in CHOs including the transition of Health Promotion and Improvement.
- Improve co-ordination, collaboration and input to multi-agency partnerships to ensure joined up approaches to public health priorities as follows:

  - Improve the health and wellbeing of children and young people by providing national agreed training programmes and resources for the education sector.
  - Continue to provide support to Local Community Development Committees and Children and Young People Services Committees.
  - Further develop partnership working with the DoH on programmes such as Healthy Cities and Counties, workplaces, campuses, and education to improve the health of the population.
  - Develop the Women's Health Action Plan in collaboration with the DoH and the National Women's Council of Ireland.
  - Progress the next stage of the Warmth and Wellbeing Scheme in collaboration with the DoH and the Department of Communications, Climate Action and Environment.
- Collaborate with the DoH on the development of a climate change adaptation plan for the health sector.

Progress the Early Years Intervention Programme including the National Healthy Childhood and Nurture Infant Health and Wellbeing Programme

- Continue progress to ensure the timing and content of the childhood screening and surveillance programme are consistent with the evidence base and standardised across the country in line with *First Five – A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028* as follows:
  - Commence the implementation of the revised model for screening for developmental dysplasia of the hip.
  - Implementation of the standardised child developmental screening tool for children aged 21 to 24 months (Ages and Stages Questionnaire 3).
  - Provide support for mothers to breastfeed and for families, by increasing knowledge and skills of professionals through completion of online eLearning modules and skills-based training.
  - Support families by increasing knowledge and skills of professionals through the completion of eLearning modules and skills-based training.
  - Support parents with high quality, evidence-based information (*www.mychild.ie*) and services on various aspects of parenting to support child development, positive mental health and family relationships.
  - Continue progress towards the breastfeeding target rate set out in *Breastfeeding in a Healthy Ireland – Health Service Breastfeeding Action Plan 2016-2021* (i.e. annual 2% increase in breastfeeding duration rates over the period 2016-2021), through the implementation of the HSE Breastfeeding Implementation Plan.

Improve staff health and wellbeing

- Continue to support the leadership and momentum in place at local level, focusing on evidence-based initiatives to improve staff health and wellbeing.
- Increase the number of staff participating in staff health and wellbeing initiatives.
- Deliver Steps to Health and Love Life Love Walking workplace physical activity promotion.

Public Health Service

Priorities and Actions

Protect our population from threats to health and wellbeing through immunisation and infectious disease control

- Extend the existing national HPV vaccination programme to boys to reduce the risk of HPV associated cancers.
- Continue to improve immunisation and influenza uptake rates, by maintaining campaigns and supporting CHOs and Hospital Groups to drive and support uptake within relevant target populations including staff.
- Implement a national pertussis (whooping cough) vaccination programme for pregnant women in the health service.
- Develop a case and incident management system for health protection to support more efficient and robust reporting and management of infectious disease outbreaks.
- Continue to enhance the control of tuberculosis.
- Develop a new operating model for public health in Ireland, in conjunction with the DoH.

National Environmental Health Service

Priorities and Actions

Protect our population from threats to health and wellbeing through the provision of environmental health services

- In order to respond to the impact of Brexit, increase capacity to carry out official controls on food imports at ports and airports, and respond to additional requests for food export certificates. Additional funding is being made available to the HSE in 2019 to address the requirements identified by Environmental Health Services in preparation for Brexit in 2019 (central case scenario).
- Implement the *HSE and Food Safety Authority of Ireland (FSAI) Service Contract 2016-2019*.
- Undertake a sun bed inspection programme, including planned inspection, test purchase and mystery shopper, under the *Public Health (Sunbeds) Act 2014.*
- Enforce HSE environmental health tobacco control statutory responsibilities focusing on areas of greatest non-compliance and new tobacco control legislation, in particular the legislation on licensing of retailers.
- Support the development of guidance on the provisions of the *Public Health (Alcohol) Act 2018* in partnership with the DoH and prepare for the enforcement of the provisions that will be operational in late 2019.
- Engage in on-going discussions with the DoH and Irish Water to review the current level of compliance with fluoridation requirements and identify and agree a sustainable funding model that can meet legislative requirements.

National Screening Service

The National Screening Service (NSS) delivers four national population-based screening programmes – for cervical, breast and bowel cancer, and for detecting sight-threatening retinopathy in people with diabetes. These programmes aim to reduce morbidity and mortality in the population through early detection and treatment across the programmes. Screening programmes internationally and in Ireland are based on a call / re-call system where eligible populations are invited to take part and clinical services are provided for the further investigation and treatment of people identified as at risk of having or developing disease.

Scoping Inquiry into the CervicalCheck Screening Programme, 2018 (Scally Report)

In May 2018, the Government established a scoping inquiry led by Dr Gabriel Scally to investigate the issues that came to light in relation to the CervicalCheck screening programme.

Dr Scally published his final report in September 2018 which contained 50 recommendations that, when implemented, will improve the CervicalCheck screening programme and other screening programmes and will address the particular shortcomings within the health service that Dr Scally found during his scoping inquiry work.

The HSE has established a Steering Group chaired by the Chief Operations Officer and Chief Clinical Officer to oversee the implementation of the HSE recommendations. A senior manager has been appointed to lead on the development of a HSE implementation plan as part of an overall implementation plan, developed under the auspices of the CervicalCheck Steering Committee established by the Minister earlier this year.

The NSS will support the implementation of all recommendations contained in the *Scally Report* as a key priority for 2019. Many of the recommendations apply to all screening programmes.

Priorities and Actions

National Screening Programmes

- Ensure full implementation of all recommendations of the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018 (Scally Report).*
- Implement strengthened organisation and governance arrangements in line with the reviews undertaken of screening services.
- Implement a communications strategy, in conjunction with HSE communications, to ensure continued support, education and information for the public on screening programmes.
- Develop and implement a public and patient engagement plan across screening to enhance public input to screening programmes.
- Enhance the NSS Client Services function to support women and their families.
- Implement a staff engagement programme across all screening services.

CervicalCheck

- Ensure the continued operation of cervical screening including mitigating the impact of the cytology backlog on women.

- Provide for the introduction of HPV testing in 2019 including communications, training and education, ICT reconfiguration and for the increase in colposcopy referrals expected to arise as a result of the introduction of HPV testing.
- Support the International Clinical Expert Review Panel (RCOG) in their review process.
- Maintain the current screening uptake rate of greater than 80%.

BreastCheck

- Continue to implement the age-extension of the BreastCheck Programme by rolling out the Programme to remaining 67 year olds (50%) and 68 year olds (50%) in line with the agreed programme of implementation.
- Maintain uptake >70%.

BowelScreen

- Increase uptake through targeted communications and promotion amongst eligible men and women aged 60-69 years.
- Liaise with acute services to develop a capacity plan that meets the current endoscopy demand for the screening population.
- 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*.

Diabetic RetinaScreen

- Roll out a digital surveillance screening programme and model of care that will improve timeframes for treatment of diabetic retinopathy to a further 2,500 patients in 2019.
- Increase uptake amongst eligible population aged 12 years and over.

Section 6:
Health and Social Care

Community Healthcare

Introduction

Community healthcare services (including primary care, social inclusion, older persons' services, palliative care, and specialist services including mental health and disability services) are provided for adults and children across the lifespan including those who are experiencing marginalisation and health inequalities. Community healthcare services are delivered across nine CHOs and are provided through a mix of HSE direct provision as well as through voluntary section 38 and 39 service providers, GPs and private providers. The community healthcare budget accounts for almost 40% of the HSE spend.

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.

Sláintecare sets out the need for the shift from the provision of care from acute to community settings, supporting the prevention and management of chronic disease at a community level. The strategic direction outlined in *Sláintecare* and the current provision of community services is underpinned by a number of strategies including *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, Healthy Ireland*, *Transforming Lives*, *The Irish National Dementia Strategy*, *Vision for Change*, *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020* and *The National Carers' Strategy – Recognised, Supported, Empowered*.

Sláintecare positions Community Healthcare Networks (CHNs) as the 'fundamental unit of organisation for the delivery of services' in the community. CHNs are geographically-based units delivering services to an average population of 50,000. There will be 96 CHNs and each CHO will have between eight and 14 CHNs. The implementation of CHNs will see a co-ordinated multi-disciplinary approach to care provision, providing better outcomes for people requiring services and supports both within and across networks.

The development of CHNs is a critical step in transforming our healthcare system and will enable real change that will be experienced by all who use our services and work in the HSE. Similarly, it is accepted that there is a need to ensure that general practice is sustainable both for current GPs in practice and those entering the profession. Building capacity in general practice will enable GPs to play a central role in achieving this shift in emphasis towards primary care.

Issues and Opportunities

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 hospitals in responding effectively to the planned, unplanned and emergency needs of patients. Similar pressures are faced by community services, including primary care, older persons' services, people with disabilities and those who need mental health supports, with demand outstripping supply leading to delays in accessing services. 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.

Changes in the demographics of the population will see a projected increase of 3.3% in people over 65

years and 4.3% in people over 85 years in 2019, requiring both a change in how community services will be delivered and the need for improved integration with acute services. The *Health Service Capacity Review 2018* acknowledges this demand for services across primary and social care settings in the next 15 years as a result of demographic changes. It is estimated that there will be up to a 46% increase in demand for primary care, 39% in the need for long term residential care and a 70% increase in the demand for home care over this period.

Although many people experience high quality services in the community health sector, often navigating the complexity and scale of current arrangements is difficult and service users do not have equal access to health services across the country. Therefore, there is a need to improve access to primary care and specialist services across CHOs. During 2019, we will work to continue to deliver a number of key programmes focused on improving integrated care across community services and acute services including the ICPs for older persons, children and people with chronic diseases. In addition, five clinical programmes will be progressed across mental health services.

Enhanced ICT is a critical enabler for healthcare reform across community services including CHNs. The need to record and share information on patients' and service users' interaction across community services is key to improving integrated care and improved care pathways for patients, service users, carers, health and social care professionals and wider stakeholders in the health system.

The rise in the numbers of persons experiencing homelessness is creating increased demand on health services. Our primary care and network services will need to work across social inclusion and mental health services to address the needs of those who have co-morbidity needs, those who are homeless, and have addiction and mental health needs.

Community services continue to be delivered in a more regulated environment. Services across community settings including mental health, disability and older people services are working to comply with regulations and will develop a range of programmes to ensure service user safety and quality.

Delivering the maximum amount of services, as safely and effectively as possible, within the limits of the available funding will remain a critical area of focus and concern in 2019. Each Chief Officer, Head of Service and their teams, other senior managers including CEOs and teams of voluntary sector providers will face specific challenges to ensure the type and volume of safe services are delivered within the available resources.

It is recognised that the scale of the challenge in 2019 will present particular difficulties in adequately meeting the demand for our residential care services, emergency places for people with disabilities, maintaining compliance with HIQA regulation and responding to the growing need of an ageing population for home support services.

While recognising these service pressures our community services will seek to maximise the use of available resources to respond to the priority needs of our population. In this context, a range of measures will be implemented during 2019 to improve the efficiency and effectiveness of our services and develop more sustainable models of service.

A significant challenge is maintaining the required workforce and skillset across all community services which has led to a reliance on agency staffing. Similarly we are experiencing issues in the area of recruitment of available staff in key areas.

In this context a range of measures will be implemented to ensure that the available resources are maximised. These include:

- Reduce reliance on agency and overtime through a robust conversion programme to contracted arrangements, particularly in all residential care services.
- Revise staffing levels and implement employment control measures, particularly in all residential care services.
- Prioritise service provision to those most in need based on risk assessment in order to meet the demand for services.
- Establish a dedicated operational team at national level with responsibility for co-ordination and oversight of CHO assignment of all residential places in particular any emergency residential provision.
- Manage short stay beds numbers in the course of the year and reconfigure residential care centres as appropriate.
- Deliver efficiencies in non-pay areas including procurement, transport travel and subsistence etc.
- Ensure that all income sources are fully maximised.
- Review voluntary provider costs, particularly in non-frontline areas, to identify duplication.

For 2019, 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. The system will ensure that the resources which have been made 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. It will be more important than ever that we secure value for money, achieving maximum benefit from the available financial, staffing and infrastructure resources.

Overarching Priorities and Actions

- Develop community services in line with *Sláintecare Implementation Strategy*.
  - Establish CHNs with the implementation of nine learning sites across CHOs involving the management of primary care staff by a network manager working collaboratively with community nursing and GPs.
  - Recruit additional therapy and nursing posts across primary care services.
  - Increase access in general practice to diagnostic imaging and support additional paediatric home care packages in community settings.
- Agree and implement GP contractual changes including the roll-out of a structured approach to chronic disease management.
- Improve health outcomes for the most marginalised groups who experience health inequalities.
- Progress the development and implementation of the standard Single Assessment Tool (SAT) across older people and disability services.
- Enable people with disabilities to live ordinary lives, in ordinary places as independently as possible.
  - Reduce waiting times for assessment of need under the *Disability Act 2005* through the provision of 100 additional posts.
  - Complete the move of 160 people from congregated settings to their own homes in the community.

  - Provide an additional 90 new emergency residential placements.
  - Develop a national commissioning model for residential disability services, which will enable centralised commissioning and local delivery model similar to the Nursing Homes Support Scheme (NHSS) on a non-statutory basis
- Delivering care closer to home.
  - Continue to provide home support services to over 53,000 people in their own homes.
  - Continue to provide 28,000 day care places each week.
  - Progress the opening of new palliative inpatient facilities in Waterford, Wicklow, Mayo and Kildare.
- Improve quality of care and patient safety.
  - Continue improvements in compliance with national standards for the prevention and control of healthcare associated infections across community services.
  - Progress the roll-out on a phased basis of the revised HSE safeguarding policy across all community health and acute care areas through raising awareness and on-going training with staff and service providers.
- Improve integration between community and acute services to provide joined up pathways of care for patients and service users.
  - Progress the roll-out of the ICP for older persons.
  - Continue to implement the ICP for the prevention and management of chronic disease.
  - Ensure alignment of service developments in both acute and community healthcare where there is an opportunity to build upon existing pathways of care (e.g. FIT teams and older persons' services) which provide the most gain for patient outcomes across community and acute services.
  - Co-ordinate cross-cutting and effective service delivery between community and secondary care in a way that promotes enhanced use of technology.
- Promote the mental health of the population and continue to build new models of service.
  - Work to develop a seven day per week service for child and adolescent mental health services (CAMHs) to ensure supports for vulnerable young persons in line with *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020*.
  - Implement agreed development of a 24/7 contact line, crisis text line and other eMental health digital responses.
  - Provide increased access to talk therapies to improve treatment outcomes for service users.
  - 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 continued appointment of agreed new staffing.
- Ensure that the views of service users, family members and carers are central to the design and delivery of services.
  - Develop a standardised approach for the inclusion of service users in the design and delivery of

services, including the development of service user and family member forums across CHOs across identified care groups.

- Continue to implement the health and social care related actions in *The National Carers' Strategy – Recognised, Supported, Empowered*.

- Enhance ICT capability across community services.
  - Deploy a pilot ICT solution to support the new CHN learning sites.
  - Deliver hand held technology devices to community healthcare professionals.
  - Further develop the use of SAT in older persons' services and its expansion in other care groups.
  - Complete procurement of technology to deliver digital patient records and all associated technology for the new National Forensic Mental Health Services Hospital.

Primary Care Services

Services Provided

Primary care services deliver care to service users close to home through a community-based approach. A wide range of core services are provided by GPs, nursing and HSCPs, working with wider community services (older people, disability, mental health, palliative) and acute hospital services in response to service user needs.

In 2019 the key quantum of services will be:

- 581,661 patients to avail of physiotherapy.
- 356,314 patients to avail of occupational therapy.
- 279,803 patients to avail of speech and language therapy.
- 743,605 patients to avail of the community nursing service.
- 202 GP training places.
- 1,147,496 GP out of hours contacts.
- 457 children with complex medical conditions to avail of paediatric homecare packages following discharge from hospital.
- 45,432 referrals to community intervention teams (CITs) to facilitate a high volume of complex hospital avoidance and early discharge.

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.

In line with *Sláintecare,* the longer-term focus is on providing improved, speedier and earlier access to services through the provision of a bigger range of primary care services. A challenge in delivering on this objective is the requirement to build additional capacity to enable a broader range of primary care services to be provided in the community. It will be necessary for the increase in capacity to be put in place in a structured way, resulting in the maximum scale and quantum of services being provided in the community with the appropriate care pathways and access to scheduled and unscheduled care.

In 2019, a number of service redesigns are taking place in primary care, under the governance and leadership of the commissioning teams, which will commence building and implementation of this additional capacity and service models.

Community Healthcare Networks (CHNs)

CHO implementation will enter an exciting phase in 2019 with the establishment of CHNs. The networks are a key building block in the establishment of the infrastructure to deliver *Sláintecare*. CHN managers will manage the delivery of primary care services and co-ordinate the integration of services within / outside

CHNs through the identification of clear access and referral pathways to services for older people, people with disabilities, people with mental illness and to acute hospitals. Implementation of the networks will commence in 2019 with the establishment of nine learning sites, involving the management of primary care staff by the network manager, working collaboratively with community nursing and GPs. In CHNs the move to collaborative and cross-boundary working that encourages primary and secondary care to be aligned in one system closer to the community, will facilitate a more streamlined co-ordinated transfer of care and improved service user experience. As service users move through their healthcare journey, CHNs will support service users and their families and co-ordinate their care in acute hospitals as required.

Within the overall resource package, opportunities to make improvements in areas such as CHN services will be developed through:

- Recruitment of 130 posts on a half year basis, with an estimated 4,500 additional patients to be seen in 2019, with a full year impact in 2020 of 9,000 additional patients. The specific profile of community nursing and therapies will be determined in consultation with CHOs early in 2019.
- An increase in general practice access to diagnostic imaging with 67,000 ultrasounds and 79,500 x-rays in 2019.
- 80 additional paediatric home care packages during the course of 2019.

The commissioning of primary care centres continues to be a key enabler for the effective and efficient delivery of Primary Care Team (PCT) and CHN services.

Building capacity in general practice

To achieve a shift to primary care-centred health services, it is accepted that there is a need to ensure that general practice is sustainable both for current GPs in practice and those entering the profession. GPs will be expected to play a central role in achieving this shift of emphasis towards primary care service. Contract negotiations with GPs are on-going with a view to:

- Ensuring that general practice is sustainable.
- Agreeing significant reform and modernisation.
- Facilitating significant and strategically aligned service development such as in the areas of chronic disease, CHN model and special items of service.

Chronic disease management

A population level approach, at CHN level, to the management of chronic disease involves moving a step further upstream from the level of the individual, to assess whole population needs with a view of targeting different interventions at individual risk groups. An enhanced GP contractual framework would lead to better health surveillance for chronic disease through the introduction of structured chronic disease prevention and management in general practice on a phased basis for a number of specific conditions.

ICT

2019 will see development of a business case for the community EHR and preparation for implementation to connect records across the system and support integrated models of care. It will also involve the development of the Primary Care Management System and the deployment of a proof of concept ICT

solution to support the CHN implementation learning sites which are critical enablers to build primary care capacity.

The MEDLIS solution, which enables direct ordering has been refined over the last two years in conjunction with a wide group of stakeholders and is at an advanced stage. Ordering capability for GPs will be introduced in a phased manner aligned with the hospital roll-out as detailed below.

- Beaumont Hospital in late 2019.
- Cavan General Hospital in first quarter of 2020.
- Mater Misericordiae University Hospital and St James' Hospital second quarter of 2020.

Improve integration between community and acute services to promote a modernised and streamlined delivery model

In conjunction with acute services, a strategic elective care plan is being developed that will promote the redesign of services, implementing clinically recommended care pathways that will reduce variability in clinical practices and manage the quality and safety of patient care through standardised processes. Access by primary care services to specialist advice, appropriate diagnostic imaging and alternative pathways, underpinned by appropriate technology, will support the management of patients in primary and community healthcare as much as possible, while reserving the acute hospital for high acuity care.

Priorities and Actions

Primary care will continue to focus on improving the quality, safety, access and responsiveness of services and working to integrate the delivery of other community services.

CHN – Network operating model

- Develop CHNs in line with *Sláintecare*.
- Implement nine CHN learning sites.
- Build the governance of CHNs with new structures at primary care level.
- Deploy a pilot ICT solution to support the new CHN learning sites.

Primary care services

- Improve access for primary care occupational therapy services with a focus on addressing patients waiting over 52 weeks, through the appointment of 40 occupational therapists.
- Develop and enhance CHNs through the recruitment of 130 additional posts across nursing, physiotherapy and other health and social care professionals.
- Improve access waiting times for oral health and orthodontic services for children within existing resources.
- 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, lymphoedema model of care, GP out of hours service, primary care eye care services and civil registration.

- Provide 80 additional packages of care for children discharged from hospital with complex medical conditions.
- Refocus CIT and Outpatient Parenteral Antimicrobial Therapy (OPAT) services with a focus on increased referrals of complex hospital avoidance and early discharge cases, and develop and implement quality improvement initiatives.
- 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.
- Commission additional primary care centres.

Deliver safe high quality termination of pregnancy services on a universal basis

In line with the *Health (Regulation of Termination of Pregnancy) Bill 2018*, a primarily community led service will be delivered by GPs in primary care settings and women's health service providers with appropriate access and care pathways to acute hospital services as required. Services will be available from January 2019.

- Deliver termination of pregnancy (ToP) services to ensure they can be accessed in community settings through primary care providers on a universal basis, free of charge.
- Support and enable the implementation of a safe, high quality ToP service in the acute hospital system.
- Support staff working across HSE services through education and training to roll out ToP services in line with clinical guidelines and model of care.

Social Inclusion Services

Services Provided

Social inclusion works across a range of statutory services in partnership with the community and voluntary sectors, to address health inequalities and to improve access to health services for socially disadvantaged groups.

In 2019, the key quantum of services will be:

- 10,063 clients will be in receipt of opioid substitution treatment (outside prisons).
- 1,126 service users admitted to homeless emergency accommodation hostels / facilities whose health needs will have been assessed within two weeks of admission.
- 1,650 individuals will attend pharmacy needle exchange.

Issues and Opportunities

Ensuring that we improve health outcomes for socially excluded groups in society is a key priority. Capacity to meet government commitments as set out in the Irish Refugee Protection Programme, *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016*, *Housing First Implementation National Implementation Plan 2018-2021*, *National Traveller and Roma Inclusion Strategy 2017-2021*, *National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021*, 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 services.

Priorities and Actions

- Improve health outcomes for socially excluded groups who experience severe health inequalities including those with addiction issues, the homeless, refugees, asylum seekers and members of Traveller and Roma communities.
  - Prioritise the expansion of community-based healthcare services to minimise the harms from misuse of substances and to promote rehabilitation and recovery, in line with *Reducing Harm Supporting Recovery.*
  - Continue to implement the health-led response to the *Reducing Harm Supporting Recovery* with an emphasis on strengthening governance structures.
  - Mental health and social inclusion services working together will develop a model of service for co-occurring mental health and substance misuse concerns among at risk groups.
  - Implement the health actions, identified as a priority in 2019, in *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016*, and *Reducing Harm Supporting Recovery* in order to provide the most appropriate primary care and specialist addiction / mental health services for homeless people.
  - Implement new models of care for homeless people with complex and multiple needs, as part of an integrated housing and health policy response, in line with the *Housing First National Implementation Plan 2018-2021*.

- Implement the recommendations of HSE Intercultural Health Strategy 2018-2023 on a phased, prioritised basis.
- Improve access to primary care services for refugees in emergency reception and orientation centres / resettlement phase, in line with the *EU Reception Conditions Directive 2013 / 33 / EU* to support people seeking asylum, with particular regard to development and implementation of a vulnerability assessment.
- Finalise and implement the Traveller Health Action Plan in line with the *National Traveller and Roma Inclusion Strategy 2017-2021.*
- Implement agreed HSE assigned actions under the *Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021* within existing resources.
- Progress identified actions in mental health / social inclusion area in conjunction with mental health services.
- Improve addiction treatment and rehabilitation services in Dublin North East Inner City, in partnership with the NEIC Programme Implementation Board.

Disability Services

Services Provided

A wide range of disability services are provided to those with physical, sensory, intellectual disability and autism. Disability services focus on supporting and enabling people with disabilities to maximise their full potential, living ordinary lives in ordinary places, as independently as possible. Disability services strive to ensure the voices of service users and their families are heard, and are fully involved in planning and improving services to meet their needs.

Disability services are delivered through a mix of HSE direct provision as well as through non-statutory section 38 and 39 service providers, and private providers.

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 government departments and services in the development of cross-sectoral strategies to maximise access to services and supports for people with disabilities.

In 2019, the quantum of services will be:

- 8,568 people with a disability are supported by a range of residential supports (65% of budget).
- 27,067 people with disabilities access the 22,272 day places and supports in over 800 locations throughout the country (20% of budget).
- 90 new emergency residential places.
- On a quarterly basis (15% of budget):
  - 6,559 people with disabilities will avail of respite.
  - 10,629 people with disabilities will avail of 4.7m hours of personal assistant / home support hours.
  - 1,424 multi-disciplinary clinicians will provide therapeutic services.

Issues and Opportunities

The increase in funding for disability services in recent years is welcome. However, to meet the demographic challenges associated with the increase in the number of people living with a 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.

In addressing this challenge, disability services have a significant programme of reform underway 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:

- *Time to Move on from Congregated Settings – A Strategy for Community Inclusion* in respect of residential centres to support the transition of people from institutional settings to community-based living.
- *New Directions* Programme is improving day services and supports and aims to meet the needs of school leavers and those graduating from rehabilitative 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 these national policy objectives.

Time to Move on from Congregated Settings – A Strategy for Community Inclusion identified over 4,000 people in congregated settings which by the end of 2019 will be reduced to just over 2,000, ensuring that the HSE is in line to meet the target reductions as set out in the Programme for Government. This change is being supported by the service reform fund, a partnership arrangement between Atlantic Philanthropies, the DoH, Genio and HSE.

In addition, the disability sector has, for the first time, fully registered with HIQA, all 1,200 residential centres. While it is important to recognise this progress it has only been achieved through high levels of unplanned expenditure both capital and revenue over the last two years. Having achieved this milestone and having regard to the range of other priorities within the service, the intention in 2019 with the support of the DoH, will be to consider further improvement in regulatory compliance in the context of available resources.

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 unplanned emergency residential places to respond to the most urgent cases on our waiting list leading to significant unplanned over-expenditure annually.

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 2019 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.

In this context, a particular challenge in 2019 will be to maximise the capacity of the service to respond to residential care needs. A total of 8,568 places will be provided in 2019, representing an increase of 39 on the expected outturn for 2018. The service will seek to maximise current residential and respite capacity to ensure an appropriate response to emerging needs during the year. Emergency cases will continue to be addressed on an individual prioritised basis.

In recognising the service pressures and capacity issues in the sector, for 2019, each CHO and all providers of residential services will be required to implement measures to maximise to the greatest possible extent, the use of existing residential capacity and improve overall value for money in this sector. A range of control measures have been implemented at CHO level over the past two years and these arrangements will be further enhanced in 2019 to ensure that all service providers at local level prioritise the placement of the most urgent cases including the most effective use of 90 placements provided for in 2019. In addition, in order to achieve this objective, the HSE will establish an improvement programme involving the establishment of a dedicated team at national level with responsibility for co-ordination and oversight of all residential places including the most effective use of 90 placements provided for in 2019.

Separately, to support the strategic planning of residential services into the future, the HSE will commence the development of a national commissioning model, which will enable centralised commissioning and local delivery similar to the NHSS on a non-statutory basis.

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.

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. There is a need to further monitor the cost and reliance on agency staff. The use of agency staffing and / or overtime will be strictly controlled.

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 will be required to manage within the available resources while seeking to prioritise services to those in greatest need.

Priorities and Actions

Continue to implement the *Disability Act 2005* – including assessment of need

- Reduce the waiting times for assessment of need under the *Disability Act 2005* through the provision of 100 additional posts.
- Progress Disability Services for Children and Young People (0-18) Programme.

Progress implementation of *Time to Move on from Congregated Settings – A Strategy for Community Inclusion*

- Complete the move of a further 160 people with disabilities from congregated settings to transition to homes in the community in 2019. This is supported by the disability capital investment programme.
- Provide an additional 90 new emergency residential placements.
- Develop a national commissioning model, which will enable centralised commissioning and local delivery similar to the NHSS on a non-statutory basis.
- Establish a dedicated team at national level with responsibility for co-ordination and oversight of all residential places in particular any emergency residential provision.

Provide high quality respite care to persons with disabilities and their families

- Continue to provide 182,506 nights, with or without day respite to people with disabilities. This incorporates the additional capacity from the 51 new respite beds commenced in 2018.

Continue to provide day services and supports to persons with disabilities including young people due to leave school to rehabilitative training

- Progress implementation of *New Directions* national policy on the provision of day services for people with disabilities and strengthen the quality of day service provision throughout all CHOs.

- Continue to provide adult day services and supports for 27,067 adults with physical and sensory disabilities, intellectual disability and autism in over 800 service locations throughout the country.
- Implement the person-centred planning framework in four disability day service provider organisations, and review and evaluate the process with a view to wider application.
- Identify those young people due to leave school or rehabilitative training that will require day placements in 2019 and agree the process to develop and provide appropriate day services for approximately 1,500 young people.
- Continue to implement the interim standards for *New Directions* through the EASI (Evaluation, Action and Service Improvement) process commenced in 2018.

Continue to deliver high quality personal assistant (PA) and home support

- Continue to deliver home support and PA hours to more than 10,000 people with disabilities.

Commence the implementation of the *National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015*

- Commence a pilot project in CHO 6 and 7 to support the roll-out of the *National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015*.

Implement the recommendations arising from the *Report of the Review of the Irish Health Services for Individuals with Autism Spectrum Disorders*, carried out in 2017

- Establish a Programme Board with responsibility for implementing the report's recommendations across the spectrum of existing CHO services and supports (comprising representation of persons with lived experience of autistic spectrum disorder along with senior decision-makers, independent expertise as well as clinicians working in this area).

Advance the personal budgets demonstration projects

- Progress the pilot projects for the implementation of personalised budgets.
- Progress the implementation of a single standardised assessment tool with a view to wider implementation across all disability services.

Strengthen and enhance the governance and accountability of CHOs, service providers / statutory section 38 and 39 service providers and private providers

- Review Part 1 and Part 2 of the service arrangements for section 38 and section 39 service providers and private providers taking account of the recommendations from the independent review group set up to examine the role of voluntary organisations in publicly funded health services.

Progress the roll-out of the revised HSE safeguarding policy in line with DoH national policy

- Continue the implementation of *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures, 2014.*

Mental Health Services

Services Provided

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 a need for less than 10% to be 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.

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 continue to work to develop and enhance community-based services and reduce, where appropriate, those treated in more acute services.

Specialist mental health services are provided in local community areas. 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 the need for mental health services along with service design being informed by expressed 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 will lead to an increased need for services for children and adolescents with a corresponding requirement for service provision both in primary care and in specialist CAMH services. Additionally, Mental Health Services will, in collaboration with Social Inclusion services provide enhanced responses to those with mental illness and co-morbid addiction, those who are homeless with mental illness and to the Traveller community.

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. Between 2014 and a projected outturn for 2018, there will be an increase of 7.2% nationally in the number of referrals accepted by the psychiatry of old age service. The increase in the population aged over 65 years, and especially those over 85 years, will have implications for the psychiatry of later life services. Mental Health will address this challenge by continuing to grow psychiatry of later life teams to provide services to this population.

There is an increasing and more complex nature in the demand for services, particularly for CAMHs. By the end of 2018 it is projected, there will be 12,822 referrals accepted by the community CAMHs teams. In

2019, Mental Health Services will continue to invest in CAMHs through increased staffing of community teams and enhanced day services to reduce admissions and length of stay of young people in acute units.

Youth mental health is a key issue for mental health services and will continue to be a focus for 2019. Service developments will be in line with the recommendations outlined in the *National Youth Mental Health Task Force Report 2017* and will include further development of Jigsaw services.

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, dual diagnosis services for people with mental health illness and addiction, and initiatives in Traveller mental health. Rehabilitation services are also being expanded to respond to the needs of those with enduring mental illness and challenging behaviour.

The clinical care programmes in mental health include early intervention for first episode psychosis, eating disorder services spanning CAMHs and adult services, responses to self-harm presentations at emergency department (ED), those with dual diagnosis of mental health and substance misuse, and attention deficit hyperactivity disorder in adults.

Successfully recruiting and retaining staff continues to present a challenge in mental health services. Measures taken to address this include the provision of funding to increase the number of educational places available for mental health nurses, increased clinical psychology trainee places and the introduction of new disciplines / workers such as peer support etc. Additionally, there is continued investment in facilities that improve the work environment for all. This recruitment challenge can also provide opportunities to deliver service improvements that are focused on increased productivity towards maximising service delivery.

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 in 2019 will provide for an agreed level of mental health services nationally. Where demand for services continues to exceed what can be supplied through the available funding level taking account of realistic and achievable efficiencies, the HSE is required to manage within the available resources and will, therefore, 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, as well as providing safe levels of service through the use of non-permanent staffing arrangements.

Priorities and Actions

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* and continue to deliver evaluated evidence-based programmes through both government and non-governmental organisations as set out in the national training plan for suicide reduction.
- Implement agreed actions as recommended by the work of the National Youth Mental Health Taskforce for those aged 18 to 25 years.
- Implement agreed development of a 24/7 contact line, crisis text line and other eMental health digital responses.
- Work with sports, community and voluntary groups to develop resilience and reduce demand for mental health services.

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 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 model of care for specialist perinatal mental health services through the continued appointment of agreed new staffing resources nationally.
- Implement the recommendations of *A National Framework for Recovery in Mental Health 2018-2020*.
- Provide increased access to talk therapies to improve treatment outcomes for service users.
- Further develop and deliver enhanced peer support workers in line with *A Vision for Change* recommendations.

Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements

- Work to develop a seven day per week service for CAMHs to ensure supports for vulnerable young persons in line with *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020*.
- Progress day programme / day hospital services within CAMHs.
- Develop eating disorder specialist community teams in both adult and CAMH services.
- 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 continued appointment of agreed new staffing.
- Continue to implement enhanced services for those who are deaf and mentally ill.

- Continue planning for the transition to the new national forensic facility which will increase the current bed number to 170 including a 30 bed Intensive Care Rehabilitation Unit due to open in 2020.
- Increase capacity in the existing 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.
- 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.
- Improve compliance through monitoring services, in collaboration with the Mental Health Commission (MHC), to achieve real time oversight supported by ICT automation.
- Further implement the HSE *Best Practice Guidance for Mental Health Services*, through continued development and delivery of training and reporting for quality surveillance.
- Continue to implement a revised HSE *Incident Management Framework 2018*.

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 *A National Framework for Recovery in Mental Health 2018-2020*.
- Continue the implementation of 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.

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 an updated 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.

Older Persons' Services

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 necessary, can avail of high quality residential care. 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.

We will work with the DoH to implement the recommendations of *Sláintecare*, in the areas of integration of services across hospital and community services to face the challenge of the increase in demographics of older people.

Within the budget allocation to the HSE for older persons' services:

- Over 53,000 people will receive home support services, to a total of 17.9m hours.
- Over 230 people will receive intensive home care packages through a further 360,000 hours.
- 28,000 places per week will be provided across 300 day care centres.
- 4,900 long stay and 1,850 short stay public residential care beds will be available.
- Over 10,900 people will be supported through transitional care funding in their discharge from acute hospitals.
- Over 23,042 people on average at any one time in long stay care will be supported by the NHSS.

Issues and Opportunities

In 2019, the HSE will deliver 18.2m home support hours to over 53,000 people including intensive home care packages, representing an increase on 2018 outturn of over 700,000 additional hours. Given the significant and growing pressure of an ageing population and increasing demand for service, it will be essential that CHOs maximise the utilisation of current resources prioritising those requiring discharge from acute hospitals.

A key component in our winter plan will be to improve responses to frail older people in quarter one. It is likely then that the demand for services will outstrip the available provision impacting on waiting lists.

Home support services will continue to be delivered through a single funding model and we will examine options to develop a single assessment process to integrate home support services for both older people and those with a disability to simplify and streamline access for service users.

Community and acute hospital services will continue to develop integrated working arrangements across the health and social care settings to ensure the successful delivery of a range of services to support older people to return or remain at home for as long as possible.

Support to carers is vital in their work in maintaining older people in their own homes and communities. Identifying carers and their needs as early as possible, is of critical importance if they are to be supported in their caring role. The introduction of the Carers' Needs Assessment Tool will be a key step in helping to identify carers at all stages and will also play a role in identifying the supports required. We will also explore how we will develop a programme of support to carers within our own workforce.

In relation to residential service provision, our approach this year having regard to the available resource will be to maximise access to the NHSS for eligible applicants, supporting 23,042 people on average at any one time in long stay care through the NHSS. Every effort will be made to maintain the waiting list at the current four week level, particularly during the peak period of demand during winter 2018 / 2019. We will continue to review and improve service delivery in residential care centres with emphasis on a person-centred care approach.

Maintaining the required workforce and skill set is a challenge across all services and has led to a reliance on agency staffing particularly in residential care services. With the support of the DoH, agreeing a model of residential care staffing and skill mix is a priority for 2019 to assist in developing a sustainable recruitment and retention process. The outcome of the DoH-led value for money (VFM) study will help inform this process. These workforce and cost of care issues also impact our short stay public residential care services. In this overall context, we will review the use of our current short stay bed stock to maximise supports for acute hospital discharge and facilitate hospital avoidance. We will also need to reconfigure the overall public bed stock to a more sustainable level giving rise to a reduction in bed numbers of 80 – 100 beds.

Similarly, home support providers have experienced issues with recruitment leading to some delays in the delivery of home support services. We will continue to work with providers in the context of the outcome of the Tender 2018 in developing home support services in a sustainable way. The process of establishing rosters and team-based approaches for directly provided home support services, delivered by healthcare support assistants (HCSAs), will be implemented across the CHOs, again, leading to more sustainable work patterns, and aiding staff retention.

The implementation of *The Irish National Dementia Strategy* progresses with a focus on developing care pathways across all care settings, implementing flexible and personalised approaches to care. One of the biggest challenges is the growing number of people living with dementia, many of whom have complex care needs, and the demands this places on available services.

The support of communities and voluntary agencies, is hugely valued in both social and health service provision. Integration of services including, local and community-based activity is a key fundamental to maintaining older people at home.

Priorities and Actions

Continue to provide older persons with home support

- Strengthen our governance and management capability and work with our home support service providers to improve the quality and reliability of service to recipients, through new procurement arrangements, with external providers and revised contracts for directly employed staff.
- Provide additional home support of 410,000 hours to a level of 18.2m hours, (including intensive home care package values) to an average of just over 53,000 people, at any one time.
- Target 550 people with home support, to return home from acute hospitals, during the winter period.
- Ensure that each CHO area has a core service of direct HSE provision to enable continuity in any crisis of delivery, arising from an inability of other funded providers to deliver the service.
- Support the DoH in relation to the development of plans for a new statutory scheme and system of regulation for home support services.

- Develop and implement a 'Discharge to Assess' protocol for people who require home support to leave hospital. This will allow for the review of home support hours following an initial period post discharge in recognition that people may require a different level of service, when they are at home, after a period post discharge.

Provide quality and safe residential and transitional care to meet the needs of older persons

- Maximise the use of residential care services including transitional care to support hospital avoidance and discharge requirements.

Continue to administer the Nursing Homes Support Scheme within the available resource

- NHSS is forecast to support 23,042 people on average in residential care at year end 2019.
- Legislative changes will be introduced to benefit those requiring the support of the scheme who may have farms or small businesses.
- Finalise the reconfiguration of nursing home support offices to improve our services to the public.

Implement *The Irish National Dementia Strategy* through the National Dementia Office

- Maintain the current provision of memory technology resource rooms across 20 sites providing a network of resource for people with dementia and their families / carers.
- Continue the roll-out of the Dementia Understand Together campaign with a specific focus on community activation.
- Continue to develop the most appropriate model for a dementia registry.
- Implement the learnings and outcomes from the HSE / Genio-supported dementia specific initiatives which focus on personalised and flexible approaches to care.
- Continue the roll-out of primary care team dementia education.
- Continue to develop national clinical guidelines on the use of psychotropic drugs in dementia.

Continue to provide day care and other community supports either directly or in partnership with other providers

- Continue to provide a broad range of other community and voluntary services including, meals on wheels, social satellite services, befriending services etc. to older people.
- Provide 28,000 day care places per week across 300 day care centres.
- Enable voluntary providers to seek support for urgent and enhanced services levels with 25% to be allocated specifically for dementia-related services.
- Provide support to existing supported care home services in CHO 5, to maintain existing services in accordance with regulations.
- Enhance support to the community support project which commenced in 2018 with the provision to facilitate the current service in North Dublin, Louth, Meath and Midlands centres, in conjunction with ALONE.

Progress the roll-out of the revised HSE safeguarding policy in line with DoH national policy

- Progress the roll-out on a phased basis of the revised HSE safeguarding policy across all community health and acute care areas including mental health and primary care, through raising awareness and on-going training with staff and service providers.
- Prepare for the Introduction of HIQA / MHC new national standards in adult safeguarding.
- Support the development of the DoH national policy, in adult safeguarding.

Continue the falls prevention and bone health programme

- Progress the AFFINITY and bone health programme across all services in developing an integrated approach to the prevention and management of falls.

Continue the implementation of the Single Assessment Tool across all CHOs

- Commence the development of a single assessment process to integrate home support services for both older people and those with a disability, to simplify and streamline access for service users.
- Develop a module specifically for carers, and support its implementation.

National Carers' Strategy – Recognised, Supported, Empowered

- Continue to implement the health and social care related actions in *The National Carers' Strategy – Recognised, Supported, Empowered* and support the DoH to elaborate an action plan for the further implementation of the strategy.

Continue implementation of the integrated care programme for older persons

A range of initiatives to progress the roll-out of the ICP for Older Persons is proposed. This programme provides specialist care bridging hospital and community services and is effective in reducing ED attendances and admission.

- Continue to develop and embed new models of integrated care in 13 existing pioneer sites nationally. This includes the development of redesigned care pathways and ensuring linkages with other strategic changes that are underway (dementia services, home support, falls prevention initiatives, SAT).
- Work with the Office of the Chief Information Officer to develop ICT support for integrated care and work towards refining and integrating data collection into a national KPI data suite.
- Work with Age Friendly Ireland and the third sector in engaging older people in service redesign.

Palliative Care Services

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 either at home, in hospices or 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. Improving access to specialist palliative care inpatient beds for adults remains a challenge in a number of geographic areas. Supporting individuals who wish to be cared for at home and to remain at home for end of life care remains a priority.

We are continuing to work with local hospice organisations to progress the hospice development plan. We will continue to partner local voluntary organisations to improve access to quality care in the community. The heavy reliance on voluntary fundraising along with staff recruitment and retention remains a significant challenge within the sector.

Priorities and Actions

Improve access, quality and efficiency of palliative care services

- Expand the provision of specialist palliative care inpatient beds.
- Progress the opening of three new inpatient units in quarter four, in Waterford, Mayo and Wicklow, with them reaching full capacity of 49 additional beds in 2020.
- Achieve the full extension of service in St Brigid's, Kildare.
- Commence the implementation of the Palliative Care Model of Care.
- Continue the implementation of the *Palliative Care Services – Three Year Development Framework 2017-2019*.
- Continue to partner local voluntary organisations to improve access to quality care in the community.
- Support sustainable services for Marymount Hospice and St. Francis Hospice in line with agreed plans.
- Support the DoH in the revision of national palliative care policy.
- Continue the implementation of the Children's Palliative Care Programme within available resources.

Acute Hospital Care

Introduction

Acute services, including scheduled care (planned care), unscheduled care (unplanned / emergency care), specialist services, diagnostics, cancer services and maternity and children's services, are provided for adults and children by 49 acute hospitals within six Hospital Groups and Children's Health Ireland. These services are provided in response to population need, consistent with wider health policies and objectives, including those of *Sláintecare*. Hospitals continually work to improve access to healthcare, whilst ensuring quality and patient safety issues, including management of infection, are prioritised within allocated budgets.

Hospitals play a key role in improving the health of the population by providing a range of health services, ranging from brief intervention and self-management support and early diagnosis to optimum care pathways and specialist tertiary services. Changes to the demographic profile of the population require increasing integration of acute services with primary and community care services through Integrated Care Programmes (ICPs) for older persons, children, and for patients with chronic diseases. There is a strong focus at national and Hospital Group level, working with CHOs, on the redesigning of health services to promote greater integration.

The *National Cancer Strategy 2017-2026* promotes early detection of disease in order to optimise patient outcomes, and acute hospitals continue to support aspects of screening services for bowel, breast and cervical cancer as well as rapid access pathways for breast, lung and prostate cancers. Acute hospitals also provide follow-up care for patients from the screening programmes in collaboration with the NSS. Implementation of the recommendations of the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* will continue in 2019.

Issues and Opportunities

Demand for acute services continues to grow as the population expands and ages and as technological advances facilitate new interventions in disease management. *Sláintecare* emphasises the need to invest in increased capacity while also shifting the balance of care from hospitals to community services for better health outcomes and a more sustainable health service. We will strive to continue to improve length of stay and rates of conversion from inpatient to day case activity which will also contribute to managing demand for acute care.

Bed occupancy is continuing to exceed 95% (*Health Service Capacity Review 2018*), which is above international norms and presents significant pressure on acute services. The lack of single room availability is also a particular challenge in relation to the management of HCAIs. Much of the acute services are demand driven with demand expected to increase again in 2019 similar to previous years. Acute and community services are working jointly to develop a range of integrated plans aimed at reducing the reliance on acute hospitals and improving access to diagnostics, particularly for low acuity conditions and with the aim of reducing emergency attendances and emergency admissions. The time to implement the bed capacity review means that the system will continue to operate in excess of 95% capacity for 2019 with associated risks in terms of patient experience and outcome.

Waiting time for admission following ED attendance is improving due to patient flow initiatives. However demand still outweighs capacity, particularly for inpatient beds, and regrettably some patients can still wait longer than they should for admission when presenting as an emergency. New ED presentations and admissions are expected to increase further in 2019, and provision for this is outlined in the activity schedule as acute services of necessity prioritise urgent patients. The continued switch from inpatient elective treatment to day cases and outpatients, coupled with the requirement to manage capacity in line with the significant increase expected in emergency admissions will influence elective inpatient activity in 2019. As a result, a strong focus will be put on maximising elective treatment activity in the context of significant increased demand for beds following ED presentation. Various programmes of work, described in this plan will give effect to this. Day case activity will increase by nearly 14,000 cases over the 2018 planned activity (Appendix 3(c) refers).The HSE will work closely with the NTPF in order to mitigate the impact of this on patients and collaborate also with NTPF and clinical programme colleagues on the achievement of waiting time targets for elective care. The achievement of the targets also assumes that the NTPF resource will continue to be targeted at longest waiters.

There is also evidence of surgical waiting lists containing patients who do not require surgical treatment and may be more appropriate for management through alternative clinical pathways. Actions in this regard are being pursued in the area of scheduled care. Improving access to inpatient and day case elective procedures and to outpatient consultations remains a constant challenge which the service is continuing to address by implementing waiting list action plans aligned to the *Sláintecare Implementation Strategy*, and by working with the NTPF to drive the roll-out of the *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.*

The number of patients undergoing surgical procedures annually in acute hospitals continues to increase (a 16.2% increase since 2010) while bed day usage has decreased by 9.7% in the same period. This has been achieved by driving improvements in inpatient to day case conversion, reducing average length of stay (ALOS) and increasing day of surgery admission. Length of stay targets are set at feasible levels for 2019 and the hospitals will continue to strive for improvements in this regard within the constraints of current bed occupancy levels. Acute services will continue to implement improvements in capacity usage with further scoping of incentivisation schemes, e.g. day case laparoscopic cholecystectomy, transfer of minor procedures to appropriate low acuity settings, analysis of referral pathways and the application of Health Technology Assessments.

The continued implementation of the *National Cancer Strategy 2017-2026* and the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* will also lead to improvements in the standard of acute clinical care. However, the NCCP allocation for 2019 will not enable the service to match referral demands in areas such as radiotherapy, rapid access cancer clinics and diagnostics.

There is also a renewed focus on activity based funding (ABF) with the advent of *Sláintecare*. In 2019 the HSE will undertake a review of work completed to date in terms of data quality, costing and incentives such as the Hip Fracture Tariff Uplift. Working with the DoH, the HSE will set out a roadmap for enhancing the existing infrastructure and developing the use of the funding mechanism to drive greater efficiency. The Hospital Groups will also continue to optimise their income potential following the external review of income-billing processes.

NSP2019 sets out the range of acute services for patients within the funding provided while also managing for patient safety and risk. A set of measures to improve the efficiency and the effectiveness of services is required in order to manage within available resources. These measures include:

- Implementation of value for money savings through improved procurement.
- Reducing agency and overtime costs.
- Controlling staff numbers to funded levels.
- Maximising the use of drugs with proven cost effectiveness such as biosimilars.
- Driving further efficiencies in relation to the utilisation of acute services.
- Preventing unplanned growth in relation to diagnostic tests and therapies, including drug therapies in order to stay within the funding levels available.

The financial context for 2019 is challenging, particularly in light of the growing demand for services. The acute service levels are calibrated to align activity with the available resources in 2019.

The activity profile for acute services as set out in NSP2019 is dependent on the delivery of the above measures in a safe and sustainable manner having regard to risk. Key risks to be managed in this regard include the need to:

- Maintain safe staffing levels to deliver front line patient services.
- Provide for infection prevention and control of HCAIs in hospitals.
- Manage critical care bed access and utilisation in the context of existing bed capacity.
- Manage growing demands for diagnostic testing and new drug therapies beyond affordable levels to support both GPs and acute services.

Overarching Priorities and Actions

Improve quality of care and patient safety

- Enhance quality and patient safety governance structures, patient partnership initiatives and monitoring systems, including the continued roll-out of clinical audit and patient registers.
- Manage antimicrobial resistance and infection prevention within available resources in accordance with HIQA standards and the *National Action Plan on Antimicrobial Resistance 2017-2020.*
- Improve compliance with medication safety standards in acute hospitals.
- Implement the *EU Falsified Medicines Directive 2016 / 161* to ensure an end-to-end verification system is in place in hospitals.
- Support hospitals to ensure completion of a self-assessment against the *National Standards for Safer, Better Healthcare*, as preparation for hospital licensing in the future.
- Support the design and development of clinical guidelines in conjunction with the Chief Clinical Officer.
- Improve compliance with Children First through enhanced awareness, information and training.

Improve integration between community and acute services to promote a modernised and streamlined service model in line with *Sláintecare.*

- Develop joint plans for scheduled and unscheduled care that promote integrated service provision through outreach services, telemedicine, virtual health clinics, integrated assessment services and cross-sector working, which will support independence and choice for patients.

- Co-ordinate cross-cutting and effective service delivery between community and secondary care in a way that promotes enhanced use of technology.
- Ensure alignment of service developments in both acute and community service areas where there is an opportunity to build upon existing pathways of care (e.g. frail intervention therapy teams and older persons' services) which provide the most gain for patient outcomes across community and acute services.

Improve patient and staff health and wellbeing by implementing *Healthy Ireland* plans

- Support the on-going implementation of *Healthy Ireland* plans in Hospital Groups.

Improve performance management of operational services

- Monitor and manage financial allocations in line with the Performance and Accountability Framework.
- Implement the comprehensive framework for consultant contract compliance.
- Review work completed in terms of data quality, costing and incentives as part of the renewed focus on ABF.
- Monitor activity and ensure that service providers maintain performance against required activity targets.

Support the development of eHealth capability

- Continue to roll out the Integrated Patient Management System through engagement with the Office of the Chief Information Officer, Hospital Groups and other stakeholders, primarily focusing on the projects in Children's Health Ireland and the Saolta University Health Care Group.
- Support the implementation of eHealth programmes such as the Maternal and Newborn Clinical Management System (MN-CMS), the National Integrated Medical Imaging System (NIMIS) and the Individual Health Identifier (IHI).
- Continue the planning for the implementation of the National Electronic Healthcare Record with the initial focus for phase 1 in the new children's hospital.

Support the progress of policies and initiatives led by the Office of the Chief Nursing Officer

- Roll out the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland 2018* in model 4 hospitals, and establish the National Safe Nurse Staffing Unit within available resources.
- Support the pilot for the phase 2 Framework for Staffing and Skill Mix for Nursing in Emergency Care Settings in conjunction with the DoH and within available resources.

Scheduled Care – Planned care

Priorities and Actions

Improve access to scheduled care, maximising the resources available

- Reduce waiting times to promote fair, timely access to services, within available resources.

  - Reduce waiting times for access to scheduled care on a phased basis, as set out in *Sláintecare.*
  - Develop and implement waiting list action plans for patients in outpatient, day case and inpatient scheduled care areas with a particular focus on long waiting patients.
  - Support and progress cross-cutting initiatives between primary and secondary care that focus on reducing waiting times for scheduled care services and delivery of services closer to home.
- Enhance capacity in secondary care to promote a safe, quality scheduled care service.
  - Improve internal efficiencies and appropriate bed usage by striving to reduce average length of stay and improve access to diagnostics.
  - Maximise the move from inpatient to day case activity in line with clinical guidelines and international norms.
  - Implement the NTPF *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.*
  - Extend the clinical prioritisation system into the day case and inpatient areas for four specialties (urology, otolaryngology, ophthalmology and orthopaedics).
  - Plan for the implementation of the hub and spoke delivery model to enhance the provision of scheduled care services in line with *Securing the Future of Smaller Hospitals: A Framework for Development (2013)*. This will include planning for the redesign proposals in relation to Our Lady's Hospital, Navan.
  - Progress the development of care pathways in the outpatient, day case and inpatient areas, with a particular focus on the urology and ophthalmology clinical specialty areas.
  - Roll out the new minimum data sets to support outpatient, day case and inpatient activity areas.
- Improve interaction between primary and secondary care to promote a modernised, integrated service model.
  - Develop and implement the three-year Elective Care Plan, aligned with the work of the *Strategy for the Design of Integrated Outpatient Services 2016-2020* and the 2018 *Sláintecare Implementation Strategy*.
  - Refine proposals for advanced practitioner-led clinics (e.g. increased use of physiotherapists, clinical nurse specialists, advanced nurse practitioners, optometrists, etc.) in key specialties with the longest waiting lists, with a strong focus on delivering services closer to home.
  - Implement the service provision agreement approach as a key commissioning tool.
  - Develop the business case for a digital care pathway system that enables patient access to a self-management portal, including decision support, electronic referral to the appropriate healthcare setting, and eTriage capability as well as providing transparent monitoring of all elements of the patient journey.
  - Undertake the necessary planning for the establishment of new elective, ambulatory and urgent care centres in line with national policy on elective hospitals, once developed and agreed by the DoH.
  - Develop plans for improved access to radiology diagnostics by continuing to work collaboratively with the National Clinical Programme for Radiology, Hospital Groups, the NIMIS and the NTPF.
  - Develop measures to promote safe and effective medical and surgical interventions and reduce the delivery of clinically ineffective interventions.

Unscheduled Care – Unplanned / emergency care

Priorities and Actions

Improve access to unscheduled care, maximising resources available

- Commence work on the redesign of services in line with *A Trauma System for Ireland* and *Sláintecare* and within the context of the three-year Plan for Unscheduled Care and the Five Fundamentals of the Unscheduled Care Programme (leadership and governance, patient flow (pre and post admission), integrated services and using information to measure and monitor improvement).
- Plan activity and ensure alignment with the *Sláintecare Implementation Strategy* to anticipate and manage critical demand pressures, most particularly during winter. An integrated approach to planning for increased demand on services has been applied by acute and community services to put the following in place:
  - Winter 2018 / 2019 – Increase acute bed capacity by 75 beds (part year) across ten locations with particular focus on maximising available capacity during the winter months.
  - Winter 2019 / 2020 – Plan and prepare for a further increase in acute bed capacity of 202 beds (including 16 critical care beds) across 14 locations, to be operational by quarter 1, 2020.
- Improve access to unscheduled care through integrated action with community services, with the focus on:
  - Continuing to improve access to diagnostics.
  - Improving clinical pathway implementation for admitted patients to ensure that variances in average length of stay, particularly for medical patients, are monitored and reduced where possible.
  - Developing admission avoidance pathways, providing care closer to home and improving services for frail older persons within acute hospitals and in the community as part of care redesign.
  - Developing proposals for enhanced senior decision-making capacity in emergency medicine to deliver more timely and appropriate assessment, streaming, treatment and care so that patients are seen and treated by the most appropriate clinician, at the right time and in the right place.
- Continue to commission additional high dependency unit beds in the Mater Misericordiae University Hospital (MMUH) and Cork University Hospital (CUH), an additional 30-bed ward in Our Lady of Lourdes Hospital Drogheda, and a 40-bed modular ward block in South Tipperary General Hospital.
- Plan for the implementation of the Emergency Medicine Early Warning System (EMEWS) in pilot areas to ensure safer patient care.
- Implement the acute floor clinical design model as an integration and co-ordination mechanism for unscheduled care presentations.
- Ensure protocols for rapid access to diagnostics and treatment for stroke care in EDs are in place and operating consistently.

Specialist Services

Priorities and Actions

Progress the implementation of *A Trauma System for Ireland*

- Recruit a national clinical lead and establish the National Office for Trauma Services.

- Designate the major trauma centre and trauma unit(s) for the central trauma network.
- Prepare the implementation plan for the further recommendations of *A Trauma System for Ireland.*

Develop and improve national specialist services

- Progress the opening of transplant service beds for pre, peri and post-transplant related activity in MMUH.
- Further develop the national organ retrieval service in compliance with the European Working Time Directive (EWTD).
- Implement the recommendations of the National Genetic and Genomic Medicine Network Strategy Group Report with the recruitment of a national clinical lead associated with an academic centre, a lead for genetics diagnostics and a programme manager.
- Support the roll-out of a Laboratory Information System in acute hospitals.
- Support the implementation of recommendations of the policy review on sexual assault treatment units, once completed, including the provision of enhanced resources in 2019 to support the phased implementation, and support the continuing professional development of forensic examiners.
- Continue to support bariatric surgery and weight management services within existing resources.
- Implement the HSE's response to Valproate Plan to ensure the safe prescribing of Epilim (Valproate) for women of childbearing age.
- Continue service enhancements in GI physiology, the national neonatal transport programme, deep brain stimulation, narcolepsy, spina bifida, intestinal failure, and paediatric otolaryngology (ENT) complex airways management, which commenced in 2018 in association with the national clinical programmes.

Cancer Services

Services Provided

Dealing with illness is a significant challenge for those diagnosed with cancer and their families. Each year approximately 38,000 people in Ireland develop cancer (National Cancer Registry Ireland, 2016). Cancer is the second most common cause of death after diseases of the circulatory system such as heart attack or stroke. The risk of developing cancer increases with age therefore rates are not expected to reduce as our population of over 65s increases. However, due to developments in the available treatments and organisation of services in Ireland, more people are living with cancer and survivorship support programmes are now a very important component of care.

The configuration and co-ordination of cancer services within the HSE is led by the National Cancer Control Programme (NCCP) which was established in response to the *National Cancer Strategy – A Strategy for Cancer Control in Ireland 2006*. The 2006 strategy advised that Ireland needed a comprehensive cancer control policy programme. A subsequent strategy, the *National Cancer Strategy 2017-2026* was published in 2017 to build on the developments driven by the earlier strategy and its implementation is a key priority for 2019.

Services for the treatment of cancer include surgery, radiotherapy and systemic anti-cancer therapy (SACT). The majority of cancer surgery now takes place in the designated cancer centres. Nine hospitals are designated cancer centres (with a satellite unit in Letterkenny University Hospital). A further 17 public hospitals provide SACT (chemotherapy, immunotherapy, etc.).

The National Programme for Radiation Oncology (NPRO) provides the strategic direction for the provision of radiotherapy services across Ireland. There are five public sites for radiotherapy with an additional two private centres (under service level agreement) that provide radiotherapy treatments. The NPRO phase 2 capital development is in progress at the CUH and University Hospital Galway (UHG) sites. 2019 will also see the continued development of the cross-border radiotherapy initiative at Altnagalvin.

Issues and Opportunities

The demand for cancer services, including chemotherapy, radiotherapy, surgery and medical care is continuously rising as the incidence of the disease increases and treatment and mortality improves. Therefore, the costs associated with cancer treatment and in particular cancer drugs are increasing every year.

Many cancers can be avoided by living a healthy lifestyle, for instance by not smoking, consuming only moderate amounts of alcohol, maintaining a healthy body mass index and availing of cancer screening services. Therefore, cancer prevention and early detection initiatives are key to reducing the cancer burden on people and on the health service. A Cancer Prevention Network has been established, including a number of charitable and voluntary organisations which have a cancer prevention focus. The network is actively supporting health and wellbeing and *Healthy Ireland* initiatives which engage the public in positive health behaviours. Preventative efforts will be particularly directed at more deprived or at risk populations. Cancer control will continue to develop integrated care programmes in collaboration with GPs and specialist colleagues. Following on from the National Survivorship Needs Analysis, a model of care is in development to support those living with and beyond cancer.

Managing increased demand as a result of growth expected in the number of cancer patients, and particularly 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.

Management of the reimbursement of cancer drugs by the Primary Care Reimbursement Service (PCRS) is through the Oncology Drug Management System.

To ensure services are underpinned by evidence and best practice, services are monitored against agreed performance parameters. The 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.

The successful implementation of the strategy requires a strengthening of the NCCP commissioning role, on-going leadership and ensuring that priorities are always aligned with desired outcomes at national and local level.

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. The strategy sets out four key priorities:

- Reduce the cancer burden.
- Provide optimal care.
- Maximise patient involvement and quality of life.
- Enable and assure change.

Priorities and Actions

Reduce the cancer burden

- Strengthen the prevention and early detection function of the NCCP.
- Contribute to the national skin cancer prevention action plan.
- Support health and wellbeing and *Healthy Ireland* initiatives which will engage the public in positive health behaviours.
- Develop a rolling programme of early detection initiatives to improve early diagnosis of cancers.

Provide optimal care

- Progress the development of an adolescent and young adult service within Children's Health Ireland and the adult services.
- Continue focus on the NCCP rapid access clinic KPI improvement recommendations for breast, lung and prostate cancers.
- Continue focus on the implementation of the surgical oncology centralisation project.
- Support the expansion of the NPRO including NPRO phase 2 developments and the cross-border radiotherapy initiative.
- Monitor and evaluate the provision of private radiotherapy providers in University Hospital Limerick (UHL) and University Hospital Waterford.

- Further develop cancer clinical guidelines, GP referral guidelines, follow-up protocols and national chemotherapy regimens.
- 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.
- Roll out and implement the NCIS (National Cancer Information System), formerly the Medical Oncology Clinical Information System and the NCIS multi-disciplinary meeting module.
- Progress the development of an oncology service for older persons.
- Progress development of a national cancer genetics programme.

Maximise patient involvement and quality of life

- Develop comprehensive survivorship care plans for those living with and beyond cancer.
- Prioritise psycho-oncology services as a core part of cancer care.
- Encourage active participation by patients, as partners, in the development of cancer care guidelines and strategic initiatives.
- Implement the recommendations of the national survivorship needs assessment.

Enable and assure change

- Ensure appropriate clinical and non-clinical staff are in place across cancer services nationwide within available resources.
- Support the development of national leads and sub-specialisation as identified in the *National Cancer Strategy 2017-2026*.
- Improve quality and patient safety in cancer services by enhancing a specifc quality framework for cancer care in line with the HSE quality framework.
- Strengthen the research and clinical guidelines function within the NCCP and across cancer services nationwide.

Women and Children's Services

The HSE is committed to the development of health services for women and children. The strategic development and organisation of maternity, benign gynaecology and neonatal services is being led by the National Women and Infants' Health Programme (NWIHP). The ICP for Children aims to improve the way healthcare services are designed and delivered to children and their families, including the development of the national paediatric model of care. The focus of both is on strengthening services by bringing together primary, community and acute services in an integrated way.

Women and Infants' Health Programme

Services Provided

Ireland's first *National Maternity Strategy 2016-2026 – Creating a Better Future Together* was launched in January 2016. The strategy sets out a blueprint to significantly improve the service provided to mothers and their babies. The implementation of the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* is a key priority for the HSE, and is underpinned by four core principles:

- Health and wellbeing;
- High quality, safe, consistent, women centred care;
- Facilitation of appropriate choice for women;
- Maternity services with appropriate resourcing, governance and leadership.

There are 19 maternity hospitals / units in the acute hospital sector. The hospitals / units vary from four standalone maternity hospitals with an annual number of births of between 4,500 and 9,000, and 15 units within general hospitals where the number of births per annum is between 1,000 and 8,500. The diversity of the scale of the operations in the different locations adds to the complexity.

Issues and Opportunities

The clinical and corporate governance of maternity services are central to the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* and HIQA standards. Recent reports into adverse events within maternity services have highlighted the imperative of maternity networks in enabling the provision of safe care and it is essential that a consistent approach to the delivery of maternity services is achieved. The absence of full provision for 2018 developments will result in delays in the commencement of certain key staff in 2019. Whilst there are a number of significant challenges associated with the formation of these maternity networks, the opportunities for the establishment of solid maternity networks are beginning to be realised. These include but are not limited to robust referral pathways, consistent clinical protocols, regional-based educational programmes and shared learning, clinical governance and management arrangements and enhanced oversight and deployment of resources. The development of maternity networks within each Hospital Group will create the vehicle by which this can be achieved, with the NWIHP providing the overview and connectivity at national level.

The outcome of the referendum on the Eighth Amendment means that termination of pregnancy will be legislated for, with a start date of 1st January 2019. Termination of pregnancy planning is well advanced, with the clinical guidelines and model of care in the process of being finalised. The roll-out of this service is

a key priority for the HSE with the NWIHP collaborating closely with other sections of the HSE in this regard.

In July 2018 the Minister paused the use of transvaginal mesh devices. The NWIHP is now working with a group of experts to develop appropriate consent forms and information for women; a system of training and credentialing; and the development of a register for transvaginal mesh device procedures. This work is being carried out at the request of the Chief Medical Officer and the HSE is preparing a detailed implementation plan for the complete set of recommendations on the use of transvaginal mesh, working in conjunction with other stakeholders.

The implementation of the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* will require significant additional investment to target deficits in the workforce, in technology and in basic infrastructure. The NWIHP is responsible for targeting that investment to ensure the successful implementation of the plan. The priorities and actions set out below are informed and guided by the suite of recommendations identified in the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* and also include work streams in the area of women's health which have been allocated to the NWIHP since its inception.

Priorities and Actions

Improve services for women and infants guided by the *National Maternity Strategy 2016-2026 – Creating a Better Future Together*

- Continue to drive the development of robust maternity networks within each of the Hospital Groups.
- Plan for and support the establishment of a Serious Incident Management Forum for maternity services in each Hospital Group.
- Ensure anomaly scanning is available to all women attending ante-natal services.
- Pilot the anaesthetics model of care for general hospitals with maternity services.
- Implement a phased national plan for benign gynaecology.
- Identify the suite of clinical guidelines required in maternity services and manage any gaps identified in terms of the development / review of new or existing clinical guidelines.
- Support and enable the implementation of a safe, high quality termination of pregnancy service.
- Define the detailed care pathways to be made available to women in all maternity services based on the model of care proposed in the national strategy thereby enabling a standardised and consistent planning approach.
- Prepare a detailed implementation plan for the recommendations set out in the report on the use of transvaginal mesh.
- Assess midwifery workforce levels against the 2016 Birth Rate Plus methodology within the context of the new model of care.
- Develop a national suite of KPIs for maternity services, including the model of care, which will enable on-going review of services at local, regional and national level.
- Identify and define the educational supports and training programmes required by staff to ensure a safe, competent and supported maternity workforce.

Paediatric Model of Care

Services Provided

Children comprise approximately 25% of the population. A national model of care has been developed to describe how children should be cared for in acute and community settings. The model of care sets out the vision for high quality, integrated, accessible healthcare services for children from birth to adulthood. The model aims to ensure that all children should be able to access high quality services in an appropriate location, within an appropriate timeframe, irrespective of their geographical location or social background.

Immunisation and early years intervention programmes are provided for children through public health, and health and wellbeing services, with community programmes including developmental screening and paediatric home care packages provided through primary care services. Specific initiatives for children with disabilities and mental health issues are also provided through community services. Acute paediatric services are provided in acute hospitals in Ballinasloe, Castlebar, Cavan, Clonmel, Cork, Drogheda, Dublin, Galway, Kilkenny, Letterkenny, Limerick, Mullingar, Portlaoise, Sligo, Tralee, Waterford and Wexford. The *Children's Health Act 2018* (No 27 of 2018) provides for the establishment of a single statutory entity, Children's Health Ireland, to provide paediatric services, including taking responsibility for the services currently provided by the existing three Dublin children's hospitals.

Issues and Opportunities

The vast number of healthy children can be cared for through a range of primary care supports, vaccination schemes, parental education and wellbeing programmes. Significant work is being undertaken through the Healthy Childhood and Nurture Programme in this regard. However, children's healthcare needs are becoming increasingly complex and are changing due to, for example, increased survival of extreme prematurity, increased numbers of children with chronic health issues, allergies and obesity.

The national model of care strongly advocates a network model where a large unit providing more complex care supports a number of smaller units within a geographical area. The new children's hospital and the two paediatric outpatient and urgent care centres provide for this service design on two fronts. The new children's hospital will be the national hub providing support to the regional and local units and will act as the hub for the two paediatric outpatient and urgent care centres in the delivery of secondary paediatric care within the greater Dublin area. The model of care explicitly supports the development of the new children's hospital and an integrated national network for paediatrics, with strengthened and interconnected roles for local and regional paediatric units.

The initial priorities for children's services nationally are the progression of the children's hospital programme, which in 2019 will see the opening of the paediatric outpatient and urgent care centre at Connolly Hospital, Blanchardstown, and also the development of paediatric services in the regional centres Cork, Galway and Limerick.

Priorities and Actions

Continue to oversee the new children's hospital development and development of paediatric services

- Provide oversight of the new children's hospital development in line with the governance structures in place – in particular the Children's Hospital Project and Programme (CHP&P) Steering Group.

- Continue the work of the Children's Hospital Integration Programme planned for 2019 as part of the on-going corporate, clinical and operational merging of services.
- Open the new Paediatric Outpatient and Urgent Care Centre at Connolly Hospital in 2019, including the recruitment of the relevant staff to support the expansion of a consultant-delivered workforce and increased capacity through additional outpatient clinics.
- Commence the roll-out of the paediatric model of care in 2019.
- Continue the development of acute paediatric units in CUH, UHG and UHL, in line with the paediatric model of care, including additional consultant paediatricians, clinical nurse specialists and allied health professionals.
- Continue the development of the all-island paediatric cardiology service in Children's Health Ireland (Crumlin Services) and the development of the paediatric cardiology network in CUH, UHG and UHL.
- Increase the staffing for paediatric rheumatology to improve the access and timelines of treatment.
- Continue to build on the improvements in access to paediatric orthopaedics including surgery for scoliosis to ensure clinically appropriate waiting times.
- Continue close working between Cappagh Orthopaedic Hospital and Children's Health Ireland (Temple Street) to ensure that children / young adults have their scoliosis surgery undertaken in the most appropriate setting, based on clinical need and within clinically appropriate timeframes.
- Continue the implementation of the care pathway for the transition of adolescents with scoliosis from Children's Health Ireland (Crumlin Services) to the MMUH.
- Appoint an additional allergy consultant, genetics consultant and dermatology consultant in Children's Health Ireland to address capacity and reduce waiting lists for these services.
- Increase staffing to include a consultant haematologist and advanced nurse practitioners for the haematology stem cell transplant service, to address increase in demand.
- Appoint two additional clinical nurse specialists to the outpatient antibiotic therapy service that allows suitable patients on intravenous antibiotics to be discharged early from hospital and treated in their home.
- Appoint an advanced nurse practitioner to the paediatric neurosurgery service in the Children's Health Ireland (Temple Street).
- Further develop the service for Cardiac Risk in the Young (CRY) in order to address the increase in the number of patients needing to be screened in Tallaght University Hospital.

National Ambulance Service

Services Provided

The National Ambulance Service (NAS) is the statutory pre-hospital emergency and intermediate care provider for the State. In the Dublin metropolitan area, ambulance services which are funded by the HSE are provided by the NAS and Dublin Fire Brigade. The NAS mission is to serve the needs of patients and the public as part of an integrated health system, through the provision of high quality, safe and patient-centred services. This care begins immediately at the time the emergency call is received and continues through to the safe treatment, transportation and handover of the patient to the clinical team at the receiving hospital or ED.

In the continued implementation of a significant reform agenda, the service is moving towards a more multi-dimensional urgent and emergency care provision model which is safe and of the highest quality. This is in accordance with international trends, the desire to implement the recommendations of the various reviews into the service and the ultimate aim of improving patient outcomes whilst ensuring appropriate and targeted care delivery.

The NAS responds to over 300,000 ambulance calls each year, employs over 1,800 staff across 100 locations and has a fleet of approximately 500 vehicles. In conjunction with its partners the NAS transports approximately 40,000 patients as part of the Intermediate Care Service, co-ordinates and dispatches more than 800 aero-medical / air ambulance calls, completes 600 paediatric and neonatal transfers and supports community first responder schemes.

Issues and Opportunities

There is an on-going challenge in achieving compliance with response time targets, particularly for calls in rural areas because of the longer travel distances, and this challenge is recognised in the base line capacity review report commissioned in 2014 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 HSE and the NAS.

As part of the long term evolution of the service and in recognition of the opportunity to engage in the implementation of *A Trauma System for Ireland* and the *Sláintecare Implementation Strategy,* the NAS is embarking on a change pathway from an emergency medical service to a mobile medical service.

Priorities and Actions

Support the *Sláintecare Implementation Strategy*

- Continue to work collaboratively with healthcare providers to identify and develop alternative patient care pathways and a directory of services.
- Target capacity deficits identified in the *National Ambulance Service of Ireland, Emergency Service Baseline and Capacity Review*.
- Continue to support the NAS Critical Care and Retrieval Service.
- Continue to support and expand community first responder schemes in line with the *National Ambulance Service of Ireland, Emergency Service Baseline and Capacity Review*.

Implement *A Trauma System for Ireland*

- Implement trauma and orthopaedic bypass protocols in parallel with the implementation of the recommendations of *A Trauma System for Ireland*.

Deliver improved governance and patient safety

- Progress the implementation of additional clinical key performance indicators.
- Complete the move from paper-based patient data collection in clinical operations to an electronic patient care record.
- Continue to support the NAS business continuity and emergency planning function.
- Continue to develop NAS monitoring and assurance mechanisms for quality and patient safety and risk and incident management.
- Implement the NAS fleet and equipment plan.
- Continue to integrate further into the Healthcare Delivery System to ensure seamless care delivery.

Section 7:
Finance

Finance

Summary

The headline 2019 budget level of €16,050m received from the DoH is a €848m / 5.6% year on year budget increase over and above the **final** 2018 budget of €15,202m.

The 2019 funding includes Dormant Accounts funding of €2.5m and €198m of Development Funding, €20m of which relate to the full year cost of 2018 developments, with €178m relating to new 2019 developments.

Accordingly €15,869m is available to meet:

1. The estimated 1st charge from 2018. This will not be known until the AFS are signed off in 2019, but is estimated for planning purposes at €114m.
2. The cost, in 2019, of the existing level of service activity in place by the end of 2018. This includes centrally agreed pay rate and pension changes as well as other price increases.
3. The cost in 2019 of additional service activity to meet demographic and other service pressures.

When the first charge is applied[1], €15,755m is available to provide services in 2019, which is an increase of €547m from the equivalent in-year 2018 projected expenditure in 2018.

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 HSE in 2019 will plan, within the level of available resource, to maximise the delivery of safe service activity levels subject to the delivery, service and financial risks being managed within the overall plan. In doing so the HSE seeks to use the totality of the funding available as flexibly as is practical to best meet the needs of those who rely on health and social care services whilst also preparing for the implementation of *Sláintecare.*

Detailed cost and budget movements

The cost, in 2019, of providing the level of service activity in place by the end of 2018, is estimated at €15,805m, which is an increase of €597m over the 2018 costs of €15,208m.

This €597m is summarised below:

€m	Thematic view of this €596.8m cost in 2019
287.0	Public service pay awards (including consultant contract settlement)
58.0	Public service pension scheme changes
7.7	S39 pay restoration 2019 – initial 50 agencies
26.0	Public service salary scale increments – not funded via pay rate funding
102.0	Full year cost in 2019 of 2018 developments approved via NSP2018
19.4	FYC in 2019 of 2018 home support levels including 2017/2018 winter plan
17.0	FYC in 2019 of 2018 primary care levels (paediatric home care packages, GP out of hours, GP training, CIT, etc.)
14.0	FYC in 2019 of 2018 emergency residential places

[1] The legislation requires that any overrun on the HSE's directly provided services, as set out in the Annual Financial Statements (AFS), is treated as a 1st charge i.e. deducted from the following years available budget at the start of the year (€15,869 less €114m = €15,755m)

€m	Thematic view of this €596.8m cost in 2019
33.0	Acute activity uplift / run rate 2018 into 2019
21.5	NHSS – FYC in 2019 of price impact on 2018 bed week levels
33.2	FYC in 2019 of other costs running by end 2019
618.8	
-22.0	Less 2018 once-offs (Storm Emma, Surge etc.)
596.8	

This €15,805m cost is €50m or 0.4% higher than the €15,755m funding available to meet all 2019 costs. Furthermore, it excludes the cost of additional service activity from 1st January 2019 to deal with demographic, technology, unmet need and other pressures on the system.

Approach to addressing the financial challenge 2019

The HSE has modelled the theoretical level of activity that the 2019 funding will pay for and identified service areas where the HSE is expected to address service demands, even where these exceed the available funding. This provides an estimate of the likely scale of financial challenge facing our health and social care services in 2019, before options to mitigate that challenge.

In light of the above the HSE will adopt a range of actions / initiatives to address the financial challenge in 2019. This includes:

Areas where lower provision is being made, cost reduction or improved income generation is required:

- Legal Costs – Improved co-ordination and control arrangements – (€5.3m)
- Consultancy Costs – Prioritisation and reduction in costs – (€10.5m)
- Procurement – Reduction in prices and costs via contracting – (€16m)
- Office of the Chief Information Officer cost mitigation initiatives – (€1m)
- Shared Services (HBS) – multi-annual cost efficiency and reduction programme – (€5m)
- National HR – cost avoidance and cost reduction programme – (€4.5m)
- Overhead and other non-pay efficiencies – (€12.7m)
- Agency / Overtime conversion – (€17.5m)
- Laboratory – general efficiencies including demand management – (€1m)
- Acute hospital income improvement programme to mitigate actions of PHIs – (€10m)
- Community voluntary organisations – prioritisation, rationalisation, insurance, income and general efficiencies – (€4m)
- Drugs and Medicines – €3m 'invest to save' programme funded by DoH – (€19m)
- Vacancy control i.e. prioritisation of frontline staff replacement within pay budgets – (€15m)
- Vacancy control community voluntary organisations – (€2m)
- Reduction in complex delayed discharges and specialling – (€6m)
- Disability – DoH to agree HIQA compliance phased investment programme 2019-2021 – provision limited to €2.6m for 2019

- High cost community residential care including external placements – centralised procurement and co-ordination – (€9.6m)
- Reconfigure the overall bed stock to a more sustainable level giving rise to a reduction in bed numbers of 80 -100 beds – (€7m)
- Setting activity levels at the affordable level within 2019 budget – Patient Transport (€10m)
- DoH led sustainability programme re community pharmaceutical costs – (€38m) and PCRS pharmacy service – (€13m).

Areas where cost growth is being provided for. Actions, including but not limited to phasing of commencement, will be undertaken to limit cost growth to the available budget:

- Once-off saving from normal recruitment phasing of Acute 2019 demographic posts – (€10m)
- Once-off saving from normal recruitment phasing of new primary care posts – (€4m)
- Once-off saving from timing of opening of new / expanded units – (€9.5m)
- Maximising the retention of nurse graduates, on a fully budget neutral basis
- Implementation of Women and Infants' Programme within funded limits – (€5m)
- Chief Clinical Officer – phasing and prioritisation of certain initiatives
- Implementation of ED WRC agreement on budget neutral basis – (€3m)
- Phased implementation of ED early warning system – (€3m)
- Joint DoH and HSE approach to avoiding any unfunded IR / ER settlements – (no provision made)
- Progressing implementation of car-parking review on a cost neutral basis
- Provision made to fund €10m of new drugs / new indications supported by invest to save programme
- S.38 voluntary deficits beyond 2018 approved expenditure limits to be dealt with by each organisation
- Expenditure to be avoided through limiting planned activity levels to the affordable level within 2019 budget:
  - NHSS
  - Disability residential places*
  - Acute elective

** This element of the plan is predicated on the DoH providing, in 2018, an additional once-off allocation of €15m to the HSE from its own resources.*

Areas of a technical financial nature

- Vaccine cost growth – once-off timing saving – (€1.4m)
- Bad Debt Management – DoH guidance re PHI 'retraction' issue – (2018 €17m and 2019 €19m)
- DoH planning assumption re PCRS cost of cards 2019 – (€15m)
- Once-off saving from use of prior year provisions – (€68m)

€20m is being provided in 2019 (€30m in a full year) for demographic related staffing growth. This figure is a subset of the total staffing growth indicated by our demographic modelling and reflects the fact that capacity constraints within acute hospitals will naturally limit such staffing growth.

In addition to the range of specific actions / initiatives listed above, and following review at leadership team level, the HSE will seek, notwithstanding the delivery and other risks already being managed within the plan, to secure up to an additional €30m in savings by further evaluation of potential opportunities in the following areas:

- Reduction in absenteeism rates in addition to measures already assumed
- Further stock and logistics efficiencies
- Income generation re surplus property assets
- Reduction in low value / no value care
- Further prioritisation of staff travel
- Additional modernisation and prioritisation of training and development
- Campaign spending
- Community income
- PCRS probity and scheme costs.

Full delivery on all of the actions / initiatives listed above, as well as success in identifying and delivering the full additional €30m in potential savings opportunities, leaves a residual requirement for savings of €50m. The Directorate of the HSE is fully cognisant of its legal obligation to set out the type and volume of services that can be delivered within the limit of the funding provided.

In that context, the HSE will work with DoH and other internal and external stakeholders to seek to identify further potential areas where additional savings may be sourced to mitigate this residual €50m savings requirement. To the extent that this does not prove fully achievable, or is achieved through once-off measures, €50m of funding, allocated to a once-off purpose in 2019, will be available in 2020 to deal with the incoming balance. It should be noted that, as more detailed work is completed on the various savings efforts above, it may, in certain instances, become necessary to adjust budgets internally to reflect same.

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 models, 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 €16.1m in net expenditure terms for the HSE as a whole.

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 summary 2019

Please see Appendix 1, tables 1 – 3 for full 2019 budgetary breakout.

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 2018.
- 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 2018 developments – €102.2m

The incremental cost of developments and commitments approved in 2018 is €102.2m. This includes the cost of providing services which commenced part way through 2018, over a full year in 2019. It also includes the full year cost of Mental Health 2018 developments of €20m, funding for which has been provided for with the total 2019 developments of €198.5m.

Pay rate funding – €287.3m

This funding is provided in respect of the growth in pay costs associated with National Pay Agreements, 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 likely significant pay-related costs emerging from the IR / ER, identified as part of the estimates process, were not funded within the overall allocation. See actions to address financial challenge above.

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

Other ELS funding (including adjustments) – €260.2m

Please refer to Appendix 1, table 3 for a service breakdown of this funding.

Expanding existing services / developing new services – €198.5m which is being held by the DoH

Within the total allocation of €16,050m, funding of €198.5m will be applied to enhance or expand existing services, including responding to demographic pressures, and to commence new approved service developments. Of this amount, €128.2m (64%) is allocated to operational service areas performance managed by the HSE and €70.3m (36%) 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, €198.5m development funding 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:

- Acute hospital services – €6.7m to invest in the new children's hospital.
- Mental health services – €35m to initiate new developments in 2019 with an additional €20m for the full year effect of 2018 developments.
- Disability services – €14.5m for school leavers and disability needs assessments.
- Palliative Care – €2m Marymount Hospice and St. Francis Hospice – supporting sustainable services.
- National Screening Service – €9m for CervicalCheck (including HPV vaccination).
- Termination of Pregnancy – €12m.
- Primary Care Scheme Changes (PCRS) – €70.3m for GP Contracts, reductions in prescription charges, reductions in the drug payment scheme (DPS) threshold, GP visit cards threshold increase and provision of GP visit card to full time carers.
- System Wide Measures – €29m for care redesign and new entrant pay.

The effect of the funding held at the DoH on the opening 2019 divisional budgets is illustrated in Appendix 1, table 3, column H.

Key risk areas

Reliance on once-off funding / initiatives to deal with recurring costs

There will be a reliance on once-off funding sources to address recurring costs in this plan. This includes where 2019 recurring costs will be supported, on a once-off basis in 2019, by the use of prior year provisions (€68m). In addition, funding allocated for a once-off purpose in 2019, will be available in 2020, if needed, to deal with any residual balance related to the final €50m of savings requirement identified above.

Given the above, the NSP2020 process will, as a minimum, need to address the €68m of recurring costs plus any under-delivery against the final €50m on-going savings requirement.

This risk is separate to the delivery, service and financial risks otherwise being managed within this plan. It is also separate to the financial risk related to the advised DoH approach to management of bad debts in relation to the actions of private health insurers regarding the 'retraction' issue. This is where bills due from date of admission are only paid by the insurer from date of signing of a PIP form.

The HSE is not in a position to hold a contingency

As in previous years it is reiterated that the HSE does not hold a contingency against delivery or other financial risks contained within this plan. In a private sector organisation such a contingency would be normal and may be in the minimum range of 1% to 2% (€150m to €300m for the HSE).

There is no scope for the HSE to deal with any financial impacts from the outcome of any legal, IR, regulatory or other processes, beyond what is already specifically provided for in this plan.

There is limited scope to transfer resources from one area to another, or to address any over-run in one area by compensating under spends in another area, beyond what is already assumed within the plan.

The emergency management and pandemic contingency (combined €10m) was subsumed into general service provision some years ago by agreement with DoH. Accordingly any relevant 2019 costs that arise under these headings will be the subject of direct engagement between the HSE and the DoH in order to address their impact in a way that does not impact on the provision of services in 2019.

Operational Service Areas

The scale of the financial challenge will present particular difficulties within disability services in the areas of de-congregation and HIQA compliance, as well as in primary care services particularly in terms of responding to the growing numbers of complex paediatric discharges. This is in addition to having to respond to and balance the level of homecare provision in older persons' services that is consistent with funding levels in 2019 (The winter period to end March 2019 will be prioritised in this regard). There will also be additional pressures within acute hospitals in 2019 including in relation to responding to emergency presentations and the demand, including backlog, for planned assessment and treatment.

In addition cost pressures will arise as a result of the cost of maintaining appropriate staffing levels, the additional demands of treating an ageing population and the growing cost of drugs and medical technologies.

Acute Hospital Care

Acute services have modelled the expected level of activity that the 2019 funding will pay for and identified service areas where the HSE is expected to address service demands. It has also assessed the costs that cannot be avoided or are fixed. 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 often pressure to respond to need even if this exceeds the available funding level.

Community Healthcare

Community services have modelled the expected level of activity that the 2019 funding will pay for and identified service areas where the HSE is expected to address service demands. It has also assessed the costs that cannot be avoided or are fixed. 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 often pressure to respond to need even if this exceeds the available funding level.

Community Services – Disability

Within disability services the service and financial risk will primarily relate to residential places and emergency cases. This is the cost 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.

Community Services – Mental health

Mental health services will rely on a combination of the timing of funded development posts and adherence to funded workforce plans to break even financially. The key challenge will be around managing the level of

growth in agency and emergency residential placements beyond funded levels while also managing service risk.

Community Services – Older persons

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.

Pensions and demand-led areas

Expenditure in these areas is not amenable to normal budgetary control measures given the statutory and policy basis for the various schemes:

Primary Care Reimbursement Service (PCRS)

The PCRS continues to face significant financial challenges and increased demand for services. 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. An additional budget of €118.1m (including allocation within supplementary 2018) has been assigned by the DoH to support the schemes run by PCRS.

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, including monitoring probity, and progressing the medicines management programme. 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 2019 under each scheme.

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. As part of NSP2019 an additional €86.9m has been assigned to pensions bringing the budget available in 2019 to €490m.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. Pension costs and income will be monitored carefully and reported on regularly. In the event that actual expenditure emerges in 2019 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 NSP2019 an additional €20m has been assigned to SCA bringing the budget available in 2019 to €340m. 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 2019 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 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. As part of NSP2019, an additional €6m has been assigned to demand-led schemes. The budget will allow the HSE to fund a maximum of €262.4m for these services.

Overseas Treatment

The Overseas Treatment schemes include treatment abroad, cross-border healthcare and EU schemes (such as the European Health Insurance card (EHIC)). These schemes relate to the provision of clinically urgent care and treatment abroad. As with other demand-led services it is exceptionally difficult to predict with accuracy the expenditure and activity patterns of these schemes. As part of NSP2019, an additional €6m has been assigned to Overseas Treatment schemes.

Section 8:
Value Improvement Programme

Value Improvement Programme

The Value Improvement Programme (VIP) commenced in 2018 responding to the requirements laid out in NSP2018 to support services and corporate units in realising cash savings, improvements in efficiency and service effectiveness.

Value Improvement for NSP2019 will be a more balanced approach across the four aims at the core of the programme, population health, patient experience, per capita cost and staff experience. This focus is rooted in the Quadruple Aim, Bodenheimer and Sinsky's expansion of the Triple Aim (*From Triple to Quadruple Aim: Care of the patient requires care of the provider* Annals of Family Medicine 12 (6):573-276) improving the patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare adding the goal of improving the work life of healthcare providers. VIP is a multi-year programme, it reaches beyond what could be perceived as purely cost saving measures and will deliver on all four elements of the Quadruple Aim. The programme aims to highlight the successes in delivering specific projects / schemes, providing sign posts to these case studies and support for their implementation in partnership with existing programmes such as the Programme for Health Service Improvement, Quality Improvement Services and in particular the many local projects highlighted in the annual Health Service Excellence Awards. The key underpinning principle of the Programme is that value does not come at the expense of service quantum or quality. Indeed, the goal is to improve quality and quantum by driving efficiency and effectiveness equally.

The VIP will be deployed across three focus areas in 2019:

- Financial balance
  - A greater emphasis will be placed towards back office and corporate functions for value improvement savings in order to positively assist patient and service user facing areas. We will support both corporate and service areas in realising spending reductions.
- Pharmacy
  - We will work with the National Drugs Management Programme to oversee and measure the returns and results from the invest to save initiative. This will see the HSE invest up to €3m for the early establishment of a dedicated pharmaceutical VIP across community and hospital expenditures, building on initiatives already underway to make savings in 2019.
- Improvement and accountability – clinical service improvement
  - We will support clinical services in reducing unwarranted variation in efficiency across key service areas including: theatre operations (Theatre Quality Improvement Programme), outpatients (Outpatient Services Performance Improvement Programme), and the musculoskeletal programme.

The VIP Team will assist project teams in identifying the value improvement opportunities, verifying their validity and measuring and reporting the value gained across the Quadruple Aim framework. The VIP will engage with the various patient and staff engagement processes to measure and report patient and staff satisfaction associated with the specific VIP initiatives and projects.

Further detail is set out within the finance section.

Section 9:
Workforce

Workforce

People Strategy 2019-2024

Building on progress to date and following a robust review process, the revised People Strategy 2019-2024 will guide all organisational people services in 2019 with an emphasis on encouraging leadership, talent and capability. The People Strategy is positioned to build a resilient workforce that is supported and enabled to deliver the *Sláintecare* vision. This will include a dedicated focus on workforce planning, enhancing leadership and accountability, and building organisational capacity. Supporting the delivery system and working with key strategic partners will be prioritised to ensure relevance and connectivity to meeting people's needs and local service requirements. This will be enabled by on-going attention to progressing national frameworks and standards that can add value, and support the delivery system.

National HR will work with the *Sláintecare* Office of the DoH to lead, develop and implement the strategic actions outlined in actions 4 and 9 of the *Sláintecare Implementation Strategy* (outlined below). This work will be determined within the context of the *Sláintecare Implementation Strategy* and action plan timelines.

Accelerating progress to date on the implementation of the People Strategy and extending the reach and relevance into the delivery system requires greater connectivity between national and local services. The focus for 2019 is on:

- Implementation of the People Strategy.
  - Working with Health Business Services (HBS) to attract, recruit and retain the right people, ensuring their integration and development into a workplace that cares about their wellbeing, motivation and opportunities at work.
  - Ensuring easy access to professional HR services in a way that meets the needs of those delivering services.
  - Connecting people services in a more integrated way to create the people and culture change platform for meaningful and healthy work environments.
- Implementation of *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning*.
- Implementation of the *Strategic Review of Medical Training and Career Structure* (MacCraith Report), including increased training on a two year phased basis (see Appendix 1 Table 4) and progressing a review of the recruitment of non-consultant hospital doctors (NCHDs).
- Implementation of the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland 2018* and the phase 2 Framework for Staffing and Skill Mix for Nursing in Emergency Care Settings.
- Implementation of workforce agreements.
  - Continued commitment to *Public Service Stability Agreement 2018-2020* including support for the work of the Public Service Pay Commission and implementation of recommendations where relevant.
  - Implementation of Consultant Contract 2008 Settlement Agreement and consultant contract compliance arrangements.
  - Implementation of Workplace Relations Commission (WRC) agreement on pay restoration in section 39 organisations.

  - On-going implementation of WRC nursing and midwifery recruitment and retention agreement and ED agreement.
- Building a sustainable, resilient workforce that is supported and enabled to deliver the *Sláintecare* vision.
- Complete review and risk assessment of consultants not on the specialist register.
- Expand community-based care to bring care closer to home.

People's Needs Defining Change – Health Services Change Guide

People's Needs Defining Change is the policy framework and agreed approach to change signed off by HSE Leadership and the Joint Information and Consultation Forum representing the trade unions. It presents the overarching Change Framework that connects and enables a whole system approach to delivering change across the system and is a key foundation for delivering the people and culture change required to implement *Sláintecare* and Public Sector Reform. The Change Guide complements all of the other service, quality and culture change programmes that are currently making progress towards the delivery of person-centred care, underpinned by our values of Care, Compassion, Trust and Learning and can be applied at all levels to support managers and staff to mobilise and implement change. Building this capacity will enable and support staff to work with and embrace change as an enabler of better outcomes for service users, families, citizens and local communities. The guide is available on *www.hse.ie/changeguide.*

Wellbeing and Engagement

Active promotion of health and wellbeing in the workplace continues to be a priority. The Workplace Health and Wellbeing Unit provides support for all staff and assists in preventing staff becoming ill or injured at work. The unit maximises access to, and retention of, work through timely rehabilitation services via occupational health services, rehabilitation / case management services, and organisational health.

Our staff bring a range of skills, talents, diverse thinking and experience to the organisation. We are committed to creating a positive working environment whereby all employees inclusive of race, religion, ethnicity, gender, sexual orientation, responsibility for dependents, age, physical or mental disability, civil status, membership of the Traveller community, and geographic location are respected, valued and can reach their full potential. We aim to develop our workforce reflecting the diversity of HSE service users, and which is strengthened through accommodating and valuing different perspectives, ultimately resulting in improved service user experience. This is achieved by increasing awareness of diverse needs, and through supporting the disability bridging programme and other initiatives.

Our staff survey seeks employees' views on a range of themes concerning them directly such as culture and values, working environment, career progression and development, equality, diversity and inclusion, leadership direction and communications, staff engagements, managing change, terms and conditions and job satisfaction. National HR undertakes this staff survey every two years, the latest of which was in 2018. We will work with services to take actions based on the findings from this survey. In addition, staff engagement forums are on-going and provide valuable information and feedback from those working in frontline services, creating a space for conversations about what matters to staff, giving a sense of ownership and personal responsibility for engagement, promoting staff engagement.

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 projected that the number of WTE posts in place at the end of 2018 will be 116,712 WTEs. 2019 indicative WTE limits for health service staff numbers, by service area, are set out in Appendix 2 of this NSP.

Effective control over workforce numbers and associated pay expenditure will be essential to ensuring that we deliver services within the available financial resources for 2019. Further details in this regard are set out in the following paragraphs.

Pay and Staffing Strategy 2019

Based upon key learning from previous Pay and Staffing Strategies, the approach being taken in 2019 begins with a central 'top down' high level affordability assessment of the level of staff, on an average cost per WTE basis, that the indicative pay budget for 2019 can support. This approach is designed to enable more realistic and affordable forecasting and follows on from the WTE limits process implemented in late 2018. All key stakeholders (National Directors, CHOs and Hospital Groups, supported by Finance and HR) will operationalise the WTE limits through a 'bottom up' process that takes account of service priorities and maintenance of services, whilst equally identifying the opportunities for optimisation and efficiency. This year's combination of a top down affordability assessment to set the overall WTE limits, and the bottom up prioritisation by service providers, is intended to ensure maximum flexibility for services to determine the deployment of the limit across their services.

Central to the process for 2019 is:

- Engagement at key service levels on the development of robust operational workforce plans based on a centrally constructed WTE limit that takes account of a range of factors including priorities determined by the Government.
- Striking the balance between safe, effective, efficient service delivery and affordability.
- Realising opportunities to reinvest in the workforce through agency conversion, for example, as allowable growth factors within the WTE limits, enabling constructive WTE limits review at key intervals throughout the year, underpinned by evidence, notwithstanding that all services need to closely monitor agency and overtime spend and implementation of measures to reduce same.
- Realising opportunities to redeploy the existing workforce to ensure maximum alignment between our staffing and the delivery of priority health and social care needs.
- Necessity of monitoring WTE movement against the limits alongside overall pay expenditure so as to appropriately manage direct employment costs, in addition to overtime and agency costs.

WTE limit monitoring is an integral component of the overriding principle of compliance to allocated pay expenditure budgets. The monitoring of both WTE limits and pay expenditure at all service levels will further support and enhance performance and governance of same, with key actions and interventions on deviation in place, in line with the Performance and Accountability Framework. In line with this framework, as with any other key performance areas, performance against these WTE limits will ultimately be considered as part of the National Performance and Oversight Group.

Capability and Learning

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.

Leadership is the most influential factor in shaping organisation culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed in fundamental. We are continuing to enhance leadership development, capacity and capability through the Health Service Leadership Academy. The first cohorts of both Leading Care I and Leading Care II commenced in October 2017, the second cohorts of both programmes commenced in April 2018 and the third cohort of both programmes have commenced in October 2018. There are approximately 50 participants in each cohort, with approximately 300 health service staff currently undertaking a Leading Care Programme.

All leadership and development programmes will have a people and culture change ethos to build change capacity at all levels with a particular emphasis on the skills and behaviours needed to lead change. This will be supplemented by 'on the job' practice-based learning.

HSELanD (Health Services eLearning and Development) is the HSE's online learning portal used by approximately 120,000 health and social care employees at all levels across the statutory and voluntary healthcare sectors. It will continue to be developed including through the wider implementation of the Health Electronic Learning Management project, which emphasises the need to develop a single overarching approach to learning and development throughout the health sector. A module of Respect and Dignity at Work has now been introduced and is mandatory for all staff.

The national coaching service is a free confidential service available to all staff working in the HSE and in our partner organisations. Its aim is to enhance employees' capacity to lead and flourish within their role in order to support the provision of safer better healthcare for all.

Performance and Partnering

The Health Services Change Guide is the agreed approach that will underpin our process for change and reform in line with the *Public Service Stability Agreement.* Over the past period, we have continued to take the lead role for employers on all national industrial relations matters, with particular input into the extension of the *Public Service Stability Agreement*, which now remains until end 2020.

The HSE is committed to maintaining and progressing compliance with the requirements of the EWTD for both 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 Service Providers

Adherence to *Supporting a Culture of Safety, Quality and Kindness: A Code of Conduct for Health and Social Service Providers, 2018* is a key priority for the health services. Its primary purpose is to ensure the safety of those that access our services and to support our staff in providing safe services. The Code assists in this by setting out both service provider obligations and individual responsibilities to deliver quality safe care.

Section 10:

Enhancing EU and North South Co-operation and Preparing for Brexit

Enhancing EU and North South Co-operation and Preparing for Brexit

Brexit

Ensuring effective preparation for Brexit has been and will continue to be a key priority for the HSE. Working closely with the DoH, the HSE will be intensifying and deepening its preparedness work and contingency planning for Brexit which extends across the full range of service areas, from continued environmental and health protection to ensuring the maintenance of services on a cross-border, all-island and Ireland-UK basis. A steering group has been established to oversee Brexit preparations and we are working closely with the DoH, all bodies under our remit, and other relevant stakeholders to mitigate any negative impact of Brexit on human health. On foot of government decisions, this work includes preparation for the Central Case Scenario as well as contingency planning for a Disorderly Brexit.

Given the potential implications of Brexit for service continuity, the HSE has established a project team to review and co-ordinate preparations and contingency planning. This function will be strengthened in 2019 to ensure that sufficient priority attaches to Brexit preparations. Eight work streams have been established under the Brexit preparation programme, including continuation of current patient and client health services, cross-border and frontier arrangements including Co-operation and Working Together, continuity of supply of goods and services, procurement arrangements, workforce issues and environmental health. Key priorities for 2019 are to:

- Undertake full preparedness and contingency planning to mitigate risks and provide timely support to the DoH, and the cross-departmental structure in place to support the intensification of the on-going work being undertaken on Brexit on a whole of government basis, including the preparation and updating of an overall HSE plan.
- Ensure all bodies under the remit of the HSE such as section 38 and section 39 bodies undertake and update full preparedness and contingency planning.
- Step up engagement with other EU Member States to look at potential alternative or additional service and supply arrangements.
- Ensure inclusion of accessible Brexit preparedness material on the HSE website, in line with the whole of government preparedness communications plan and its ‘Getting Ireland Brexit Ready’ campaign.

North South and EU Issues

The EU and North South Unit will continue to support services to identify appropriate programmes and establish projects where possible. The strategic priorities for 2019 are to:

- Broker partnerships between the health services, North and South, 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.
- Act as lead partner on four EU Interreg VA projects to the value of approximately €30m in the areas of acute services, mental health services, population health and children’s services. These Interreg VA projects are financed by the European Regional Development Fund (ERDF) of the European Union,

designed to support strategic cross-border co-operation in order to help overcome issues that arise from the existence of a border.

- Partner with Scotland and Northern Ireland on another EU Interreg VA project, to the value of approximately €9m ERDF, for primary care and older persons' services.
- Input as appropriate to work a future European Structural Fund Programme with relevant bodies such as the DoH Dublin, the DoH Belfast, the Special EU Programmes Body, and health service delivery personnel North and South, to help shape the future direction of European health funding through exploratory collaboration.
- Discuss a possible peace project with partners in Northern Ireland to the value of ERDF €10.75m.

Section 11:
National Services

National Services

This section of the NSP sets out the key priorities in 2019 for the following national services: PCRS, Emergency Management and Compliance.

Primary Care Reimbursement Service

The Primary Care Reimbursement Service (PCRS) is responsible for making payments to healthcare professionals – GPs, dentists, pharmacists and optometrists / ophthalmologists – for the free or reduced costs services they provide to the public across a range of community health schemes. The schemes form the infrastructure through which the HSE delivers a significant proportion of its primary care services to the public.

The PCRS also makes payments to suppliers and manufacturers of High Tech drugs as part of the High Tech Arrangement and facilitates direct payment to hospitals involved in the provision of national treatment programmes such as the NCCP, the National Hepatitis C Treatment Programme and multiple sclerosis services.

All medical card and GP visit card applications are processed by the National Medical Card Unit (NMCU). In addition, statistics and trend analyses are compiled to be provided as required to the HSE, the Government, customers, stakeholders and members of the public.

In 2019, the PCRS will make total net payments and reimbursements of €2.667bn to over 7,000 contractors under the General Medical Services (GMS), Drugs Payment (DPS), Long Term Illness (LTI), Dental Treatment and Community Ophthalmic Schemes and, in relation to High Tech and other arrangements, involving in excess of 75m individual contractor claims. Altogether, some 3.6m people are registered for primary care schemes, with approximately 1.6m medical cards and 0.5m GP visit cards in circulation.

Priorities for 2019 are to:

- Administer applications for eligibility under the primary care schemes including the GMS, DPS and LTI in a timely and efficient manner.
  - Roll out a fully integrated online application process for those wishing to apply or renew their eligibility under the GMS, LTI or DPS schemes that ensures service users who may not be eligible under the GMS scheme will have their eligibility for DPS or LTI assessed without the need for a separate application so that they will not lose out on their entitlements.
  - Implement changes announced in Budget 2019 to increase the GP Visit Card eligibility threshold by 10% from April 2019, reduce the monthly DPS threshold by €10 and reduce prescription charges for people aged 70 and over by 50c, with the monthly cap reduced by €5.
- Reimburse contractors in line with service level agreements and health policy regulations.
  - Further expand and refine the suite of dashboards for pharmacies, GPs, dentists and optometrists / ophthalmologists to interface with the PCRS, enabling a fully electronic claiming interface for all types of claims and eliminate the need for paper.
  - Continue, through the High Tech hub, the electronic purchasing and stock control of High Tech medicines for their supply and dispensing through community pharmacies.
- Reimburse services approved for expansion or centralisation.

  - Centrally reimburse hospitals under the National Drugs Management Scheme, which ensures equitable access for all patients to specified high-cost drugs in acute hospitals.
- Ensure probity and value of services.
  - Continuously review all services and reimbursements for probity and value to ensure and protect patient and tax payer interests.
- Implement the provisions of the *Framework Agreement on the Supply and Pricing of Medicines 2016-2020.*
  - Reduce the price of patent-expired, non-exclusive, non-biologic medicines where first generic products become available.
  - Reduce the price of patent-expired, non-exclusive, biologic medicines where first biosimilar products become available.
- Strengthen quality, accountability and value for money across the organisation and develop the workforce to deliver the best possible service.
  - Improve access to PCRS data for health researchers, service providers and other stakeholders through open data.
  - Carry out and enhance levels of inspections where necessary to provide assurance in relation to the use of public monies.
  - Implement customer engagement surveys and establish information exchange sessions with representative organisations.
- EU Regulations Office.
  - Provide a more customer friendly support mechanism in relation to health entitlements for citizens who are coming to Ireland or going from Ireland to other EU / EEA States and to the UK post Brexit.
  - Fully implement the European Commission's Electronic Exchange of Social Security Information.

Emergency Management

The Emergency Management function within the HSE is central to the generation of resilience across the organisation, for major incidents and emergencies. It provides counsel and advice to management in the preparation of Major Emergency Plans, assists in the identification and mitigation of strategic and operational risk to the organisation and helps to identify capability gaps and inform capability development. The function also provides training and mentoring to HSE management around Emergency Management governance structures, planning groups and crisis management teams, and engages with the other Principle Response Agencies (PRAs), government departments and external bodies in order to ensure co-ordinated national resilience.

In 2019 the central objective for Emergency Management is to ensure that essential patient facing services face minimal impact due to unforeseen external events and severe weather. A number of priorities have been identified in this regard:

- Develop co-ordinated preparedness and surge potential across the HSE to deal with a mass casualty incident.
- Promote severe weather preparedness with management across the organisation.

- Continue to advance preparedness to counter emerging viral and other biological threats.
- Continue to develop the HSE's capability to deal with the clinical decontamination of casualties following a hazardous material incident.
- Develop a business continuity management policy and framework for the HSE.
- Continue to implement and exercise updated hospital major emergency plans.
- Engage with the HSE 'new ways of working' in order to enhance the quality and level of functional support for emergency planning across the organisation.
- Engage with the other PRAs and government departments to complete the review of *A Framework for Major Emergency Management*, agree a protocol for the management of large crowd events and prepare an updated interagency protocol for response to chemical, biological, radiological and nuclear threats.

Compliance

The HSE Compliance Unit was established in 2014 to support the implementation of the HSE Governance Framework as it applies to section 38 and section 39 providers. Its main functions are to maintain oversight of the service arrangement / grant aid agreement process including its annual review and development; develop and update other documentation relating to the Framework and Annual Compliance Statement (ACS) processes; manage the ACS process; co-ordinate governance issues within the HSE regarding providers; interface with key stakeholders involved in the Framework; provide support and advice to service areas, including CHOs and Hospital Groups, in their governance work with providers; and take initiatives to enhance and improve the Framework where gaps are identified. Robust governance is required for all funding provided by the HSE to service providers. This in turn seeks to ensure that all such services provided are accounted for, and ultimately benefit the HSE, service users and the wider public.

Priorities for 2019 are to:

- Continue to support the implementation of the Framework through:
  - Ensuring that service arrangements and grant aid agreements are in place with all section 38 and section 39 service providers.
  - Completing the 2018 ACS process for all section 38 service providers, and section 39 service providers that receive annual funding over €3m.
- Facilitate the process to establish Contract Management Support Units in each CHO on a phased basis.

Section 12:
Enabling Healthcare Delivery

Enabling Healthcare Delivery

Delivery of NSP2019 is dependent on a number of key enablers which underpin service delivery. In conjunction with frontline services, the provision of a modern and efficient healthcare system in enabled by these essential support services.

Corporate support services include the Office of the Chief Information Officer, Health Business Services (HBS), Corporate Finance, Corporate HR, National Communications, Research and Evidence, and Internal Audit.

Technology and Information

The Office of the Chief Information Officer (CIO) delivers ICT services and support throughout the HSE to a current user base of over 50,000 staff, using approximately 1,400 applications in 1,000 networked sites. There are in excess of 300 ICT projects currently being progressed or in development.

This technology and systems facilitate integration within and across community-based care, hospitals and other specialised care providers, acting as a key enabler to create a modern health service that empowers patients. The *eHealth Strategy for Ireland, 2013* is focused on improving population wellbeing, health service efficiencies and economic opportunity through the use of technology enabled solutions. eHealth – when applied effectively – delivers more personalised 'citizen-centric' healthcare, which is more targeted, effective and efficient and helps reduce errors, as well as the length of hospitalisation.

Recognising the importance of ICT investment for healthcare, *Sláintecare* sets out clear goals for the eHealth agenda to both digitally connect the health service and digitally connect the citizen (to health). For 2019, the highest priorities relate to the development of electronic healthcare, including the EHR programme, ePrescribing, NIMIS and Digital Maternity. In addition, through the establishment of the Integrated Information Service, our goal is to provide robust knowledge and information drawing on good quality, timely and relevant data sources. Our ambition is to create a vibrant research and development and health analytics division, investing in health information and research, and the infrastructure and skills required for their generation and exploitation.

The strategic imperatives for the Office of the CIO are clearly informed by the *Sláintecare Implementation Strategy* and the *eHealth Strategy for Ireland, 2013*, and are also cognisant of *Our Public Service 2020*, *Europe 2020*, and the *Knowledge and Information Plan*. The specific deliverables for 2019 are set out below, grouped under each of these imperatives – stabilisation and protection against risks to public health applications and critical information; major digital programme milestones on our pathway to *Sláintecare*; investment in modern integration capability to allow for a more complex technology footprint; connecting people and health; and informing decision-makers. In 2019, the ICT capital allocation is €85m and further details are contained in the ICT Capital Plan.

Priorities and Actions

Stabilise and protect the current environment and our patient data from on-going cyber threats

- Develop a cyber strategy and ensure patch management technology is fully operational.
- Develop security as a service strategy.
- Develop an approved cloud strategy and establish a cloud framework.

Deliver the core digital programmes advancing the *Sláintecare Implementation Strategy*

- Commence procurement for the national EHR system and the shared care record, preparing for a first implementation in the new children's hospital.
- Develop a business case for the community EHR and prepare for implementation to connect records across the system and support integrated models of care.
- Complete procurement of a technology to deliver digital patient records and all associated technology for the new National Forensic Hospital and the National Rehabilitation Hospital.
- Commence the Primary Care Management System.
- Complete and assess current ePrescribing pilot with a view to implementation.
- Deliver hand held technology devices to 1,500 community care professionals.
- Develop a business case for the digital workplace and implement a pilot in UL Hospitals Group.
- Commence procurement of an acute floor information system.
- Commence the first phase implementation of medical laboratories technology.
- Complete implementation of the NCIS in first sites.
- Build enabling technology to prepare for an upgraded NIMIS.
- Complete implementation of the clinical electronic document records management system in UHG and begin implementation for Children's Health Ireland.
- Deliver enabling technology for the satellite centres for the new children's hospital.
- Develop a tele-health strategy and commence initial pilots, in conjunction with the DoH.
- Procure systems integrator and implement the integrated financial management system (IFMS).
- Complete first regional implementation of the national integrated staff records programme (NiSRP).
- Continue development of the digital maternity system to support the aims and goals of the *National Maternity Strategy 2016-2026 – Creating a Better Future Together.*

Invest in modern integration capability to ensure integration of our current and future applications and information is delivered simultaneously with solution deployments

- Initiate a healthcare business architecture model and a suite of architecture domain roadmaps to help ensure priority investments are pursued.
- Progress a data dictionary to enable common definitions and to facilitate interoperability.
- Progress 'Integrating the Healthcare Enterprise' profiles in support of the EHR programme.
- Develop a digital strategy focused on connecting health to the citizen.

Connect health to the citizen through digital technology

- Progress acquisition of an eHealth Ireland application library.
- Develop a proof of concept to provide an eDirectory of health services.
- Deliver a pilot citizen health portal.

Inform decision-makers through modern information service provision

- Develop the Integrated Information Service (IIS), enabling a health and social care service with the data and information it needs, provided in an accessible and efficient way to enable the provision of the best possible services and patient experience.
- Develop a design specification and business case, and commence procurement of a National Data Warehouse, a key IIS enabler.
- Evolve a single software approach to the provision of information to support the *Sláintecare* goals relating to sustainable improvement in access performance across health and social systems.

Health Business Services

The Health Business Services (HBS) mission is to focus on providing high quality business services in the health sector. HBS provides a range of business services on a shared basis to our corporate partners and customers, supporting the evolving health structures as they continue to mature. These include transactional elements of human resources and finance, estates and capital programme management, HR / payroll systems and analytics, and procurement.

The investment in HBS is a long-term investment, with many of our strategic objectives and actions having multi-year implementation plans, ranging in complexity and size. During the last year of the *HBS Strategy 2017-2019*, we will continue to progress our planned projects and complete a number of important strategic enabling projects. We will also begin the process of developing our third three-year strategy to identify actions for 2020 and beyond.

Priorities and Actions

Progress major enterprise resource planning initiatives for the health environment

- Work in partnership with national finance team and other stakeholders on the integrated financial management system (IFMS) programme across the health sector. This will involve the roll-out of shared services operating models, standardised processing and new ways of working across finance and procurement in the health sector.
- Commence the implementation of the national integrated staff records programme (NiSRP), a major complex change programme aligned to the IFMS.
- Expand the existing HR / payroll systems and analytics (HPSA) SAP Centre of Excellence to support IFMS and NiSRP.
- Upgrade the HBS Customer Business Intelligence products (HPSA).
- Work with Children's Health Ireland to prepare for the delivery of HBS services to the new hospital.

Deliver excellence in procurement

- Continue to implement the three-year corporate procurement plan and compliance programme, sustaining existing programmes and expanding to a number of additional stakeholders in 2019.
- Assist funded agencies to develop a three-year plan and compliance programme.
- Plan for the roll-out of the national logistics service to support new customers in the Dublin area and expand point of use locations.

- Finalise the HBS Public Procurement and Supply Chain Excellence training programme.
- Lead the programme of procurement of the EHR for the Irish health service.

Deliver excellence in HR

- Implement a service improvement programme in pensions administration, the basis of which is gaining compliance with the Single Public Service Pension Scheme together with providing a customer-centred pensions service.
- Work in collaboration with National HR to implement a new recruitment operating model that meets the need of the evolving service and market.
- Develop and implement a compliance project for Garda Vetting to ensure that the HSE can meet its statutory obligations.

Implement HBS Digital Programme business solutions

- Implement the HBS Customer Relationship Management technology solution.
- Commence deployment of the National Estates Information System.
- Continue roll-out of the Finance Invoice Capture project.
- Complete the Electronic Data Records Management System project.
- Implement the agency framework management solution.
- Implement the Garda Vetting Invitation Process.
- Build a series of enabling platforms to support a digital business.

Deliver business excellence

- Develop and embed a sustainable model of operational excellence, working with academic partners to achieve LEAN accreditation (Yellow and Green Belt programmes).
- Continue to enhance the business relationship management model to engage with customers and business partners.

Capital Investment in Healthcare

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, aligned with the Government's *National Development Plan 2018-2027*. The upkeep and maintenance of existing buildings, and planning appropriate new facilities, are key supports to the delivery of services. The five year HSE Capital Plan is reviewed and refreshed each year, taking into account works commenced, changing needs, emerging strategies and the budget available. The HSE Capital Plan is submitted to the Government alongside the NSP2019.

In 2019, the construction capital allocation is €567m and this will be managed to achieve the best value for the funding available.

Priorities and Actions

Provide additional capacity

- Develop plans to enable responses to capital implications in the *Health Service Capacity Review 2018, National Development Plan 2018-2027* and *Sláintecare Implementation Strategy.* This includes additional capacity of 2,600 acute beds, 4,500 community care beds and three new elective hospitals in Cork, Dublin and Galway.

Implement the Capital Plan

- Support, as necessary, the National Paediatric Hospital Development Board who are leading on the construction of the new children's hospital main development and the Urgent Care sites at Connolly Hospital and Tallaght University Hospital. The Paediatric Outpatient and Urgent Care Centre at Connolly is scheduled to open in 2019, followed by Tallaght in 2020 and the new children's hospital in 2022, enhancing paediatric acute services regionally and nationally.
- Progress phase 1 of the National Rehabilitation Hospital to deliver a modern 120 bed ward block, including support therapies for paediatrics and acquired brain injury wards, hydrotherapy unit and sports hall, due to be operational in 2020.
- Continue the radiation oncology programme to deliver replacement and additional facilities and equipment for the delivery of radiation oncology services at public hospitals in Dublin, Cork and Galway. Construction is underway in Cork to provide replacement and additional radiation oncology facilities and will commence in Galway in 2019. A design team has been appointed to progress the Beaumont Hospital facility.
- Continue construction of the National Forensic Mental Health Service to replace the Central Mental Hospital with an appropriate modern facility at Portrane County Dublin, due to open in 2020.
- Commence construction of the National Maternity Hospital, following enabling and decant works underway.
- Deliver primary care centres through a combination of direct building by the HSE, working with the private sector using an operational lease arrangement, and through a Public Private Partnership mechanism.
- Continue delivery of the social care residential programme for older people and people with disabilities through upgrading and / or replacing existing community nursing homes to achieve HIQA compliance and the purchase and adaptation of houses in the community to accommodate residents in congregated settings.
- Continue with medical equipment and ambulance replacement and minor capital work programme to deal with prioritised infrastructural risk issues.

Further information in relation to the progression of capital projects can be found in Appendix 4.

Corporate Finance

Corporate Finance will provide strategic and operational support, direction and advice to services within the health service to achieve the goals of providing high quality, integrated health and social care services.

Priorities and Actions

Support the organisation to secure and demonstrate value in terms of the economy, efficiency and effectiveness in order to maintain and enhance appropriate investment in our health service

- Support the delivery of the actions / initiatives to reduce costs set out in this plan including through improved measurement and reporting.
- Implement the national finance reform programme including progressing the design and implementation of a single integrated national finance and procurement system for the HSE, section 38 funded voluntary bodies and larger section 39 funded voluntary bodies. (For 2019, complete procurement of external systems implementation support partner and commence national design and build stage).
- Support the implementation of the single national integrated HR and staff records programme (NiSRP) which will link to the finance system.
- Progress the implementation of the pay foundation programme to improve and accurately cost, report, forecast and plan pay across the health service (integrated with NiSRP and IFMS above).
- Set out an updated implementation plan for ABF within acute hospital services, informed by the *Sláintecare Implementation Strategy*.
- Progress the implementation of the community costing programme.

Corporate HR

National HR through the People Strategy 2019-2024 will provide strategic support, direction, advice and interventions to all areas of the health service, recognising that line managers throughout the system are the key to the delivery of excellent people capability.

Priorities and Actions

Attract, recruit and retain the right people

- Manage on-going recruitment challenges in respect of particular groups, such as nurses, and continuing pressures in EDs in collaboration with HBS.
- Deliver two cohorts of each of the flagship leadership development programmes, Leading Care I, Leading Care II and Leading Care III.
- Develop and curate best practice and leadership materials on topics that will support the reforms underway within Irish healthcare, including resources, tools and materials, talent management supports, coaching, team interventions, etc.
- Optimise and expand technological platforms to facilitate highly relevant training courses for greater numbers of staff at a lower cost to the organisation.
- Target capacity building by ensuring that *People's Needs Defining Change – Health Services Change Guide* and the skills development to support its implementation are integrated into all appropriate learning programmes.
- Mandate and monitor the participation of staff in Respect and Dignity Module on HSELanD.

Improve staff health and wellbeing

- Implement practices to reduce the number of incidents of violence and aggression in the workplace.
- Implement a healthy workplace framework and organisational health standards.
- Launch national critical incident stress management training and programme.
- Develop and implement a Mental Health Strategy for staff.

National Communications

National Communications is responsible for leading a wide range of communications initiatives and providing high quality communications consultancy to staff across the health services.

Priorities and Actions

Enhance communication across the health service

- In partnership with the National *Sláintecare* Office, take forward the implementation of the HSE Digital Roadmap to transform the online user experience for health.
- Implement a national operating model for Communications.
- Deliver partnership projects across the HSE for national service improvement.
- Further develop consistent health service wide communications approaches, toolkits and training.
- Continue the development of HSElive as a multi-platform information hub.

Research and Evidence

A strong research culture and data-driven, evidence-based practice in health service planning and delivery is essential for the effective functioning of a health and social care system.

A research benchmarking exercise, conducted in 2018, demonstrated that a significant level of research takes place in the health service, in addition to that performed in collaboration with academic partners. However, a subsequent assessment of existing governance and support mechanisms also highlighted a number of gaps in this area. Research governance mechanisms are required to safeguard public confidence in research, ensure good use of resources and encourage public and patient participation in research. Good governance reduces the risk of harm to participants and articulates clear lines of organisational, institutional and individual responsibilities and accountability.

Priorities and Actions

Continue to pursue the development of a framework for research governance and provide stronger national support to grow research at provider level that is better aligned to strategic priorities and focused on improved and more effective patient care.

- Develop a national framework for research governance for the health service in the context of new health service structures.
- Develop best practice guidelines and an implementation plan for the roll-out of research registration, assessment and approval procedures. This work will consider risk management, compliance with

legislation (i.e. *General Data Protection Regulations* and *Health Research Regulations 2018*), research ethical approval, and will articulate the lines of accountability and responsibilities of the different actors concerned. These issues will also be addressed with respect to academic clinical research in association with the third level sector.

- Address existing geographical gaps where there is currently no access to research ethic committees for community-based research.
- Engage with CHOs, Hospital Groups, national functions, the State Claims Agency, research ethics committees and in particular with the Health Research Board and the Research and Development division in the DoH to ensure that the resultant governance frameworks are supportive of, and complementary to, evolving national research policy objectives.

Working alongside the newly established Integrated Information Service (IIS), further develop health intelligence capability to provide insights for informed decision-making, strategy development and performance improvement

- Support the organisational approach to strategic planning and the work of the newly created commissioning teams by providing population-based evidence.
- Collaborate with Office of the Chief Information Officer on the development of the EHR across the hospital and community domains, to ensure the potential of data can be exploited for health intelligence purposes.
- Continue development of Health Atlas Ireland (HAI) as a comprehensive tool to exploit the potential of available data. HAI will be expanded through incorporating additional information sources including outpatient departments, waiting list, prescribing (PCRS), HR data, and health and wellbeing datasets.

Enable access to the latest knowledge resources and support through more efficient delivery of library services at all service levels.

- Continue to implement the 2018 strategy for the National Library and Knowledge Services to deliver a reformed and specialised service that creates added value for service users, and to implement operational efficiencies to achieve sustainability into the future.

Internal Audit

The work of Internal Audit identifies risks and control issues which may have systemic implications for the HSE. Through its audit reports and recommendations to strengthen controls, it provides assurance to the Director General, the Directorate and Leadership Team, (and to the Chairman and Board once the *Health Service Executive (Governance) Bill 2018* is enacted) on the adequacy and degree of adherence to procedures and processes. Implementation by management of Internal Audit recommendations is an essential part of HSE governance mechanisms. The HSE Performance and Accountability Framework is supported by the overall work of Internal Audit.

Priorities and Actions

Conduct audits and provide recommendations to strengthen controls within the HSE and agencies funded by the HSE

- Ensure approval by the Audit Committee of the Audit Plan 2019.
- Produce a comprehensive programme of completed audit reports covering a wide variety of audit topics and geographical spread throughout the HSE.
- Expand the programme of audits including audits of funded agencies.
- Expand the programme of ICT audits.
- Report on a quarterly basis to the Leadership Team and Audit Committee on completed audit reports, audit findings and the status of implementation of audit recommendations.
- Conduct special investigations including fraud related topics as required.
- Develop a Value for Money Audit capability.
- Provide advice to senior management on controls and processes, including ICT security and assurance.

Appendices

Appendix 1: Financial Tables

Table 1: Finance 2018

Strategic Area	2018 NSP Budget €m	2018 Additional Funding €m	2018 Movements €m	2018 Closing Recurring Budget €m
Operational Service Areas				
Acute Hospital Care	4,600.5	258.5	3.3	4,862.2
National Ambulance Service	165.3	0.1	(0.9)	164.6
Primary Care				
Primary Care	852.5	6.9	(13.8)	845.6
Social Inclusion	151.8	0.2	1.3	153.2
Primary Care Total	1,004.3	7.1	(12.5)	998.8
Mental Health	918.0	0.5	(3.4)	915.1
Disability Services	1,772.1	79.5	0.9	1,852.5
Older Persons' Services				
Nursing Homes Support Scheme (NHSS)	949.7	-	11.9	961.5
Older Persons' Services	823.3	31.1	(11.7)	842.7
Palliative Care	78.2	0.3	2.6	81.1
Older Persons' Services Total	1,851.2	31.3	2.8	1,885.3
CHO HQs and Community Services	4.9	2.0	4.2	11.1
Chief Clinical Officer				
National Cancer Control Programme	85.3	0.0	0.5	85.8
Clinical Strategy and Programmes	72.1	0.0	(6.7)	65.4
Quality Assurance and Verification	5.6	0.0	(0.1)	5.6
Quality Improvement	8.4	0.0	0.3	8.7
Chief Clinical Officer Total	171.4	0.0	(6.0)	165.4
National Screening Service	81.3	1.8	0.4	83.5
Health and Wellbeing	117.9	0.0	(1.7)	116.2
National Services				
Emergency Management	1.6	0.0	(0.0)	1.6
Environmental Health	41.6	0.0	(0.4)	41.3
Office of Tobacco Control	0.5	-	(0.0)	0.5
National Services Total	43.6	0.0	(0.4)	43.3
Support Services	303.8	38.1	(5.1)	336.8
Total Operational Service Areas	11,034.40	418.9	(18.5)	11,434.9
Pensions and Demand-Led Services				
Total Pensions	403.1	-	(0.0)	403.1
State Claims Agency	274.0	46.0	-	320.0
Primary Care Reimbursement Service	2,567.8	50.1	(9.5)	2,608.4
Local Demand-Led Schemes	251.5	5.0	(0.1)	256.4
Overseas Treatment	26.0	5.0	(0.0)	31.0
Total Pensions and Demand-Led Services	3,522.48	106.1	(9.7)	3,618.9
First Charge	-	110.0	28.1	138.1
Winter Plan	-	10.0	-	10.0
Total Budget	14,556.9	645.0	(0.0)	15,201.8

Note 1: This table illustrates the movement in recurring budgetary allocation, in respect of agreed service movements, from the published NSP2018 budget to the final 2018 closing recurring budget. The 2018 closing recurring budget is then referenced in tables 2 and 3.

Note 2: An additional once-off €15m from DoH own funds, for disability emergency placements, will be provided in 2018 in addition to €625m of recurring supplementary funding. This will be in addition to the €15,201m 2018 recurring budget reflected above.

Note 3: The DoH also provided €1.8m, on a once-off basis, to the HSE from its own resources, to cover the 2017 First Charge of €139.9m. In 2018, time related savings relating to development funding was applied on a once-off basis to the 2017 First Charge. This funding has been fully restored in 2019.

Table 2: Income and Expenditure 2019 Allocation

Strategic Area	2018 Budget €m	2019 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*
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
Operational Service Areas									
Acute Hospital Care	4,862.2	5,192.2	330.1	6.8%	205.9	4.2%	*6,024.7*	*(832.4)*	*5,192.3*
National Ambulance Service	164.6	168.6	4.1	2.5%	2.4	1.4%	*168.8*	*(0.1)*	*168.6*
Primary Care									
Primary Care	845.6	897.2	51.6	6.1%	43.1	5.1%	*914.8*	*(17.6)*	*897.2*
Social Inclusion	153.2	155.9	2.6	1.7%	1.9	1.3%	*157.2*	*(1.3)*	*155.9*
Primary Care Total	998.8	1,053.0	54.2	5.4%	45.1	4.5%	*1,072.0*	*(18.9)*	*1,053.1*
Mental Health	915.1	987.4	72.2	7.9%	60.4	6.6%	*1,006.7*	*(19.3)*	*987.4*
Disability Services	1,852.5	1,904.4	51.9	2.8%	29.5	1.6%	*1,956.2*	*(51.9)*	*1,904.4*
Older Persons' Services									
Nursing Homes Support Scheme (NHSS)	961.5	985.8	24.3	2.5%	24.3	2.5%	*985.8*	-	*985.8*
Older Persons' Services	842.7	859.3	16.7	2.0%	0.8	0.1%	*1,256.4*	*(397.0)*	*859.3*
Palliative Care	81.1	86.2	5.1	6.3%	2.2	2.7%	*94.1*	*(7.9)*	*86.3*
Older Persons' Services Total	1,885.3	1,931.4	46.1	2.4%	27.3	1.4%	2,336.3	*(404.9)*	1,931.4
CHO HQs and Community Services	11.1	11.3	0.2	1.8%	0.1	0.5%	*11.3*	*(0.0)*	*11.3*
Chief Clinical Officer									
National Cancer Control Programme	85.8	94.7	9.0	10.5%	8.9	10.4%	*95.0*	*(0.3)*	*94.7*
Clinical Strategy and Programmes	65.4	65.6	0.2	0.3%	0.1	0.1%	*66.0*	*(0.4)*	*65.6*
Quality Assurance and Verification	5.6	5.6	0.1	1.2%	0.0	0.3%	*5.6*	-	*5.6*
Quality Improvement	8.7	8.8	0.1	0.9%	0.0	0.2%	*8.9*	*(0.1)*	*8.8*
Chief Clinical Officer Total	165.4	174.7	9.3	5.6%	9.0	5.4%	*175.6*	*(0.8)*	*174.8*
National Screening Service	83.5	107.8	24.3	29.1%	23.8	28.4%	*108.4*	*(0.6)*	*107.8*
Health and Wellbeing	116.2	120.6	4.4	3.8%	3.8	3.2%	*122.1*	*(1.4)*	*120.7*
National Services									
Emergency Management	1.6	1.6	0.0	1.6%	- 0.0	-1.4%	*1.9*	*(0.3)*	*1.6*

Strategic Area	2018 Budget €m	2019 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*
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
Environmental Health	41.3	44.0	2.7	6.5%	2.1	5.2%	*47.6*	*(3.6)*	*43.9*
Office of Tobacco Control	0.5	0.5	0.0	1.0%	0.0	0.2%	*0.5*	*(0.0)*	*0.5*
National Services Total	43.3	46.0	2.7	6.2%	2.1	4.9%	*49.9*	(4.0)	46.0
Support Services	336.8	486.5	149.7	44.4%	53.1	15.8%	*488.4*	*(1.8)*	*486.6*
Total Operational Service Areas	11,434.9	12,184.1	749.3	6.6%	462.3	4.0%	*13,520.4*	*(1,336.2)*	*12,184.2*
Pensions and Demand-Led Services									
Total Pensions	403.1	490.0	86.9	21.6%	86.9	21.6%	*970.1*	*(480.1)*	*490.0*
State Claims Agency	320.0	340.0	20.0	6.3%	20.0	6.3%	*340.0*	-	*340.0*
Primary Care Reimbursement Service	2,608.4	2,726.5	118.1	4.5%	117.8	4.5%	*2,815.9*	*(89.5)*	*2,726.4*
Local Demand-Led Schemes	256.4	262.4	6.0	2.3%	6.0	2.3%	*262.4*	*(0.0)*	*262.4*
Overseas Treatment	31.0	37.0	6.0	19.4%	6.0	19.4%	*38.5*	*(1.5)*	*37.0*
Total Pensions and Demand-Led Services	3,618.9	3,855.9	237.0	6.5%	236.7	6.5%	*4,426.9*	*(571.1)*	*3,855.9*
First Charge	138.1	-	(138.1)	-100.0%	(138.1)	-100.0%	-		-
Winter Plan	10.0	10.0	-	0.0%	-	0.0%	*10.0*		*10.0*
Total Budget	15,201.8	16,050.0	848.2	5.6%	560.9	3.7%	*17,957.3*	*(1,907.3)*	*16,050.1*

Note 1: €15,849.1m is the amount notified to the HSE by the DoH of net non-capital determination for 2019. The letter also notifies a further €198.5m 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 €201m. The total funding available in 2019 is €16,050m.

Note 2: The gross and income split of the 2019 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.

Table 3: Finance Allocation 2019

Strategic Area	2018 Budget €m	Full Year Impact of 2018 New Develop-ments €m	Other ELS Funding €m	2019 Total ELS Funding €m	2019 Pay Rate Funding (supports existing staffing levels) €m	2019 New Develop-ments €m	2019 NSP Budget €m	2019 NSP Budget held at DoH €m	2019 Opening Budget €m	2019 Once off Funding to be applied €m	2019 Available Funding €m
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K
Operational Service Areas											
Acute Hospital Care	4,862.2	46.5	145.8	192.2	124.1	13.7	5,192.2	13.7	5,178.5	86.4	5,264.9
National Ambulance Service	164.6	1.7	0.7	2.3	1.7	-	168.6	-	168.6	-	168.6
Primary Care											
Primary Care	845.6	7.5	31.1	38.6	8.4	4.5	897.2	4.5	892.7	-	892.7
Social Inclusion	153.2	0.2	1.7	1.9	0.7	-	155.9	-	155.9	-	155.9
Primary Care Total	998.8	7.7	32.8	40.6	9.1	4.5	1,053.0	4.5	1,048.5	-	1,048.5
Mental Health	915.1	-	5.4	5.4	11.8	55.0	987.4	55.0	932.4	-	932.4
Disability Services	1,852.5	12.5	2.5	15.0	22.5	14.5	1,904.4	14.5	1,889.9	-	1,889.9
Older Persons' Services											
Nursing Homes Support Scheme (NHSS)	961.5	-	24.3	24.3	-	-	985.8	-	985.8	-	985.8
Older Persons' Services	842.7	5.0	(4.2)	0.8	15.9	-	859.3	-	859.3	2.7	862.0
Palliative Care	81.1	-	0.2	0.2	2.9	2.0	86.2	2.0	84.2	-	84.2
Older Persons' Services Total	1,885.3	5.0	20.3	25.3	18.8	2.0	1,931.4	2.0	1,929.4	2.7	1,932.1
CHO HQs and Community Services	11.1	-	0.1	0.1	0.1	-	11.3	-	11.3	-	11.3
Chief Clinical Officer											
National Cancer Control Programme	85.8	3.9	5.0	8.9	0.1	-	94.7	-	94.7	(71.3)	23.4
Clinical Strategy and Programmes	65.4	-	0.1	0.1	0.2	-	65.6	-	65.6	(7.0)	58.6
Quality Assurance and Verification	5.6	-	0.0	0.0	0.1	-	5.6	-	5.6	-	5.6
Quality Improvement	8.7	-	0.0	0.0	0.1	-	8.8	-	8.8	(0.2)	8.6
Chief Clinical Officer Total	165.4	3.9	5.1	9.0	0.3	-	174.7	-	174.7	(78.5)	96.3
National Screening Service	83.5	-	14.8	14.8	0.5	9.0	107.8	9.0	98.8	(18.3)	80.5
Health and Wellbeing	116.2	-	3.3	3.3	0.7	0.5	120.6	0.5	120.1	-	120.1
National Services											
Emergency Management	1.6	-	0.0	0.0	0.0	-	1.6	-	1.6	-	1.6

Strategic Area	2018 Budget €m	Full Year Impact of 2018 New Develop-ments €m	Other ELS Funding €m	2019 Total ELS Funding €m	2019 Pay Rate Funding (supports existing staffing levels) €m	2019 New Develop-ments €m	2019 NSP Budget €m	2019 NSP Budget held at DoH €m	2019 Opening Budget €m	2019 Once off Funding to be applied €m	2019 Available Funding €m
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K
Environmental Health	41.3	-	2.1	2.1	0.5	-	44.0	-	44.0	-	44.0
Office of Tobacco Control	0.5	-	0.0	0.0	0.0	-	0.5	-	0.5	-	0.5
National Services Total	43.3	-	2.2	2.2	0.5	-	46.0	-	46.0	-	46.0
Support Services	336.8	-	24.1	24.1	96.6	29.0	486.5	31.5	455.1	(3.5)	451.6
Total Operational Service Areas	11,434.9	77.3	256.8	334.1	287.0	128.2	12,184.1	130.7	12,053.5	(11.3)	12,042.2
Pensions and Demand-Led Services											
Total Pensions	403.1	-	86.9	86.9	-		490.0	-	490.0	-	490.0
State Claims Agency	320.0	-	20.0	20.0	-	-	340.0	-	340.0	-	340.0
Primary Care Reimbursement Service	2,608.4	4.9	42.6	47.5	0.3	70.3	2,726.5	70.3	2,656.2	11.3	2,667.4
Local Demand-Led Schemes	256.4	-	6.0	6.0	-	-	262.4	-	262.4	-	262.4
Overseas Treatment	31.0	-	6.0	6.0	0.0	-	37.0	-	37.0	-	37.0
Total Pensions and Demand-Led Services	3,618.9	4.9	161.5	166.4	0.3	70.3	3,855.9	70.3	3,785.6	11.3	3,796.8
First Charge	138.1	-	(138.1)	(138.1)	-	-	-	-	-	-	-
Winter Plan	10.0	-	-	-	-	-	10.0	-	10.0	-	10.0
Total Budget	15,201.8	82.2	280.2	362.4	287.3	198.5	16,050.0	201.0	15,849.1	(0.0)	15,849.1

Note 1: A number of HSE areas, including National Cancer Control Programme, National Screening Services and Clinical Strategy and Programmes, utilise their budgets to 'commission' services internally from the acute hospitals, community services and other service areas. This funding is referenced in Column J.

Note 2: As per the Letter of Determination, €201m will be held by the DoH: €198.5m of development funding and €2.450m of dormant accounts funding. This funding is referenced in Column H.

Note 3: The total HSE additional budget of €848.2m consists of the totals of column, D - €362.4m, E - €287.3m and F - €198.5m = €848.2m

Note 4: Overseas Treatment includes the Treatment Abroad Scheme, Cross-Border Directive and EU schemes (such as the European Health Insurance Card (EHIC)). These schemes relate to the provision of clinically urgent care and treatment abroad.

Note 5: Some of the savings initiatives that have been specified in this plan will enable / require a reallocation of available budget resource as part of the 2019 operational planning process.

Table 4: 2020 Full Year Costs related to NSP 2019

Strategic Area	Cost in 2019 €m	Cost in 2020 (Note 1) €m	2020 Incremental funding requirement €m	2019 WTEs
Acute Hospital Care				
- New children's hospital (Note 2)	6.7	22.1	10.8	217.0
- Termination of pregnancy	7.0	12.0	5.0	155.0
Total – Acute Hospital Care (Note 3, 4)	13.7	34.1	15.8	372.0
Community Healthcare				
Termination of pregnancy	4.5	9.0	4.5	-
Palliative Care (Note 1)	2.0	2.0	-	-
Primary Care Scheme Changes (Note 1)	70.3	84.6	14.3	-
Mental Health (Note 5)	55.0	55.0	-	294.5
Disability Services				
- Disability needs assessment	2.5	6.0	3.5	100.0
- School leavers	12.0	24.5	12.5	25.0
Total – Disability Services	14.5	30.5	16.0	125.0
Population Health and Wellbeing				
National Screening Service				
- CervicalCheck (including HPV vaccination) (Note 1)	9.0	9.0	-	110.0
Total – National Screening Service	9.0	9.0	-	110.0
Termination of pregnancy	0.5	2.0	1.5	2.0
System Wide Measures				
- New entrant services	14.0	14.0	-	-
- Care redesign	15.0	15.0	-	200.0
Total – System Wide Measures	29.0	29.0	-	200.0
Total Funding available for existing / developing new services in 2019	198.5	255.2	52.1	1,103.5
Demographic Pay	20.0	30.0	10.0	161.0
NCHD Training	5.0	10.0	5.0	-
Total	223.5	295.2	67.1	1,265.0

Note 1: Primary Care Scheme has been included at a cost in 2020 of €84.6m, Palliative Care has been included at a cost of €2m in 2020 and CervicalCheck has been included at a cost of €9m in 2020, pending confirmation of their expected costs in 2020.

Note 2: Cost in 2019 of the new children's hospital totals €11.3m, which is partially funded from realignment of the Children's Hospital Integration of €4.6m on a recurring basis, therefore reducing the incremental cost in 2020.

Note 3: There are capital works being undertaken in 2019 for an additional 75 beds in the acute system to focus on maximising available capacity in Q1/Q2 2019. These will have revenue implications of €9.3m from 1 January 2020.

Note 4: There are also capital works being undertaken in 2019 for an additional 202 beds in the acute system to be operational by Q1 2020. These will have revenue implications of €28.5m from 1 January 2020.

Note 5: €20m of this funding in mental health relates to the full year cost of 2018 activity.

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 Sept 2018	Initial Limit Dec 2018	Affordable Limit Dec 2019**
Total Health Service	10,400	37,220	16,193	18,196	9,476	25,011	116,496	116,712	119,127
Acute Hospital Services	8,151	22,231	7,326	9,001	6,023	5,044	57,776	57,889	58,757
National Ambulance Service	1	3	-	74	15	1,804	1,897	1,939	2,003
Acute Hospital Care	8,152	22,234	7,326	9,075	6,038	6,849	59,673	59,828	60,760
Mental Health Services	849	4,749	1,328	953	765	1,187	9,830	9,837	10,109
Primary Care Services	958	2,614	2,515	2,653	362	935	10,037	9,996	10,361
Disability Services	75	3,746	3,823	1,305	935	8,150	18,034	17,987	18,240
Older Persons' Services*	156	3,691	486	810	1,036	7,833	14,012	13,999	13,974
Health and Wellbeing	119	22	104	275	5	44	568	601	609
Corporate and National Services*	92	165	611	3,125	334	15	4,342	4,464	5,074

Source: Health Service Personnel Census

* Palliative Care included within Older Persons' Services and PCRS included within Corporate and National Services

** Includes 1,263 WTE associated with 2019 development funding

HSE / Section 38 Agencies Workforce Numbers

	Medical / Dental	Nursing	Health and Social Care	Manage-ment / Admin	General Support	Patient and Client Care	WTE Sept 2018	Initial Limit Dec 2018	Affordable Limit Dec 2019
Total Health Service	10,400	37,220	16,193	18,196	9,476	25,011	116,496	116,712	119,127
HSE	6,732,	24,528	9,211	12,831	5,858	16,404	75,564	75,888	77,971
Voluntary Hospitals	3,497	9,464	3,497	4,155	2,568	1,722	24,904	24,853	24,977
Voluntary Agencies (Non-Acute)	171	3,227	3,485	1,210	1,049	6,886	16,028	15,971	16,179
Section 38	3,668	12,692	6,982	5,365	3,618	8,608	40,932	40,824	41,156

Source: Health Service Personnel Census

The projected Dec 2018 HSE / Section 38 Agencies Workforce Numbers are based on an estimated pro rata rating and may differ from actuals in Dec 2018

Note 1: 2019 whole time equivalents (WTE) limits are based on a high level affordability assessment, utilising an indicative split of total budget as between pay and non-pay. This split may be adjusted as detailed operational budgets are finalised, with consequent adjustment to the affordable WTE limit(s).

Note 2: All figures are expressed as WTEs and include home helps. Rounding may result in minor variances.

Note 3: Interpretation of the WTE variance to year end requires a detailed assessment of multiple variables as part of a separate process.

Appendix 3(a): National Scorecard

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
		Rate of new cases of hospital acquired C. difficile infection
		% of acute hospitals implementing the requirements for screening of patient with CPE guidelines
	Urgent Colonoscopy within 4 weeks	No. of people waiting > 4 weeks for access to an urgent colonoscopy
	Surgery	% hip fracture surgery carried out within 48 hours of initial assessment (Hip Fracture Database)
		% of surgical re-admissions to the same hospital within 30 days of discharge
	Medical	% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge
	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
	Chronic Disease Management	No. of people who have completed a structured patient education programme for type 2 diabetes
	Healthy Ireland	% of smokers on cessation programmes who were quit at four weeks

National Scorecard		
Scorecard Quadrant	Priority Area	Key Performance Indicator
Access and Integration	Therapy Waiting Lists	Physiotherapy – % on waiting list for assessment ≤ 52 weeks
		Occupational Therapy – % on waiting list for assessment ≤ 52 weeks
		Speech and Language Therapy – % on waiting list for assessment ≤ 52 weeks
		Psychology – % on waiting list for treatment ≤ 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	Number of beds subject to delayed discharge
	Disability Act Compliance	% of child assessments completed within the timelines as provided for in the regulations
	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 and day case)
		% of children waiting < 15 months for an elective procedure (inpatient and day case)
		% of people waiting < 52 weeks for first access to OPD services
	Cancer	% of new patients attending rapid access breast, lung and prostate clinics within recommended timeframe
		% 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 (pay + non-pay - income)
	Governance and Compliance	% of the monetary value of service arrangements signed
		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

Appendix 3(b): National Performance Indicator Suite

Note: 2018 and 2019 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	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Finance Net expenditure variance from plan (pay + non-pay - income)	M	≤0.1%	To be reported in Annual Financial Statements 2018	≤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)	25% increase	52%	25% increase
Audit % of internal audit recommendations implemented, against total no. of recommendations, within six months of report being received	Q	75%	74%	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 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	≤0.1%	To be reported in Annual Financial Statements 2018	≤0.1%
WTE variance from plan		New PI NSP2019	New PI NSP2019	Reporting to commence in 2019
EWTD <24 hour shift (acute – NCHDs)		100%	95%	95%
<24 hour shift (mental health – NCHDs)		100%	95%	95%
<24 hour shift (disability services – social care workers)		95%	95%	95%
<48 hour working week (acute – NCHDs)		95%	95%	95%
<48 hour working week (mental health – NCHDs)		95%	95%	95%

System Wide

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
<48 hour working week (disability services – social care workers)		90%	95%	90%
Respect and Dignity % of staff who complete the HSE-land Respect and Dignity at Work module	Annual	New PI NSP2019	New PI NSP2019	60%
Performance Achievement % of staff who have engaged with and completed a performance achievement meeting with his/her line manager	Bi-annual	New PI NSP2019	New PI NSP2019	70%
Quality and Safety Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	Q	75%	65%	75%
Serious Incidents % of serious incidents being notified within 24 hours of occurrence to the senior accountable officer	M	99%	21%	80%
% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident		90%	1%	80%
Incident Reporting % of reported incidents entered onto NIMS within 30 days of occurrence by CHO / Hospital Group / NAS	Q	90%	50%	90%
Extreme and major incidents as a % of all incidents reported as occurring		<1%	0.7%	<1%
% of claims received by State Claims Agency that were not reported previously as an incident	Annual	<30%	63.3%	<30%

Population Health and Wellbeing

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Tobacco % of smokers on cessation programmes who were quit at four weeks	Q (1 Qtr in arrears)	45%	54.1%	45%
Immunisations and Vaccines % of children aged 24 months who have received three doses of the 6 in 1 vaccine		95%	94.7%	95%
% of children aged 24 months who have received the measles, mumps, rubella (MMR) vaccine		95%	92.5%	95%
% of first year girls who have received two doses of HPV vaccine	Annual	85%	65%	85%
% of healthcare workers who have received seasonal Flu vaccine in the 2018-2019 influenza season (acute hospitals)		65%	44%	60%
% of healthcare workers who have received seasonal Flu vaccine in the 2018-2019 influenza season (long term care facilities in the community)		65%	33.9%	60%
% uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card		75%	67%	75%

Primary Care Reimbursement Service

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Medical Cards % of completed medical card / GP visit card applications processed within 15 days	M	96%	99%	99%
% of medical card / GP visit card applications, assigned for medical officer review, processed within five days		91%	93%	95%
% of medical card / GP visit card applications which are accurately processed from a financial perspective by National Medical Card Unit staff		95%	96%	96%

National Screening Service

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
National Screening Service BreastCheck % BreastCheck screening uptake rate	Q (1 Qtr in arrears)	70%	73%	70%
% of women offered hospital admission for treatment within three weeks of diagnosis of breast cancer	Bi-annual (1 Qtr in arrears)	90%	94%	95%
CervicalCheck % of eligible women with at least one satisfactory CervicalCheck screening in a five year period	Q (1 Qtr in arrears)	80%	79.8%	80%
BowelScreen % of client uptake rate in the BowelScreen programme		45%	38%	45%
Diabetic RetinaScreen % Diabetic RetinaScreen uptake rate		65%	65%	68%

Community Healthcare

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Primary Care Services				
Healthcare Associated Infections: Medication Management Consumption of antibiotics in community settings (defined daily doses per 1,000 population) per day based on wholesaler to community pharmacy sales – not prescription level data	Q (1 Qtr in arrears)	<21.7	23.7	<23.1
Nursing % of new patients accepted onto the nursing caseload and seen within 12 weeks	M (1 Mth in arrears)	96%	99%	100%
Physiotherapy % of new patients seen for assessment within 12 weeks	M	80%	81%	81%
% on waiting list for assessment ≤52 weeks		93%	95%	95%
Occupational Therapy % of new service users seen for assessment within 12 weeks		68%	65%	68%

Community Healthcare				
Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
% on waiting list for assessment ≤52 weeks	M	85%	76%	85%
Speech and Language Therapy % on waiting list for assessment ≤52 weeks		100%	96%	100%
% on waiting list for treatment ≤52 weeks		100%	93%	100%
Podiatry % on waiting list for treatment ≤12 weeks		26%	32%	32%
% on waiting list for treatment ≤52 weeks		77%	75%	77%
Ophthalmology % on waiting list for treatment ≤12 weeks		26%	23%	26%
% on waiting list for treatment ≤52 weeks		66%	59%	66%
Audiology % on waiting list for treatment ≤12 weeks		41%	38%	41%
% on waiting list for treatment ≤52 weeks		88%	87%	88%
Dietetics % on waiting list for treatment ≤12 weeks		37%	34%	37%
% on waiting list for treatment ≤52 weeks		79%	70%	79%
Psychology % on waiting list for treatment ≤12 weeks		36%	27%	36%
% on waiting list for treatment ≤52 weeks		81%	75%	81%
Oral Health % of new patients who commenced treatment within three months of scheduled oral health assessment		92%	90%	90%
Orthodontics % of patients seen for assessment within six months	Q	46%	45%	46%
% of orthodontic patients (grades 4 and 5) on the treatment waiting list longer than four years		<1%	6%	<6%
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	M (1 Mth in arrears)	95%	93%	95%
% of newborn babies visited by a PHN within 72 hours of discharge from maternity services	Q	98%	96%	98%
% of babies breastfed (exclusively and not exclusively) at first PHN visit	Q (1 Qtr in arrears)	58%	56%	58%
% of babies breastfed exclusively at first PHN visit		48%	40%	48%
% of babies breastfed (exclusively and not exclusively) at three month PHN visit		40%	40%	40%
% of babies breastfed exclusively at three month PHN visit		30%	30%	30%

Community Healthcare				
Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Social Inclusion Services				
Opioid Substitution Average waiting time from referral to assessment for opioid substitution treatment	M (1 Mth in arrears)	3 days	5 days	4 days
Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced		28 days	20 days	28 days
Homeless Services % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed within two weeks of admission	Q	73%	87%	87%
Substance Misuse % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q (1 Qtr in arrears)	100%	93%	100%
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment		100%	99%	100%
Disability Services				
Safeguarding *(combined KPIs with Older Persons Services)* % 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	Q (1 Mth in arrears)	100%	98%	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%	100%	100%
Quality % of compliance with regulations following HIQA inspection of disability residential services	Q (2 Qtrs in arrears)	80%	71%	80%
Day Services including School Leavers % of school leavers and rehabilitation training (RT) graduates who have been provided with a placement	Annual	100%	100%	100%
Disability Act Compliance % of child assessments completed within the timelines as provided for in the regulations	Q	100%	9%	100%
Progressing Disability Services for Children and Young People (0-18s) Programme % of Children's Disability Network Teams established	M	100%	43%	100%
Mental Health Services				
General Adult Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks by General Adult Community Mental Health Team	M	90%	91.7%	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by General Adult Community Mental Health Team		75%	72.3%	75%
% of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month		<20%	22.6%	<22%

Community Healthcare				
Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Psychiatry of Later Life Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks by Psychiatry of Later Life Community Mental Health Teams	M	98%	97.8%	98%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Psychiatry of Later Life Community Mental Health Teams		95%	95.1%	95%
% of new (including re-referred) Psychiatry of Later Life Psychiatry Team cases offered appointment and DNA in the current month		<3%	3.1%	<3%
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%	71.5%	75%
% 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%	94.4%	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks by Child and Adolescent Community Mental Health Teams		78%	79%	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Child and Adolescent Community Mental Health Teams		72%	71.3%	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		100%	94.8%	95%
% of urgent referrals to Child and Adolescent Mental Health Teams responded to within three working days		New PI NSP2019	New PI NSP2019	Reporting to commence in 2019
Older Persons' Services				
Safeguarding *(combined KPIs with Disability Services)* % 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	Q (1 Mth in arrears)	100%	98%	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%	100%	100%
Residential Care % occupancy of short stay beds to commence Q3 2019	M	New PI NSP2019	New PI NSP2019	90%
Quality % of compliance with regulations following HIQA inspection of HSE direct-provided Older Persons' Residential Services	Q (2 Qtrs in arrears)	80%	82%	80%
Intensive Homecare Packages (IHCPs) % of clients in receipt of an IHCP with a key worker assigned	M	100%	91.6%	100%

Community Healthcare

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Nursing Homes Support Scheme (NHSS) % of population over 65 years in NHSS funded beds (based on 2016 Census figures)		≤4%	3.4%	≤3.5%
% of clients with NHSS who are in receipt of ancillary state support		10%	13.4%	13.5%
% of clients who have Common Summary Assessment Reports (CSARs) processed within six weeks	M	90%	89%	90%
Palliative Care Services				
Inpatient Palliative Care Services Access to specialist inpatient bed within seven days during the reporting year	M	98%	98%	98%
% of patients triaged within one working day of referral (inpatient unit)		95%	96.8%	90%
Community Palliative Care Services Access to specialist palliative care services in the community provided within seven days (normal place of residence)		95%	89.3%	90%
% of patients triaged within one working day of referral (community)		94%	95%	95%

Acute Hospital Care

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Acute Hospital Services				
Outpatient attendances New: Return Ratio (excluding obstetrics, warfarin and haematology clinics)	M	1:2	1:2.5	1:2.3
Activity Based Funding (MFTP) model HIPE Completeness – Prior month: % of cases entered into HIPE	M (1 Mth in arrears)	100%	91%	95%
Inpatient, Day Case and Outpatient Waiting Times* % of adults waiting <15 months for an elective procedure (inpatient)	M	90%	82%	85%
% of adults waiting <15 months for an elective procedure (day case)		95%	91%	95%
% of children waiting <15 months for an elective procedure (inpatient)		90%	84%	85%
% of children waiting <15 months for an elective procedure (day case)		90%	83%	90%
% of people waiting <52 weeks for first access to OPD services		80%	71%	80%
Colonoscopy / Gastrointestinal Service % of people waiting <13 weeks following a referral for routine colonoscopy or OGD		70%	53%	70%
No. of people waiting > four weeks for access to an urgent colonoscopy		0	334	0
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within six hours of registration		75%	64%	75%
% of all attendees at ED who are discharged or admitted within nine hours of registration		100%	79%	99%

Acute Hospital Care				
Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
% of ED patients who leave before completion of treatment		<5%	6.4%	<5%
% of all attendees at ED who are in ED <24 hours		100%	96%	99%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration		95%	42%	95%
% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration		100%	60%	99%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration		100%	91%	99%
Length of Stay ALOS for all inpatient discharges excluding LOS over 30 days	M (1 Mth in arrears)	4.3	4.8	≤4.8
Medical Medical patient average length of stay		≤6.3	7.2	≤7.2
% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration		75%	60%	75%
% of all medical admissions via AMAU		45%	31%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge		≤11.1%	11.3%	≤11.1%
Surgery Surgical patient average length of stay		≤5.0	5.5	≤5.5
% of elective surgical inpatients who had principal procedure conducted on day of admission		82%	74.5%	82%
% day case rate for Elective Laparoscopic Cholecystectomy		60%	48%	60%
% hip fracture surgery carried out within 48 hours of initial assessment (Hip fracture database)	Q (1 Qtr in arrears)	New PI NSP2019	New PI NSP2019	85%
% of surgical re-admissions to the same hospital within 30 days of discharge	M (1 Mth in arrears)	≤3%	2%	≤3%
Healthcare Associated Infections (HCAI) Rate of new cases of hospital acquired Staph. Aureus bloodstream infection	M	<1/10,000 bed days used	0.9	<1/10,000 bed days used
Rate of new cases of hospital acquired C. difficile infection		<2/10,000 bed days used	2.2	<2/10,000 bed days used
% of acute hospitals implementing the requirements for screening of patients with CPE guidelines	Q	100%	36%	100%
% of acute hospitals implementing the national policy on restricted antimicrobial agents		100%	35%	100%
Medication Safety Rate of medication incidents as reported to NIMS per 1,000 beds	M	New PI NSP2019	New PI NSP2019	2.4 per 1,000 bed days

Acute Hospital Care				
Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
National Early Warning System (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals (as per 2019 definition)	Q	New PI NSP2019	New PI NSP2019	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning System)		100%	72.4%	100%
National Standards % of hospitals that have completed a self-assessment against all 53 essential elements of the National Standards for Safer, Better Healthcare		New PI NSP2019	New PI NSP2019	100%
% of acute hospitals which have completed and published monthly hospital patient safety indicator report	M	100%	67%	100%
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Q (2 Qtrs in arrears)	90%	68.9%	90%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis		12%	9.1%	12%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		90%	73.8%	90%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Q	90%	95%	95%
% of reperfused STEMI patients (or LBBB) who get timely PPCI		80%	65%	80%
National Women and Infants Health Programme Irish Maternity Early Warning System (IMEWS) % of maternity units / hospitals with full implementation of IMEWS (as per 2019 definition)		New PI NSP2019	New PI NSP2019	100%
% of all hospitals with implementation of IMEWS (as per 2019 definition)		New PI NSP2019	New PI NSP2019	100%
% 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	M (2 Mths in arrears)	100%	94.7%	100%
Cancer Services				
% of new patients attending rapid access breast, lung and prostate clinics within recommended timeframe	M	New PI NSP2019	New PI NSP2019	95%
Symptomatic Breast Disease Services Non-urgent % 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%	73%	95%
Clinical Detection Rate – breast cancer % of new attendances to the rapid access clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer		6%	10%	>6%
Clinical Detection Rate – lung cancer % of new attendances to the rapid access clinic that have a subsequent primary diagnosis of lung cancer		25%	30%	>25%

Acute Hospital Care

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Clinical Detection Rate – prostate cancer % of new attendances to the rapid access clinic that have a subsequent primary diagnosis of prostate cancer		30%	33%	>30%
Radiotherapy % 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%	80%	90%

** Projected Outturn 2018 and Expected Activity does not include or take account of the impact on performance of any NTPF funded inpatient, day case or outpatient procedures in public hospitals or private hospitals.*

National Ambulance Service

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
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	Q (1 Qtr in arrears)	40%	40%	40%
Audit National Emergency Operations Centre (NEOC) Tallaght and Ballyshannon - % medical priority dispatch system (MPDS) protocol compliance	M	90%	90%	93%
Emergency Response Times % of clinical status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less		80%	80%	80%
% of ECHO calls which had a resource allocated within 90 seconds of call start		95%	95%	95%
% of clinical status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less		80%	58%	80%
% of DELTA calls which have a resource allocated within 90 seconds of call start		90%	90%	90%
Intermediate Care Service % of all transfers provided through the intermediate care service		90%	90%	90%
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		100%	89%	95%

Appendix 3(c): Activity 2019

Note: 2018 and 2019 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).

Population Health and Wellbeing

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Environmental Health No. of initial tobacco sales to minors test purchase inspections carried out	Q	384	384	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	225	225	295
No. of official food control planned, and planned surveillance, inspections of food businesses.		33,000	31,445	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*		40	40	40
Tobacco No. of smokers who received face to face or telephone intensive cessation support from a cessation counsellor	Q (1 Qtr in arrears)	13,000	11,258	11,500
No. of smokers who are receiving online cessation support services	Q	New PI NSP2019	New PI NSP2019	11,000
Chronic Disease Management No. of people who have completed a structured patient education programme for type 2 diabetes	M	4,500	3,089	4,190
Public Health No. of infectious disease (ID) outbreaks notified under the national ID reporting schedule	Q	500	916	500
Making Every Contact Count No. of frontline staff to complete the eLearning Making Every Contact Count training in brief intervention		7,523	162	1,425
No. of frontline staff to complete the face to face module of Making Every Contact Count training in brief intervention		1,505	0	284

Primary Care Reimbursement Service

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Medical Cards No. of persons covered by medical cards as at 31st December	M	1,564,230	1,573,783	1,541,667

Primary Care Reimbursement Service

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
No. of persons covered by GP visit cards as at 31st December	M	492,293	503,739	528,079
Total		2,056,523	2,077,522	2,069,746
General Medical Services Scheme Total no. of items prescribed		56,854,793	59,474,644	58,347,423
No. of prescriptions		18,721,471	18,765,506	18,685,315
Long Term Illness Scheme Total no. of items prescribed		8,241,730	8,829,947	8,829,947
No. of claims		2,342,248	2,506,941	2,506,941
Drug Payment Scheme Total no. of items prescribed		7,872,735	7,544,139	7,544,139
No. of claims		2,389,599	2,272,160	2,272,160
Other Schemes No. of high tech drugs scheme claims		650,150	709,979	708,859
No. of dental treatment services scheme treatments		1,261,381	1,147,714	1,185,985
No. of community ophthalmic services scheme treatments		869,891	793,256	793,256

National Screening Service

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
National Screening Service BreastCheck No. of women in the eligible population who have had a complete mammogram	M	170,000	168,000	185,000
CervicalCheck No. of unique women who have had one or more smear tests in a primary care setting		255,000	340,000	255,000
BowelScreen No. of clients who have completed a satisfactory BowelScreen FIT test		125,000	115,000	125,000
Diabetic RetinaScreen No. of Diabetic RetinaScreen clients screened with final grading result		93,000	100,000	104,000

Community Healthcare

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Primary Care Services				
Community Intervention Teams Total no. of CIT referrals.	M	38,180	43,084	45,432

Community Healthcare				
Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Paediatric Homecare Packages Total no. of Paediatric Homecare Packages	M	584*	377	457
Health Amendment Act: Services to people with State Acquired Hepatitis C No. of *Health Amendment Act* card holders who were reviewed	Q	459	119	340
GP Activity No. of contacts with GP Out of Hours Service	M	1,105,151	1,039,496	1,147,496
Nursing No. of patients seen	M (1 Mth in arrears)	743,605	728,148	743,605
Therapies / Community Healthcare Network Services Total no. of patients seen	M	1,524,864	1,544,700	1,557,484
Physiotherapy No. of patients seen		581,661	575,748	581,661
Occupational Therapy No. of patients seen		336,836	353,376	356,314
Speech and Language Therapy No. of patients seen		279,803	277,884	279,803
Podiatry No. of patients seen		74,206	83,100	83,100
Ophthalmology No. of patients seen		96,404	99,192	99,192
Audiology No. of patients seen		52,548	50,700	52,548
Dietetics No. of patients seen		63,382	63,216	63,382
Psychology No. of patients seen		40,024	41,484	41,484
Orthodontics No. of patients seen for assessment within six months	Q	2,483	2,406	2,406
GP Trainees No. of trainees	Annual	198	194	202
National Virus Reference Laboratory No. of tests	M	855,288	900,217	945,228
Social Inclusion Services				
Opioid Substitution No. of clients in receipt of opioid substitution treatment (outside prisons)	M (1 Mth in arrears)	10,028	9,783	10,063
Needle Exchange No. of unique individuals attending pharmacy needle exchange	Q (1 Qtr in arrears)	1,628	1,650	1,650

Community Healthcare				
Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Homeless Services No. of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed within two weeks of admission	Q	1,035	1,120	1,126
Traveller Health No. of people who received information on type 2 diabetes or participated in related initiatives		3,735	3,767	3,735
No. of people who received information on cardiovascular health or participated in related initiatives		3,735	4,362	3,735
Substance Misuse No. of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q (1 Qtr in arrears)	4,946	4,236	4,884
No. of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment		333	340	340
Disability Services				
An agreed Standardised Assessment Tool will be developed through the 9 demonstration sites with testing of the tool commenced in one of the 9 sites in Q4 2019	Q4	New PI NSP2019	New PI NSP2019	1
Residential Places No. of residential places for people with a disability	M	8,399	8,529	8,568
New Emergency Places Provided to People with a Disability No. of new emergency places provided to people with a disability		130	169	90
Congregated Settings Facilitate the movement of people from congregated to community settings	Q	170	170	160
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)	Bi-annual	2,752	2,513	2,513
No. of people (all disabilities) in receipt of rehabilitation training (RT)	M	2,432	2,282	2,282
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	19,672	20,772	22,272
Respite Services No. of day only respite sessions accessed by people with a disability	Q (1 Mth in arrears)	42,552	32,622	32,662
No. of people with a disability in receipt of respite services (ID / autism and physical and sensory disability)		6,320	6,059	6,559
No. of overnights (with or without day respite) accessed by people with a disability		182,506	159,480	182,506
Personal Assistance (PA) No. of PA service hours delivered to adults with a physical and / or sensory disability		1.46m	1.63m	1.63m
No. of adults with a physical and / or sensory disability in receipt of a PA service		2,357	2,535	2,535

Community Healthcare				
Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Home Support Service No. of home support hours delivered to persons with a disability		2.93m	3.08m	3.08m
No. of people with a disability in receipt of home support services (ID / autism and physical and sensory disability)	Q (1 Mth in arrears)	7,447	8,094	8,094
Disability Act Compliance No. of requests for assessment of need received for children	Q	6,548	5,065	5,065
Progressing Disability Services for Children and Young People (0-18s) Programme No. of Children's Disability Network Teams established	M	129	56	80
	**In 2018 a review of children's disability network teams was undertaken to ensure their alignment with the 96 Community Networks.*			
Mental Health Services				
General Adult Community Mental Health Teams No. of adult referrals seen by mental health services	M	29,135	27,349	28,716
No. of admissions to adult acute inpatient units	Q (1 Qtr in arrears)	12,692	12,148	12,148
Psychiatry of Later Life Community Mental Health Teams No. of Psychiatry of Later Life referrals seen by mental health services	M	9,045	8,472	8,896
Child and Adolescent Mental Health Services No. of CAMHs referrals received by mental health services		18,831	18,128	18,128
No. of CAMHs referrals seen by mental health services		14,365	10,317	10,833
Older Persons' Services				
Single Assessment Tool (SAT) No. of People seeking service who have been assessed using the Single Assessment Tool (SAT) (commencing Q4)		New PI NSP2019	New PI NSP2019	300
Home Support No. of home support hours provided (excluding provision of hours from Intensive Home Care Packages (IHCPs))		17.094m	17.2m	17.9m
No. of people in receipt of home support (excluding provision from Intensive Home Care Packages (IHCPs)) – each person counted once only		50,500	52,632	53,182
Intensive Homecare Packages (IHCPs) Total no. of persons in receipt of an Intensive Home Care Package		235	219	235
No. of home support hours provided from Intensive Home Care Packages		360,000	395,348	360,000
Transitional Care No. of persons at any given time being supported through transitional care in alternative care settings	M (1 Mth in arrears)	879	1,159	1,160
No. of persons in acute hospitals approved for transitional care to move to alternative care settings		9,160	11,528	10,980
Nursing Homes Support Scheme (NHSS) No. of persons funded under NHSS in long term residential care during the reporting month	M	23,334	22,951	23,042

Community Healthcare

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
No. of NHSS beds in public long stay units		5,096	4,986	4,900
Residential Care No. of short stay beds in public long stay units		2,053	1,930	1,850
Palliative Care Services				
Inpatient Palliative Care Services No. accessing specialist inpatient beds within seven days (during the reporting year)	M	3,595	3,809	3,809
Community Palliative Care Services No. of patients who received specialist palliative care treatment in their normal place of residence in the month		3,376	3,405	3,405
Children's Palliative Care Services No. of children in the care of the Clinical Nurse Co-ordinators for Children with Life Limiting Conditions (children's outreach nurse)		280	223	280
No. of children in the care of the acute specialist paediatric palliative care team (during the reporting month)		97	63	97

Notes: In 2018, Paediatric Homecare Package Quality Assurance process, activity target revised to 372 to account for a number of existing and on-going home care packages not falling within the definition of a PHCP. No reduction in quantum of service delivered to any child in this process.

Acute Hospital Care

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Acute Hospital Services				
Discharge Activity Inpatient	M (1 Mth in arrears)	634,815	637,355	637,173
Day case (includes dialysis)		1,055,851	1,062,204	1,069,702
Total inpatient and day cases		1,690,666	1,699,559	1,706,875
Emergency inpatient discharges		430,995	435,776	444,010
Elective inpatient discharges		92,172	92,076	85,660
Maternity inpatient discharges		111,648	109,503	107,503
Inpatient discharges ≥75 years		119,146	123,243	124,197
Day case discharges ≥75 years		183,625	189,220	190,526
Emergency Care New ED attendances	M	1,178,977	1,222,790	1,228,415
Return ED attendances		97,371	99,114	99,570
Injury unit attendances		91,588	96,077	96,518
Other emergency presentations		48,709	50,401	50,633

Acute Hospital Care

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Births Total no. of births		61,720	60,861	60,861
Outpatients No. of new and return outpatient attendances		3,337,967	3,299,294	3,339,859
Delayed Discharges No. of bed days lost through delayed discharges	M	182,500	205,047	≤200,750
No. of beds subject to delayed discharges		500	564	≤550
Healthcare Associated Infections (HCAI) No. of new cases of CPE		Reporting to commence in 2018	512	N/A

Notes: Projected Outturn 2018 is based on reported activity in 2018, however reduced activity in 2018 due to Storm Emma has been factored in to projected targets for 2019.

Projected Outturn 2018 and Expected Activity does not include or take account of the impact on activity levels of any NTPF arranged inpatient or day case procedures, or first outpatient appointments for patients in public hospitals or private hospitals. The DoH advises that, in line with the Statutory Instrument establishing the NTPF and the level of funding provided to the NTPF in 2019, the NTPF will arrange inpatient and day case procedures for approximately 25,000 patients and a first outpatient appointment for approximately 40,000 patients.

National Ambulance Service

Activity	Reporting Period	NSP2018 Expected Activity	Projected Outturn 2018	Expected Activity 2019
Total no. of AS1 and AS2 (emergency ambulance) calls	M	318,370	336,402	333,800
Total no. of AS3 calls (inter-hospital transfers)		31,100	32,913	34,000
No. of intermediate care vehicle (ICV) transfer calls		28,000	30,000	32,000
No. of clinical status 1 ECHO calls activated		5,787	5,138	5,100
No. of clinical status 1 ECHO calls arrived at scene (excludes those stood down en route)		5,494	4,940	4,940
No. of clinical status 1 DELTA calls activated		129,036	138,491	141,000
No. of clinical status 1 DELTA calls arrived at scene (excludes those stood down en route)		125,103	127,371	129,000
Aeromedical Service - Hours (Department of Defence)		480	480	480
Irish Coast Guard - Calls (Department of Transport, Tourism and Sport)		200	200	200

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that: 1) were completed in 2017 / 2018 and will be operational in 2019; 2) are due to be completed and operational in 2019; or 3) are due to be completed in 2019 and will be operational in 2020

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
Community Healthcare									
Primary Care Services									
CHO 1: Donegal, Sligo, Leitrim, Cavan, Monaghan									
Carrick on Shannon, Co. Leitrim	Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.15	0.15	0	0
CHO 2: Galway, Roscommon, Mayo									
Ballyhaunis, Co. Mayo	Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.08	0.08	0	0
Roscommon Town	Extension to Primary Care Centre, by lease agreement	Q1 2019	Q1 2019	0	0	0.16	0.16	0	0
CHO 3: Clare, Limerick, North Tipperary									
Castletroy, Limerick City	Primary Care Centre, by lease agreement	Q4 2018	Q1 2019	0	0	0.15	0.15	0	0
Kilmallock, Co. Limerick	Primary Care Centre, by lease agreement	Q3 2019	Q3 2019	0	0	0.10	0.10	0	0
CHO 4: Cork, Kerry									
Cork North City	New Primary Care Centre	Q2 2018	Phased from Q3 2018	0	0	0.95	18.35	0	0
Clonakilty, Co. Cork	Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.15	0.15	0	0
Newmarket, Co. Cork	Primary Care Centre, by lease agreement	Q2 2019	Q2 2019	0	0	0.10	0.10	0	0
Castletownbere, Co. Cork	Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.10	0.10	0	0
Carrigtwohill, Co. Cork	Primary Care Centre, by lease agreement	Q1 2019	Q1 2019	0	0	0.15	0.15	0	0
Bantry, Co. Cork	Primary Care Centre, by lease agreement	Q3 2019	Q3 2019	0	0	0.15	0.15	0	0
Tralee, Co. Kerry	Primary Care Centre, by lease agreement	Q2 2019	Q2 2019	0	0	0.15	0.15	0	0
Castleisland, Co. Kerry	Primary Care Centre, by lease agreement	Q3 2019	Q3 2019	0	0	0.10	0.10	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
St. Dympna's Hospital, Co. Carlow	Fire damage restoration project, Mental Health and Primary Care accommodation (funded from insurance)	Q1 2019	Q2 2019	0	0	0.47	1.32	0	0
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Royal Hospital, Donnybrook, Dublin 4	Primary Care Centre, by lease agreement (Interim solution)	Q3 2019	Q4 2019	0	0	0.10	0.10	0	0
Churchtown/Nutgrove, Dublin 14	Extension to Primary Care Centre, by lease agreement	Q2 2019	Q2 2019	0	0	0.10	0.10	0	0
Shankill, Dublin 18	Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.15	0.15	0	0
Rathdrum, Co. Wicklow	Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.15	0.15	0	0
CHO 7: Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West									
Rialto, Dublin 8	Primary Care Centre, by lease agreement	Q2 2019	Q3 2019	0	0	0.15	0.15	0	0
Tallaght Springfield, Dublin 24	Extension to Primary Care Centre, by lease agreement	Q4 2019	Q4 2019	0	0	0.05	0.05	0	0
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
St. Fintan's campus, Portlaoise, Co. Laois	Community Addiction Services Unit - new facility for counselling and support services	Q1 2019	Q1 2019	0	0	0.59	3.10	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Roselawn Health Centre, Blanchardstown, Dublin 15	Refurbishment of Roselawn Health Centre to complete provision of Primary Care Services in the Corduff / Blanchardstown network	Q4 2019	Q1 2020	0	0	1.03	1.17	0	0
Dublin North East Inner City (Summerhill), Dublin1	Primary Care Centre by PPP	Q4 2018	Q1 2019	0	0	0.00	0.00	0	0
Disability Services									
CHO 1: Donegal, Sligo, Leitrim, Cavan, Monaghan									
Cregg House and Cloonamahon, Co. Sligo	Six units at varying stages of purchase/new build / refurbishment to meet housing requirements for 24 people transitioning from congregated settings	Phased delivery 2019	Phased delivery 2019	0	24	1.22	2.63	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
CHO 2: Galway, Roscommon, Mayo									
Brothers of Charity, Galway	One unit for purchase / refurbishment to meet housing requirements for four people transitioning from a congregated setting	Q3 2019	Q3 2019	0	4	0.10	0.88	0	0
Aras Attracta, Swinford, Co. Mayo	Three units at varying stages of purchase/new build/refurbishment to meet housing requirements for 10 people transitioning from congregated settings	Phased delivery 2019	Phased delivery 2019	0	10	1.06	1.74	0	0
CHO 3: Clare, Limerick, North Tipperary									
Daughters of Charity, Co. Limerick Daughters of Charity, Roscrea, Co. Tipperary Brothers of Charity, Co. Limerick	Five units at varying stages of purchase / new build / refurbishment to meet housing requirements for 20 people transitioning from congregated settings	Phased delivery 2019	Phased delivery 2019	0	20	2.66	3.36	0	0
CHO 4: Cork, Kerry									
Cork City	Provision of a Children's Outreach Centre. Co-funded by HSE	Q3 2019	Q4 2019	0	0	1.00	6.50	0	0
Cluain Fhionnain, Co. Kerry St. Raphael's, Youghal, Co. Cork	Six units of purchase / refurbishment to meet housing requirements for 24 people transitioning from congregated settings	Phased delivery 2019	Phased delivery 2019	0	24	2.00	3.20	0	0
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
St. Patrick's Centre, Co. Kilkenny	One unit of purchase / refurbishment to meet housing requirements for four people transitioning from congregated settings	Q1 2019	Q2 2019	0	4	0.02	0.67	0	0
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
National Rehabilitation Hospital, Rochestown Avenue, Dún Laoghaire, Co. Dublin	Phase 1 redevelopment / replacement of existing facility in a phased development. Co-funded by NRH Trust	Q4 2019	Q2 2020	0	120	34.50	78.17	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
CHO 7: Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West									
St. John of God, St. Raphael's Centre, Celbridge, Co. Kildare	One unit of purchase / refurbishment to meet housing requirements for four people transitioning from congregated settings	Q1 2019	Q1 2019	0	4	0.05	0.63	0	0
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
Muiriosa, Delvin, Co. Westmeath	One unit of purchase / refurbishment to meet housing requirements for two people transitioning from congregated settings	Q1 2019	Q1 2019	0	2	0.19	0.47	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Daughters of Charity, Rosalie, Portmarnock, Dublin 13	Two units of purchase/refurbishment to meet housing requirements for eight people transitioning from congregated settings	Phased delivery 2019	Phased delivery 2019	0	8	0.80	1.20	0	0
Mental Health Services									
CHO 4: Cork, Kerry									
University Hospital Kerry	Refurbishment and upgrade of the acute Mental Health Unit, phase 2.	Q1 2019	Q1 2019	0	15	0.79	1.90	0	0
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
St. Loman's Mullingar, Co. Westmeath	Refurbishment of former Children and Family Unit to facilitate removal of Mental Health staff from the main building	Q1 2019	Q1 2019	0	0	0.24	1.40	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 10 people currently in the Weir Home	Q4 2019	Q1 2020	0	10	1.95	2.23	0	0
National Forensic Mental Health Services Hospital, Portrane, Co. Dublin	Phase 1. National Forensic Central Hospital, 100 replacement and 70 additional beds (to include 30 intensive care rehabilitation beds, 10 child and adolescent beds, 10 mental health intellectual disability beds and 20 medium secure beds)	Q4 2019	Q1 2020	70	100	59.00	178.00	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
St. Ita's, Portrane, Co. Dublin	Upgrade ground floor, kitchen area	Q2 2019	Q3 2019	0	0	0.85	1.20	0	0
Older Persons' Services									
CHO 1: Donegal, Sligo, Leitrim, Cavan, Monaghan									
Dungloe Community Hospital, Co. Donegal	Upgrade and refurbishment to achieve HIQA compliance	Q4 2019	Q4 2019	0	0	1.40	1.67	0	0
Carndonagh Community Hospital, Co. Donegal	Upgrade and refurbishment to achieve HIQA compliance	Q4 2019	Q4 2019	0	0	1.70	2.33	0	0
CHO 4: Cork, Kerry									
Caherciveen Community Hospital, Co. Kerry	Upgrade and refurbishment to achieve HIQA compliance	Q4 2019	Q1 2020	0	0	2.00	2.50	0	0
Listowel Community Hospital, Co. Kerry	Upgrade and refurbishment to achieve HIQA compliance	Q4 2019	Q1 2020	0	0	2.00	2.68	0	0
Dunmanway Community Hospital, Co. Cork	Upgrade and refurbishment to achieve HIQA compliance	Q3 2019	Q4 2019	0	0	1.00	1.10	0	0
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
St. Patrick's Hospital, John's Hill, Waterford City	100 bed CNU to replace beds in St. Patrick's and St. Otteran's (to include 20 psychiatry of later life beds and 80 long stay elderly beds)	Q3 2019	Q4 2019	15	65	12.35	25.20	0	0
Palliative Care Unit (University Hospital Waterford)	Development of a new block to include palliative care unit, co-funded by Waterford Hospice **Details of capital costs are included within University Hospital Waterford in the South / South West Hospital Group*	Q1 2019	Q2 2019	20	0	*	*	0	0
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Dalkey Community Nursing Unit, Co. Dublin	Upgrade and refurbishment to achieve HIQA compliance	Q3 2019	Q4 2019	0	46	1.34	2.58	0	0
CHO 7: Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West									
Tymon North, Co. Dublin	New 100 bed Community Nursing Unit	Q2 2019	Q3 2019	50	50	5.00	22.68	0	0
Peamount Hospital, Newcastle, Co. Dublin	New 100 bed Community Nursing Unit. Co-funded by Peamount	Q3 2019	Q4 2019	51	49	5.00	26.58	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
CHO 8: Laois, Offaly, Longford, Westmeath, Louth, Meath									
St. Joseph's Community Nursing Unit, Trim, Co. Meath	Upgrade and refurbishment to achieve HIQA compliance (including 12 bed dementia unit) and two respite specific beds in new build of dementia unit	Q1 2019	Q1 2019	0	14	0.12	6.35	0	0
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Seancara / Clarehaven Community Nursing Unit, Dublin 11	Upgrade, extension and refurbishment to achieve HIQA compliance	Q4 2018	Q1 2019	0	0	4.60	6.20	0	0
Acute Hospital Care									
Children's Health Ireland									
Connolly Hospital, Blanchardstown, Dublin 15	Paediatric Ambulatory and Urgent Care Centre	Q3 2019	Q4 2019	0	0	8.6	26.12	0	0
Dublin Midlands Hospital Group									
Midlands Regional Hospital, Portlaoise, Co. Laois	New hospital street extension	Q4 2019	Q1 2020	0	0	1.35	1.83	0	0
RCSI Hospital Group									
Our Lady of Lourdes Hospital, Drogheda, Co. Louth	Phase 3: Fit-out and equipping of theatres	Q1 2019	Q1 2019	0	0	3.00	11.87	0	0
Beaumont Hospital, Dublin 9	Provision of accommodation for the Cochlear Implant programme - refurb of existing St. Martins ward after decant to renal dialysis.	Q1 2019	Q1 2019	0	0	0.90	1.64	0	0
Ireland East Hospital Group									
St. Vincent's University Hospital, Elm Park, Dublin	Provision of two cath labs through the Equipment Replacement Programme	Q4 2018	Q3 2019	0	0	0.10	2.85	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
Saolta University Health Care Group									
Letterkenny University Hospital, Co. Donegal	New Radiology Unit. Includes additional ultrasound and CT room plus a multipurpose interventional suite. Includes upgrade/refurb of underground duct. Part funded by Friends of LGH	Q2 2019	Q3 2019	0	0	4.25	12.10	0	0
Sligo University Hospital	Replacement of fluoroscopy room with a full Interventional Suite	Q3 2019	Q4 2019	0	0	1.00	2.97	0	0
Sligo University Hospital	Provision of a Diabetic Unit to facilitate the commencement of a paediatric insulin pump service.	Q3 2019	Q4 2019	0	0	1.00	1.31	0	0
University Hospital Galway	Provision of a new IT Room for the hospital	Q3 2019	Q3 2019	0	0	0.70	1.22	0	0
University Hospital Galway	Replacement of two cardiac cath labs and enabling works for a third cath lab	Q4 2019	Q1 2020	0	0	2.30	5.88	0	0
South / South West Hospital Group									
Cork University Hospital	New Radiation Oncology Unit	Q1 2019	Phased opening from Q4 2019	0	0	16.40	22.30	0	0
Cork University Hospital	Blood Science Project - extension and refurbishment of existing pathology laboratory to facilitate management services tender	Q4 2019	Q1 2020	0	0	3.50	4.70	0	0
South Tipperary General Hospital	40 bed modular unit	Q4 2018	Q2 2019	40	0	7.00	9.76	0	0
University Hospital Waterford	Development of a new block to include replacement inpatient beds ** *This is a joint capital project between acute services and palliative care – see under Older Persons' Services for further details*	Q1 2019	Q4 2019	0	48	7.35**	31.37**	0	0
University Hospital Waterford	Replacement of fire alarm and emergency lighting systems	Q1 2019	Q1 2019	0	0	1.20	4.20	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
UL Hospitals Group									
Nenagh Hospital, Co. Tipperary	Ward Block extension and refurbishment programme, incl. 16 single rooms and 4 double rooms - part funded by the Friends of Nenagh Hospital.	Q3 2019	Q4 2019	3	21	1.77	6.11	0	0
Ennis General Hospital, Co. Clare	Outpatients (off site solution)	Q3 2019	Q4 2019	0	0	0.60	0.60	0	0
University Hospital Limerick	AMAU and OPD reconfiguration	Q4 2019	Q4 2019	0	0	1.40	1.65	0	0
National Ambulance Service									
Edenderry Ambulance Station, Co. Offaly	New ambulance station	Q1 2019	Q1 2019	0	0	0.30	2.41	0	0
St. Joseph's Community Hospital, Stranorlar, Co. Donegal	The provision of an ambulance restroom at St. Joseph's Hospital, Stranolar	Q3 2019	Q3 2019	0	0	0.35	0.51	0	0
Corporate Services									
St. Joseph's Hospital, Limerick	Refurbish existing vacant space for pension management	Q3 2019	Q3 2019	0	0	0.40	0.60	0	0

Additional Capital Initiatives – Early bed capacity opportunities

An integrated approach has been utilised to plan for increased demand on services to anticipate and manage critical demand pressures, most particularly during winter. The plans for additional acute beds are included here as part of the HSE's response towards investment in capacity for 2019.

- Winter 2018 / 2019 – Increasing acute bed capacity by 75 beds across ten locations with particular focus on maximising available capacity in quarter 1 and quarter 2 of 2019. This initiative is for part year opening to relieve winter pressure and revenue funding reflects this. There are revenue implications for 2020 of €9.3m in order to fully operationalise this capital investment.
- Winter 2019 / 2020 – Further increases to acute bed capacity by 202 beds (including 16 critical care beds) across 14 locations, to be operational by quarter 1 2020. There are revenue implications for 2020 of €28.5m in order to fully operationalise this capital investment.

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
Acute Hospital Care									
Winter beds 2018 / 2019									
Multiple	Provision of 75 acute beds (detailed in Winter Plan)	Q1 2019	Q2 2019	75	0	1.17	1.17	0	0
Winter beds 2019 / 2020									
Multiple	Provision of 202 beds of which 16 are critical care	Q4 2019	Q1 2020	202	0	7.43	7.43	0	0

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