Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive

National Service Plan 2016


Values
We will try to live our values every day and will continue to develop them
Care
Compassion
Trust
Learning


Vision
A healthier Ireland with a high quality health service valued by all


Mission
► People in Ireland are supported by health and social care services to achieve their full potential
► People in Ireland can access safe, compassionate and quality care when they need it
► People in Ireland can be confident that we will deliver the best health outcomes and value through optimising our resources

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Introduction

In line with legislative requirements the National Service Plan (NSP) 2016 sets out the type and volume of health and personal social services which will be provided by the Health Service Executive (HSE) within the funding allocated by Government over the course of the year. Early in 2015 we launched our *Corporate Plan* which sets out our ambition for the Health Services over the three years 2015–2017. Delivery on our vision of a 'high quality health service valued by all' is underpinned by five key goals set out below. NSP 2016 sets out the actions which we will take to deliver on the goals over the course of the year.

Our objective is to provide high quality, sustainable healthcare grounded in our values of Care, Compassion, Trust and Learning.

The service plan is designed to place people at the centre of the services we provide and to help improve the overall health of the population, no matter where people live, what stage of life they are at, or what their healthcare needs may be.

Whilst continuing our efforts to improve services and health outcomes, we must also focus on the cost and sustainability of services and ensure that we are achieving the best value for money for both the public and service users. The demand for health and personal social care services continues to grow year on year. Our population is projected to increase by 4% between 2016 and 2021. People are living longer through advances in healthcare and the number of people in the 85+ age group is expected to increase by 4.2% between 2015 and 2016.

As part of Budget 2016 the HSE will receive a total revenue allocation of €12,987m to provide health and social care services. This represents an increase of €817m (6.7%) on the current 2015 allocation, of which a total of €97m is earmarked for specific new service developments. The total funding available to the HSE for existing services in 2016 is €12,890m which represents an increase in the region of €100m (0.8%) on the projected expenditure for 2015.

This is the second year in which an additional budget allocation has been made available to the health services. Following the years of austerity this additional funding is particularly welcome.

The HSE fully acknowledges the requirement to operate within the limits of the funding notified to it and will ensure this receives the very significant management focus required in 2016. Given the scale of the demographic, regulatory and other service pressures it is estimated that across the acute and community healthcare service areas there is a substantial financial risk being managed within this service plan. Particular attention in the context of the Accountability Framework will be focused in conjunction with the Hospital Groups on driving financial performance across our acute hospitals in light of the scale of the financial challenge. In addition to the performance areas there are significant financial pressures in the PCRS and other demand led areas that arise as a result of the demographic, economic and other factors. There will be particular challenges in meeting compliance with regulatory requirements in both the disability and older persons sectors within the funding available. Whilst it will not be possible to address all the challenges identified, we will strive to do the maximum we can with the additional funding provided.

During 2015, a number of serious investigations took place within both acute hospital and community healthcare services. These investigations showed clearly that the services fell short on delivering the standard of quality care to which we aspire. To ensure that we improve and do better we have tasked specific groups with implementing the recommendations arising from these reviews and investigations so that the lessons learned are embedded across the health system. Continuous learning has to be a key feature in our commitment to improve the quality of health and social care services. There will be a particular focus on maternity services reflecting the recommendations of recent reports, including the investigation into maternity services in Portlaoise.

A serious allegation of unacceptable behaviour and attitudes towards residents in one of our disability service residential units namely Áras Attracta came to light in 2014. The standard of care at this home was unacceptable and did not reflect our corporate values of care and compassion. Our Social Care and Quality Improvement Divisions are working collaboratively with residents and families to improve service delivery and the experience for residents and staff. We have developed *Safeguarding Vulnerable Persons at Risk of Abuse,* the national policy and procedures to be followed to safeguard vulnerable adults. We will continue to implement these procedures and promote a positive and open culture which respects individual rights and embeds a 'zero tolerance' approach to abuse within all services. Protected disclosure and good faith reporting will continue to be implemented to foster a fair and just culture within our health and social care services.

Improving Quality

Every person who comes into contact with our health or social care services should be able to access safe, compassionate and quality care. The national quality programme is driving both quality improvement and quality assurance. A number of key priorities have been identified for 2016 which encourage patients, service users and staff to be more involved in their services and their care where their opinions are sought and their voices heard. We will strive to:

- Drive continuous quality improvement through building capacity of all staff.
- Implement approaches which enable and empower people to be at the centre of service delivery.
- Deliver patient safety programmes including healthcare acquired infection (HCAI), pressure ulcers, falls prevention, nutrition and hydration.
- Ensure that strong leadership and governance processes are implemented in the new service delivery organisations.
- Improve compliance with standards and regulations.
- Implement recommendations and learning from serious incidents, reviews and investigations.

Given the pivotal importance of quality and patient safety we have reprioritised €3m from within our overall allocation to invest in quality and patient safety improvements and assurance. This will require an additional €3m in 2017 to meet the full year costs which will be dealt with as part of 2017 estimates / service planning

process with the DoH. A National Patient Safety Office is being established by the DoH and we will work to support the establishment of the Office in the coming year to deliver shared objectives.

Healthy Ireland

The *Healthy Ireland* (HI) Framework was adopted by the Irish Government in 2013 to improve the health and wellbeing of the population and reduce health inequalities. In line with our *Corporate Plan* Vision of a 'Healthy Ireland with a high quality health service valued by all', the HSE developed an implementation plan – *Healthy Ireland in the Health Services National Implementation Plan 2015–2017*. Three clear strategic priorities for action have been identified:

- System reform – ensuring the significant reforms underway are delivered supporting a better health system.
- Reducing chronic disease – the biggest risk to the population's health and to service provision.
- Staff health and wellbeing – ensuring a resilient and healthy workforce.

This implementation plan envisages everyone working together to create an environment that improves health and wellbeing. For the population it also presents themes which have been prioritised for action to reduce the burden of chronic disease and improve the health and wellbeing of staff. These include healthy eating, child health, active living, mental health, positive ageing and reduction in alcohol and tobacco consumption.

Person-Centred Care

In response to the challenge of increased demand in services for an ageing population, an integrated person-centred approach to care will be further developed and implemented in 2016 to support the specific needs of older people, particularly those with complex needs. This will require a strong focus on collaborative working between primary, social and acute care services at all levels of the system in order to maximise the proportion of care provided in the primary care setting to avoid the need for acute hospital or long-term care unless absolutely necessary. This includes plans for General Practitioner (GP) direct access to ultrasound and x-ray services as well as the provision of minor surgery by GPs. The continuation of home support through home help and home care packages, within the resources available, also plays a vital role in helping older people to continue to live independently in their homes in the community.

Emergency Departments

Throughout 2015 Emergency Departments (EDs) were extremely busy resulting in overcrowding in hospitals with some patients waiting for long periods of time on trolleys. This is not acceptable. During 2014 an Emergency Department Taskforce was established and an Action Plan developed. Efforts will continue in 2016 to proactively optimise existing hospital and community capacity, to improve the patient experience, patient flow and timeliness of quality service delivery. The Taskforce will focus on ED overcrowding and the Action Plan sets out a range of measures across acute, social care and primary care services to drive process improvements aimed at delivering a better service to our patients. The significant funding invested by government in the delayed discharges and ED / Winter Plan initiatives in 2015 and 2016 has, and will continue to have, a beneficial impact on both ED waiting times and timely discharge from hospital.

This is the second year where additional funding has been made available within social care for older people services and this will support work in implementing ED taskforce recommendations. However there will be a continuing challenge in maintaining and building on progress to date in the context of demographic pressures particularly in respect of the very elderly.

Reforming services and achieving better outcomes

The people in Ireland rely on public health services. The ambition of the HSE is to deliver the best health service possible within the funding available. To do this it is necessary to embark upon a programme of reform

to ensure that the changes necessary to deliver on the ambition are achieved. The HSE has a programme of reform in place with a range of projects all aimed at improving the health services and realising the ambition.

Any funding provided for health must be prioritised towards the actual delivery of specific frontline services. However, we must also invest in creating the overarching conditions that are essential for good governance, accountability and delivering sustainable change. Investment in reform is particularly important given that we need to make very substantial improvements at a reasonable pace while continuing to deliver the vast range of day to day services, many of which are complex and demand-led.

In addition, there is a requirement to invest in the infrastructure that guides and supports the delivery of services. Essential investment is required in this infrastructure which includes clinical audit, activity based funding, business intelligence, risk management, professional and technical staff in ICT, Human Resources (HR), financial and procurement support. There is also a need in the short term to invest in change management and programme management capacity to ensure that the pace and changes required are sustainable. To achieve this we will be reprioritising funding of up to €10m or 0.08% of our total budget for system reform.

A significant element of this investment is being targeted at the new community healthcare organisations (CHOs) and hospital groups on the basis that government policy requires that they become the accountable key providers for the majority of our health and social care services for the population they serve. Nine Chief Officers and seven Group Chief Executive Officers have been appointed to CHOs and hospital groups. In 2016 we will strengthen the supports to both the CHOs and the hospital groups to provide more responsive and better patient care. Service delivery reform projects are in place for all our services including hospital, community and ambulance services and all of the key enabling and support functions.

Ensuring the provision of integrated care and clinical programmes

One of the most significant areas of reform is the development of integrated care across all our services. This is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in our care.

Provision of care, which is provided through our CHOs, hospital groups and the National Ambulance Service (NAS), must be integrated by providing better and easier access to services which are close to where people live. Services are being re-organised to ensure they are delivered in the most appropriate and effective way as part of the HSE reform programme.

Integrated Care Programmes

Integrated Care Programmes will enable and deliver care within and across care areas through five Integrated Care Programmes – Prevention and Management of Chronic Disease, Older People, Patient Flow, Children and Maternity Care. The intention is to ensure joined up health and social care services and improve patient outcomes.

National Clinical Programmes

National Clinical Programmes are modernising and improving the way in which specific areas of health and social care services are provided and delivered by designing and guiding the implementation of standardised models of care, clinical guidelines, care pathways and associated strategies through thirty-one national clinical programmes. Clinically led multi-disciplinary teams will support evidence based effective change through a consistent national approach to improvement.

Chronic Disease Prevention and Management

The burden of chronic disease is increasing by 4% each year. We know that three quarters of deaths in Ireland are due to three chronic disease areas – cancer, cardiovascular and respiratory diseases. Considerable work took place during 2015 to prioritise a number of common chronic diseases which will be progressed in 2016. These priority areas are chronic obstructive pulmonary disease (COPD), asthma, heart failure and diabetes mellitus.

It is intended to reprioritise funding up to €9m or 0.07% of our total budget to support the development and implementation of integrated care in 2016.

Reducing waiting times and waiting lists

During 2015 significant improvements were achieved in reducing wait times for inpatient and day case procedures supported by substantial additional government funding as part of the waiting list initiative. In 2016 we will prioritise process improvements including chronological scheduling within funded levels of activity. The volume of service activity will be provided in line with the level of funding available.

Access to diagnostic tests will be improved through the development and implementation of primary care initiatives.

As a result of our move to a single state of the art national ambulance control centre in Tallaght in 2015, response times for ambulances will be improved and will be assisted by the new national call taking and dispatch system which was implemented in the second half of 2015.

Early intervention for children who require therapy services will receive focused attention in 2016. Initiatives are planned to expand the provision of speech and language therapy in primary care and to support the re-organisation and expansion of speech and language and other therapies under 'Progressing Disability Services Programme for Children and Young People'. This includes the further development of early intervention services to facilitate the inclusion of children with a disability in mainstream pre-school settings, as part of the implementation of the Early Childhood Care and Education Programme (ECCE). Access to mental health services for children and adolescents including access through primary care counselling for those under 18 years will be improved.

Managing the year on year growth in demand for community-based social services is one of the key challenges for Older Persons Services in 2016. The Nursing Homes Support Scheme will see the level of support increase to an average of 23,450 clients per week for the duration of 2016, representing 1,222,750 total weeks of care provided. To meet the growing demand for home care and transitional care, which is above the 2015 service plan level, the HSE will utilise €20m in expected time related savings from the €58.5m new initiatives monies held by the DoH. This will assist in maintaining 2015 outturn levels of 10.437m home help hours, 15,450 people in receipt of home care packages and 313 transitional care beds delivering 109 places per week during 2016.

Primary Care – Extension of GP care

Provision has been made in the HSE budget allocation for the full year costs of universal GP services for those aged under 6 years and over 70 years.

It is intended to extend GP care without fees to all children aged between 6 years and 12 years in 2016. This will require contractual negotiations with the IMO in accordance with the Framework Agreement of June 2014.

Children First

The Children First implementation plan sets out the key actions needed to ensure compliance with both the Children First legislation and national policy. Under legislation, the HSE and any HSE funded organisations who are a provider of services to children and young people will be required to undertake an assessment of any risk to a child who is availing of their services, and use this risk assessment to publish a Child Safeguarding Statement. The purpose of the Statement is to identify how the organisation will manage any risks identified in the risk assessment. The Safeguarding Statement will also outline how staff / volunteers will be provided with information to identify abuse which children may experience outside the organisation, and what they should do with any concerns about child safety.

In 2016, high level actions include the development of Children First implementation plans by CHOs and hospital groups with support from the Children First National Office; the delivery of a suite of Children First

training programmes for HSE staff and HSE funded organisations. Children First implementation will also be included in the performance assurance process. Child protection policies at CHO and hospital group level will also be developed and reports will be tracked and monitored by the Children First Office.

Connecting for Life – suicide prevention

Connecting for Life 2015–2020 is the new national strategy to reduce suicide and sets out a vision of an Ireland where fewer lives are lost through suicide and where communities and individuals are empowered to improve their mental health and wellbeing. This vision will be achieved through the adoption of a number of goals. These include a better understanding of the factors that are linked to suicidal behaviour, supporting communities to prevent and respond to recognised risks for suicide at community and individual level, targeted approaches for those vulnerable to suicide, improved access, consistency and integration of services, safe and high quality services, reduced access to means and better data and research.

Workforce

Staff are our most valuable resource and our biggest investment. They are at the core of service delivery, working within and across all care settings in communities, hospitals and healthcare offices. Investing in and developing our workforce and maintaining continuous professional development and learning is a priority. The People Strategy 2015–2018 has been developed with this in mind, recognising the vital role that our workforce plays in delivering safer and better healthcare. The strategy is underpinned by our goal to engage, develop, value and support the workforce.

In 2016 areas of particular focus include further development of our pay and staffing numbers control, recruitment processes, a review of HR structures and the development of a new performance management approach.

Occupational Safety and Health at Work

Health and safety at work is taken very seriously. The Corporate Safety Statement will be reviewed and revised, key performance indicators in health and safety management and performance will be developed, a new statutory occupational safety and health at work training policy will be launched, a national proactive audit and inspection programme will be developed and will commence. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established.

Health Business Services

The objective of our Health Business Services (HBS) is to ensure that all health services have access to a range of common support business services on a shared basis, enabling operational services to focus attention on core service delivery. A number of key actions will be progressed during 2016 including:

- Improving procurement sourcing and compliance with contracts.
- Supporting the finance reform programme.
- Developing solutions to support key service areas in recruitment and pensions management.
- Initiatives in e-invoicing, payroll rationalisation and phase two of the capital plan for the National Distribution Centre for procurement.
- Managing the HSE Estate to maximise compliance with all regulatory and statutory requirements.

HBS places a strong emphasis on the delivery of compliant services to customers by ensuring they are in line with national EU directives, legislation and regulations, and this area will be further developed in 2016.

In order to ensure efficient use of and appropriate investment in HBS services an interim model for charging out a portion of the relevant costs across our services will be considered in 2016.

Capital Plan

A 2016 capital allocation of €399m has been received including an ICT capital allocation of €55m. The main priority in 2016 will be judicious management of the capital budget and compliance with regulatory and statutory requirements. In line with the *Corporate Plan* capital projects will take account of resources and support a strategy that delivers best health outcomes, improves people's experience of using the services and demonstrates value for money.

In 2016 the Capital Plan 2016–2021 includes progressing the following projects:

- New Children's Hospital
- National Forensic Mental Health Hospital
- National Radiation Oncology programme
- Relocation of the National Maternity Hospital
- Continued investment in Primary Care Centres and mental health infrastructure
- Achieving regulatory compliance in long stay residential facilities and disability services
- National Rehabilitation Hospital.

Information and Communications Technology

Building on the *eHealth Vision for Ireland*, a *Knowledge and Information Plan* was published in 2015. It sets out how integrated information and technology will support the delivery of innovative, safe and high quality patient care to meet the needs of the population across all patient pathways and care settings.

A 2016 ICT capital allocation of €55m has been received. A targeted range of new multi-annual programmes will begin delivery in 2016 including the individual health identifier, electronic referrals, electronic health records, ePharmacy, the Digital Children's Hospital and technology in cancer services.

Funding

The HSE budget in 2015 is currently **€12,170m.**The letter of determination, dated 27th October 2015, provides for a revenue budget in 2016 of **€12,928.5m**. This represents an increase of **€758.5m (**6.2%) year on year, of which €38.5m is provided for new service initiatives and €720m is available to maintain existing services.

In addition, a further €58.5m is being held by the Department of Health (DoH) for further new initiatives and will be released during the year as specific implementation plans are agreed. This will bring the total revenue budget available in 2016 to **€12,987m**. This represents an overall increase of **€817m** (6.7%) year on year, of which a total of €97m is earmarked for specific new service developments.

The allocation of €38.5m for new initiatives includes investment in acute hospital developments (€13m), cancer services (€10m – including €1.5m for BreastCheck), disability services (€7.25m), health and wellbeing (€2.5m), NAS (€2m), respite care (€1m), palliative care (€0.7m), finance reform including activity based funding (€2m). The full year cost of these initiatives in 2017 is €82.9m.

The €58.5m being held by the DoH relates to specific initiatives in the areas of mental health €35m, primary care €13.5m, therapy services for young people €8m, and the nursing taskforce pilot implementation €2m. The release of these funds will be approved as specific implementation plans are agreed during the year. The HSE will use €20m in time related savings from these planned initiatives, on a once off basis, to continue to provide the 2015 outturn levels of home care and transitional care beds, which is above the 2015 planned service level and up to a further €1.5m to put in place an advance purchase agreement in relation to vaccines.

The HSE welcomes this increase in its allocation and recognises that it represents a significant proportion of the increase in public expenditure that is available nationally in 2016. However, the total funding available for existing services within the 2016 allocation is **€12,890m,** which represents an increase in the region of **€100m** (0.8%) above the recurring cost base in 2015. Significant inflationary pressures will require to be managed within this additional funding. The HSE will strive to increase efficiency and value for money across all

services and activities in 2016. An integrated pay bill management strategy will be developed in respect of recruitment, agency conversion and workforce planning. Cost containment and reduction programmes will be implemented across key areas of non-pay expenditure. Income generation will be sustained and maximised wherever possible. In addition, the provisions of the enhanced accountability framework will be used to further intensify the focus on budgetary control across the system.

Activity Based Funding

Progressing the *Activity Based Funding Programme Implementation Plan 2015–2017* is a key priority for the HSE and government. Implementation of ABF in acute hospitals in 2016, supported by €1m of the additional funding of €2m provided for overall finance reform, means that approximately 70% of hospital funding will be based on a set number and complexity of cases, rather than by the traditional block grant. In order to maintain stability in the hospital system, hospitals will be given transitional adjustments to their funding to reflect the difference between their current costs and the national average unit cost. For some hospitals this will mean receiving additional transitional funding with the intention being to phase these transitional payments out over a number of years as hospitals move their costs towards the national average and as any structural and other issues are addressed.

Over time the ABF model will support integrated care and will include specific clinical and patient safety standards developed in line with national clinical effectiveness guidelines and national and international benchmarks.

Accountability Framework

The HSE is the statutory body tasked with responsibility for the delivery of health and personal social care services in Ireland. In discharging its public accountabilities, it has in place a Governance Framework covering corporate, clinical and financial governance. While the HSE's primary accountability is to the Minister for Health, it has a range of other accountability obligations to the Oireachtas and to its Regulators.

An Accountability Framework was developed and operationalised in 2015. This sets out the arrangements in place between the National Performance Oversight Group in the HSE (NPOG) and the National Directors in accounting for and responding to areas of underperformance across the balanced scorecard of access to services, quality, financial management and human resources. The Framework makes explicit the responsibilities of all managers to deliver on the targets set out in the Service Plan. An Escalation and Intervention Framework is also in operation as part of this process. It sets out four levels of escalation identifying supports, interventions and sanctions when service areas are underperforming against defined thresholds.

2015 was the first year of operation of the new Accountability Framework. The Framework has been updated for 2016 to ensure that its operation, effectiveness, and application best meets the evolving needs of the organisation and drives overall performance improvement. A formal review of the Framework was commissioned and completed in 2015, focusing on the operation of the Framework during its first year of operation. Proposed recommendations for further enhancement from the review will be implemented early in 2016.

The Accountability Framework 2016 is appended at page 139 of this plan.

Code of Governance

During 2015 the HSE updated its Code of Governance. This Code is compliant with relevant legislation and the requirements of the Department of Finance Codes.

Risks to the Delivery of the National Service Plan

In identifying potential risks to the delivery of this NSP, it is acknowledged that while every effort will be made to mitigate these risks, it may not be possible to eliminate them in full:

- The impact of increased demand for services beyond the planned and funded levels arising from changes in demographics and consumer expectations.
- The capacity to recruit and retain a highly-skilled and qualified medical and clinical workforce, particularly in high-demand areas and specialties.
- Management of the scale of reform and change required to support new evolving models of service delivery and drive innovation.
- The limitations of our clinical, business information, financial and HR systems.
- Capacity and resources to continue to develop and involve staff in driving change and improving quality and safety and the culture of the organisation.
- It is for the HSE and the Hospital Groups to ensure that appropriate management effort and attention is applied to maximising the delivery of savings measures and overall budgetary performance. Thereafter the HSE and DoH acknowledge the shared risks inherent in the extent of the savings targets and the assumptions underpinning them, which have been mutually agreed following extensive engagement in light of the alternative which is service reductions.
- The ability of NHSS (A Fair Deal) to maintain the wait time at 4 weeks given the number and complexity of variables involved and the underlying assumptions.
- Capacity to comply with regulatory requirements in public long-stay residential care facilities, the disability sector, mental health and hospital services within the limits of the revenue and capital funding available.
- In relation to PCRS the scale of the financial challenge and other saving measures is linked to the numbers availing of schemes and the volume of medical cards. These measures and the underpinning assumptions around them represent a shared set of risks agreed with DoH.
- The risks associated with the sectoral discussions around the costs of medicines which are being conducted with DPER, DoH and HSE; and industry.
- Financial risks associated with the approval of new drugs and the control of existing drugs at or below 2015 funded levels.
- The capacity to exercise effective control over pay and staff numbers in the context of safety and quality, regulatory, volume and practice driven pressures.
- Unavoidable public pay policy and approved pay cost growth in areas which have not been funded including staff increments.
- Risks associated with our capacity to invest in and maintain our infrastructure and equipment.

Conclusion

The HSE welcomes an increase in budget received for 2016. However, there are significant financial challenges within acute hospitals, social care, social inclusion and the PCRS when consideration is given to the increasing demand for services arising from a growing and ageing population. We will do all within our power to maximise delivery of services within the funding available, whilst striving to deliver quality patient centred care.

Delivery of NSP 2016 will be supported by the Accountability Framework and the National Performance Oversight Group.

Corporate Goals
High Level Actions

The Corporate Plan published in 2015, sets out the HSE's Vision, Mission, Values and Goals for the three year period 2015 – 2017.

This service plan provides an organisational view of the high level actions that will be delivered under our five corporate goals.

Further detail can be seen in the individual sections of this plan and separately in Operational Plans which will be published in January 2016.

What we will do in 2016

- Implement actions from the *Healthy Ireland* framework across the organisation as set out in the three year health services implementation plan
- **Healthcare Systems Reform**
  - Support CHOs and hospital groups in the development and implementation of *Healthy Ireland* plans
- Reduce **chronic diseases**
  - Include prevention, early detection and self-management in the Integrated Care Programmes
  - Support implementation of 'Making Every Contact Count'
  - Support implementation of obesity policy and action plan
  - Train staff to promote healthier lifestyles for people
  - Commence implementation of the National Brief Intervention Model
  - Increase the number of hospital frontline staff trained in brief intervention
  - Reduce incidence of disease and support best management of chronic disease such as diabetes, COPD and coronary heart disease
- **Tobacco Free Ireland**
  - Maintain and strengthen the HSE Tobacco Free Policy
  - Maximise impact of the QUIT Campaign
  - Make all new residential units tobacco free
  - Train frontline workers to support smokers to quit
- **Healthy Eating Active Living**
  - Develop a three-year Healthy Eating Active Living (HEAL) Plan
  - Implement calorie posting in hospitals
  - Develop and implement a HSE Food and Nutrition Policy
  - Increase opportunities for physical activity with a range of partners
- **Healthy Childhood**
  - Commence implementation of Nurture, Infant Health and Wellbeing Programme
  - Implement revised child health programme
  - Promote and increase breastfeeding uptake rates
- **Alcohol**
  - Develop a three-year implementation plan to reduce alcohol consumption and related harms incorporating actions from the National Substance Misuse report and aligned to new legislation
  - Increase awareness of alcohol related harm
- Promoting positive **mental health** and resilience
  - Implement *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015–2020*
- Continue to develop early intervention and prevention services including counselling and improved psychological supports
- **Positive ageing**
  - Support all local authorities to implement the Age Friendly County Programme
  - Support people with dementia and their carers
  - Develop and launch a national communications campaign for dementia
  - Continue with implementation of Older People Remaining at Home (OPRAH) Programme
  - Develop an integrated approach to reducing falls and promoting bone health
- Implement recommendations from the **National Sexual Health Strategy**
- Improve **staff health** and wellbeing through the implementation of healthy workplace policies and practices
- Deliver and expand **screening programmes**
  - Maximise uptake of BreastCheck programme (> 70% of women aged 50–64)
  - Continue to extend BreastCheck to women aged from 65–69 years
  - Maximise coverage of CervicalCheck programme (80% of eligible women)

- Maximise uptake of BowelScreen programme (45% of eligible population)
- Maximise uptake of Diabetic RetinaScreen programme (56% uptake)

- **Immunisation**
  - Improve childhood immunisation rates targeting areas with lowest uptake
  - Improve influenza uptake rate amongst staff in frontline settings and people aged 65 and over
  - Provide the human papillomavirus vaccination to 85% of the relevant population
- Deliver **person-centred** community based services
  - Less people with a disability will live in congregated settings
  - Safeguard vulnerable persons at risk of abuse
- Implement programmes to reduce **healthcare associated infections**
  - Roll out primary care and hospital infection control standards and guidelines.

What we will do in 2016

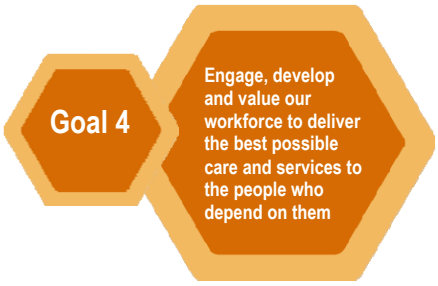
- Extend **direct access** for GPs to diagnostics including ultrasound and x-ray
- Extend the **minor surgery** project to further practices
- Extend access to **general practice care** without fees in line with government policy
- Undertake **waiting list** initiatives to reduce waiting times for:
  - Primary care and social care speech and language therapy services
  - Psychology, therapy and orthodontic services
- Enable the delivery of **integrated care** through five integrated care programmes: prevention and management of chronic disease, older people, patient flow, children and maternity care
- Undertake national **maternity service** improvements
- Continue work to improve access to planned care in **acute hospitals** for inpatient, day case and outpatient services through process improvement
- Improve access to **diagnostic tests** for outpatients
- Reduce the number of **delayed discharges**
- Continue to implement the **Emergency Department (ED) Task Force** actions
  - 75% of all attendees at ED will be discharged or admitted within 6 hours of registration
  - 100% of all attendees at ED will be discharged or admitted within 9 hours of registration
- Improve access to assessment and treatment for urgent **prostate, lung cancer** and symptomatic **breast disease**
- Improve access to **mental health** services
  - Enhance mental health services for children and adolescents
  - Improve the 24/7 response to mental health services
  - Increase high observation areas in acute units, and provide for the needs of those with severe mental illness and challenging behaviour
  - Increase community mental health team capacity for mental health intellectual disability services, the homeless mentally ill and liaison psychiatry
- Improve the quality and safety of **mental health services** through implementation of national guidelines and models of care
- Continue to implement the three existing **mental health clinical programmes** and develop two new programmes addressing ADHD and dual diagnosis
- Provide a range of home and community supports to enable **older people to live independently** for as long as possible

  - Improve and streamline home care services through the development of the Model of Home Care
  - Develop models of Living with Care outside the standard residential setting
- Complete **Short Stay Public Bed Project** and review the provision and capacity of short stay residential care
- Develop services for **people with a disability** so that they are supported to participate in society to reach their full potential
  - Continue implementation of the Progressing Disability Services for Children and Young People (0–18) Programme
  - Reconfigure day services including school leavers and rehabilitative training in line with *New Directions*
  - Provide respite for children and adults with host families in community settings
- Improve access to adult and children's **palliative care** services and improve the quality of service provision
- Improve **ambulance service** operational performance and outcomes for patients through improved response times, expansion of the Community First Responder Scheme and assisting in the delivery of a children's ambulance service
- Acute services and ambulance services will work together to reduce **ED handover** delays thereby improving ambulance turnaround times
- Improve access to services for **marginalised groups** by improving health outcomes for vulnerable groups and people with addictions and supporting implementation of the plan to reduce homelessness.

What we will do in 2016

- Develop capacity for development of quality and patient safety across all services whereby each service has a defined **patient safety and quality operating model** to address service user advocacy, complaints, incident management and response, learning systems, service improvement, clinical audit and change of culture
- Increase the rates of **service user engagement and feedback**
  - Conduct a service user and patient experience survey in each hospital and commence patient experience surveys in primary care and community services
- Engage with people, their families and carers and involve them in the **design and delivery** of services
  - Develop and implement a national person-centred care programme which engages, enables and empowers people to be at the centre of service delivery
  - Strengthen advocacy services across all services
  - Establish a Social Inclusion Working Group on community development
  - Roll out programmes to support collaboration and partnership with service users, family members and carers in the mental health services
  - Embed the role of service user, family member and carer at the heart of mental health service delivery nationally and at CHO level
  - Implement recommendations arising from the Primary Care Reimbursement Services (PCRS) reform programme
  - Expand the national Volunteer Advocacy Programme in adult disability residential settings

  - Build the capacity to promote a culture of patient partnership across acute services
  - Increase the use of *You and Your Health Service*, our patient charter
- Improve feedback methods to allow people make **a comment, compliment or complaint**
  - Early acknowledgement of errors when they occur
  - Encourage the public and staff to highlight issues of concern in an open manner
- Continue to prioritise improvements in the quality and safety of care in **maternity and perinatal services**
- Prioritise the **safeguarding** of people and support improvements in services in residential intellectual disability services
- Strengthen governance arrangements through the HSE's **Accountability Framework** to improve performance
  - Develop a report on **quality and care outcomes**
  - Strengthen quality and risk management systems including the continued roll out of the National Incident Management System (NIMS) with the State Claims Agency
- Foster a fair and just culture within healthcare by continuing to implement policies such as **Open Disclosure, Protected Disclosure** and **Good Faith Reporting**
- Respond to Regulator and HSE reports in a **timely and open manner**
- Put processes in place so that all **safety incidents** will be effectively managed, reported, investigated and the learning from such incidents is shared and implemented
  - Develop a process for sharing of learning from serious incidents
  - Establish a National Independent Review Panel with an independent chair and review team members as part of the HSE's enhanced arrangements for investigations
- Put in place an **assurance system** including measurement, healthcare audit and reviews that seek evidence that quality and safety is prioritised and committed to at all levels of the healthcare delivery system
- Conduct **special investigations** including fraud related topics as and when required
- Ensure compliance with all **national standards and regulations** with a focus on continuous quality improvement of services
  - Continue to implement the *National Standards for Safer Better Healthcare*
- Implement the **Code of Governance**.



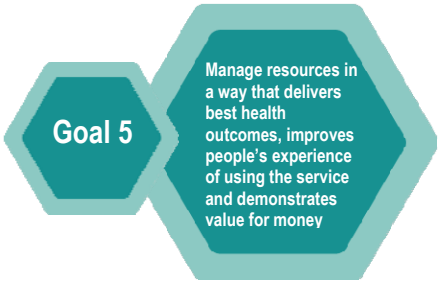
What we will do in 2016

Implement the **People Strategy** 2015–2018:

- Develop and implement **workplans** to support the operationalisation of the People Strategy
- Develop a **Leadership and Management Development Strategy** and delivery plan aligned with the People Strategy
- Create a **national leadership development academy** comprising leaders from across the system to lead, influence and develop leadership practice and succession management
- Develop a **Staff Engagement Strategy** underpinned by the values of Care, Compassion, Trust and Learning
- Conduct an annual **Employee Survey** and take actions based on findings
- Establish **HR user groups** to ensure greater connectivity with service delivery units and partners across the health service
- Put in place **Personal Development Plans**
- Work with professional bodies and staff representative associations to develop **continuous professional development** responses that support improved performance
- Develop a **talent management framework** which supports employees along their career

path and maximises their contribution to the organisation

- Ensure each **staff member and team** are clear regarding role, professional responsibilities, reporting relationship and fit within the organisation
- Progress the development of **funded workforce plans**
- Enable and develop **communications** by providing first rate communications advice, training and support
- Support the delivery of a programme to improve **communication skills** in health leaders
- Develop the skills required to **enhance the patient experience** and support multi-disciplinary team working
- Support managers in recognising good and poor **performance** and provide them with the skills to give constructive feedback.



What we will do in 2016

- Continue to **drive the health reform** required for a functional and accountable service delivery system that supports integrated models of care, needs assessment and resourcing, and is underpinned by appropriate authority and accountability frameworks
- Continue the establishment of CHOs and hospital groups and through these enable **Integrated Care Pathways** for patients and service users
- Continue to implement *Value for Money and Policy Review of Disability Services in Ireland* in order to deliver community based, person-centred models of service for people with disabilities
- Implement **activity based funding** in acute hospital services for inpatient and day case work. Commence work on frameworks for outpatient and community costing that are aligned with activity based costing principles
- Implement the **finance operating model** in line with the System Reform Programme
- Implement the **reconfiguration of national functions** through the Centre Transformation Programme in tandem with the development of the CHOs and hospital groups and develop a commissioning framework for health services in conjunction with the DoH
- Implement a **drugs cost strategy** and develop the Community Schemes Control and Inspectorate function
- Develop **Health Business Services** for hospital groups, CHOs, NAS, Corporate Services and Tusla in line with the *Health Business Services Strategy 2014–2016*.
- Implement the **HSE Capital Plan**
- Strengthen accountability with the **voluntary agencies** funded by the HSE
- Develop new programmes which will change the way services are delivered by utilising the capability of **digital technology** including the individual health identifier.

Improving Quality and Reforming Service Delivery

Improving Quality and Reforming Service Delivery

Quality and Patient Safety

The HSE places a significant emphasis on the quality of services delivered and on the safety of those who use them. A national quality programme has been put in place to improve the overall quality and safety of services with measurable benefits for patients and service users.

Five objectives which underpin quality and patient safety for 2016 are:

- Services must be accessible and responsive to individual patient and service user needs
- Patients and service users must be empowered and enabled to interact with the service delivery system
- Health services will put quality of care at the centre of all that they do by implementing an agreed Framework for Quality Improvement
- Continue to focus on safety of patients and service users by implementing the National Clinical Effectiveness Committee (NCEC) guidelines (National Clinical Guidelines)
- Services must be safe and a strong focus must be placed on ensuring quality and safety is improved through a combination of improvement programmes and formal accountability for ensuring safe services.

Progress on patient safety, clinical effectiveness and quality improvement continues to enable integrated care and promote services that are appropriate, delivered with the patients and service users at the centre and are based on best clinical practice and integrated care pathways.

Key Quality Priorities in 2016

Leadership and Governance for Quality and Safety

- Ensure that authority and accountability for the quality and safety of services across all service areas is integrated into operational service management through appropriate leadership, governance, structures and processes.
- Develop capacity for development of quality and patient safety within CHOs, hospital groups and NAS whereby each service has a defined patient safety and quality operating model to address service user advocacy, complaints, incident management and response, learning systems, service improvement, clinical audit and change of culture.
- Ensure compliance with all national standards and regulations as they relate to quality and safety of services along with a strong focus on continuous quality improvement of services.
- Build capacity and capability for leadership and improvement in quality through formal education and training programmes and supporting staff to implement quality improvement initiatives in their services.
- Strengthening the HSE's governance arrangements under the health service Accountability Framework by measuring, monitoring and reporting on the performance of the health service in relation to the quality and safety of care, with a specific focus on identifying and addressing areas of under-performance by recommending appropriate and proportionate action to ensure the improvement of services.
- Put in place an assurance system including measurement, healthcare audit and reviews that seek evidence that quality and safety is prioritised and committed to at all levels of the healthcare delivery system.

- Establish positive and effective staff engagement as a keystone of quality improvement and person-centred care by partnering with services to develop and test methodologies, build organisational leadership capacity and share learning.
- Ensure that quality and safety is central to the planning and delivery of services by enabling CHOs, hospital groups and NAS to commence implementing the Framework for Improving Quality.
- Increase the number of Quality Key Performance Indicators (KPIs) developed and used in services. This will be phased in over 2016.
- The reform process will ensure that governance, structures and resources for quality and patient safety are put in place for corporate, CHO, hospital group and ambulance services.

Safe care

- Promote the reduction of risk to the public, staff and healthcare services by adopting a risk based approach to predicting, identifying and responding to service areas where significant performance, quality and safety concerns may exist.
- Improve monitoring, investigation and learning processes from serious incidents across all service areas.
- Progress the implementation of recommendations from major reports and serious incidents across all service areas.
- Continue to support and commit to the process of development, implementation and monitoring of NCEC National Clinical Guidelines and audit in all appropriate services including Early Warning Systems, Clinical Handover, HCAIs and Sepsis.
- Put in place an effective system to identify, manage, investigate and implement the learning from serious safety incidents, safety investigations and regulatory investigations and inspections, and continue the roll out of the open disclosure policy.
- Strengthen the HSE's regulatory capacity to fulfil responsibilities in the area of medical ionising radiation.
- Continue the implementation of the HCAI / AMR Clinical Programme including the control and prevention of HCAIs / Antimicrobial Resistance (AMR) in accordance with HCAI standards across all service areas including:
  - Decontamination standards
  - Commence implementation of the STOP campaign to prevent inappropriate use of invasive devices
  - Assess feasibility of an antimicrobial usage audit tool
  - Focus on the implementation of the hand hygiene guidelines in non acute settings.
- Ensure a reduction in medication errors.
- Establish a National Independent Review Panel with an independent Chair and Review Team members as part of the HSE's enhanced arrangements for investigations. The Review Panel will initially focus on serious incidents that occur in disability services across the HSE and HSE funded services.

Effective care

- Continue to prioritise improvements in the quality and safety of care in maternity and perinatal services.
- Prioritise the safeguarding of service users and support improvements in services in residential intellectual disability services.
- Provide leadership and support to enable the services develop capacity and capability to deliver on key national patient safety programmes in primary care, social care, mental health and acute settings to address internationally recognised causes of harm to people (including HCAI, medication safety, pressure ulcers, falls prevention and nutrition and hydration).
- Implement the NCEC *Standards for Clinical Practice Guidance,* 2015.

- Develop a national framework document for Policies, Procedures, Protocols and Guidelines (PPPGs) including education training and support and commence the development of a document control system national repository for PPPGs.

Service User Experience

- Listen to and act on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals.
- Conduct a service user and patient experience survey in each hospital group and commence patient experience surveys in primary care and community services.
- Develop and implement a national person-centred care programme which engages, enables and empowers people to be at the centre of service delivery.
- Continue to develop access to advocacy for all patients and service users within CHOs, hospital groups and ambulance services. Ensure advocacy is available to older people in all settings.
- Continue implementation of the open disclosure policy in all services.

Health Service Reform

Supporting the goals of the *Corporate Plan 2015–2017,* the reform programme will drive the delivery of person-centred, integrated care across the health and social care services and better outcomes for patients and service users. The model of care which we provide must be fit for purpose and the best that it can be.

Provision of care must be integrated by providing better and easier access to services for the public which are close to where people live. Services are being re-organised to ensure they are delivered in the most appropriate way.

To drive health service reform, service delivery programmes are in place for CHOs and hospital groups, national ambulance services, integrated care and all of the key enabling programmes (including quality and safety, HR, ICT, finance) Changes in the national divisional structures reflecting the changes to service delivery are being dealt with under the National Centre Programme.

The nine CHOs are in the process of being established under the leadership of their Chief Officers. The CHO implementation programme will deliver on the recommendations of the CHO report to establish appropriate governance and management arrangements for the delivery of services at local community level.

The hospital groups' report provides the foundations for the reconfiguration of hospital services into hospital groups, each with its own governance and management that will deliver high quality, safe patient care in a cost effective manner. In addition, this reform will create hospital groups with robust academic linkages that will integrate and embed education, training, research and innovation in the acute hospital sector.

A significant programme of change is underway to enable and drive the establishment of hospital groups and CHOs with the aim of delivering integrated services and better outcomes for service users. This is supported by a robust programme management and governance structure at national and local level. Maintaining momentum in this reform programme in the context of increasing operational pressure on the health and social care delivery system is a key focus for 2016.

An Action Plan for Health Service Reform is being agreed to support NSP 2016 and will map out the key service improvement deliverables for the reform programme for 2016 and beyond to 2019.

Key Priorities in 2016

- Support the integrated care programmes in designing, developing and progressively implementing the priority programmes including older people, prevention and management of chronic disease, patient flow, children and maternity care.
- Support reform through the establishment of programme management infrastructure for CHOs, hospital groups, NAS, Service Improvement Programmes and the National Centre Programme and achieve the implementation milestones of year one of the four-year Action Plan for Health Service Reform.
- Support reform through the establishment of programme management infrastructure for the enabling services for reform (HR, ICT, Finance, Communications) and achieve the implementation milestones of year one of the four-year Action Plan for Health Service Reform.
- Support the delivery of *Healthy Ireland in the Health Services National Implementation Plan 2015–2017* to build a more sustainable health and social care service and rebalance the health system priorities toward chronic disease prevention and population health improvement.
- The HSE will continue to collaborate with DoH, the Department of Jobs, Enterprise and Innovation (DJEI), Enterprise Ireland and other relevant agencies to establish and implement a National Health Innovation Hub to enable collective progress of common innovation goals. The objectives of the initiative converge with the HSE's aim of nurturing, supporting and developing innovation for the benefit of its service users, workforce and systems. The HSE will support the Hub to achieve these objectives through the provision of dedicated resources and in-kind support once agreed.

Clinical Strategy and Programmes

Clinical Strategy and Programmes are leading a large scale programme of work to develop a system of integrated care across health and social care services – a major element of health reform in Ireland. This is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in their care, in a way which puts them at the centre of all services. The national clinical and integrated care programmes are central to this reform putting clinical leadership, including nursing and midwifery, at the core of leading improvements across CHOs and hospital groups.

The **National Clinical Programmes** continue to modernise and improve the way in which specific areas of health and social care services are provided and delivered by designing and guiding the implementation of standardised models of care, clinical guidelines, care pathways and associated strategies through 31 national clinical programmes. This will ensure the availability of clinically led multi-disciplinary teams spreading evidence based effective changes through a consistent national approach to improvement, leading to modernised, standardised, high quality, safe and efficient services.

The **Office of Nursing and Midwifery Services** leads and supports the nursing and midwifery professions to deliver safe, high quality person-centred healthcare that enables people to lead healthier and more fulfilled lives. The work is aligned to legislation and health policy.

The **Integrated Care Programmes** continue to progress the establishment, enablement and delivery of five integrated care programmes:

- Patient flow
- Older people
- Prevention and management of chronic disease
- Children
- Maternity care.

These programmes of work will contribute to:

- Standardised, high quality, safe and efficient health and social care services.
- A health service that is delivered across community healthcare and hospitals in a way that meets the needs of patients and the workforce, and other resources including buildings and equipment are organised to support patients as they move through the system.
- Clarity about what patients can expect described through defined pathways of care and a change process to ensure that people get their care in the most appropriate and convenient care setting.
- People having a better healthcare experience because of improved co-ordination of their care, clear communication with them, and the provision of care in the most appropriate setting for them in line with best clinical practice.
- People being engaged in the design of healthcare and in implementing solutions.

Key Priorities in 2016

National Clinical Programmes

Design clinical service improvements in specific areas within the health service covering:

- Models of care to support standardisation, integration, health promotion and protection, disease prevention, self-management and palliative care where appropriate
- Care pathways and the way we can best test their effectiveness
- Workforce planning and new methods of service delivery
- Education and competency development for healthcare staff
- Standard assessment documents and systems
- Awareness programmes and campaigns.

Guide and support CHOs and hospital groups in:

- Implementing the national clinical programmes models of care and associated strategies
- Standardising processes in line with the national clinical programmes
- Reviewing services
- Designing and embedding new methods of service delivery
- Developing data collection systems to support implementation of national clinical programmes models of care and associated strategies.

Guide and support acute hospital services in:

- Performance management of hospital groups
- Reconfiguration of hospitals within the context of hospital groups
- Workforce and capacity planning
- Demographic demands on service
- Specific health service improvement initiatives.

Integrated Care Programmes

- The **Integrated Care Programme for Patient Flow** will progress a number of priority projects to tackle some of the most pressing patient flow challenges in our health system and improve quality, access and resource utilisation:

- The planning and phased implementation of a pilot project to design, test and deploy the application of scientific management practices in healthcare to tackle patient flow. This will result in more effective scheduling of both workforce capability and fixed resources to meet patient service demand.
- Design and phased implementation of new service delivery models and methods – non-emergency service contact number and branding, for example GP imaging initiatives, musculoskeletal physiotherapy services, and pilot a consultant delivered paediatric service.

- The **Integrated Care Programme for Older People** will address the needs of older people including those with complex requirements through the establishment of a pioneer area. This will implement and evaluate the provision of integrated care services. By acting as a 'test and deploy area' the impact of integrated care can be established in terms of cost, quality and access. This bottom up approach will establish 'what works' best in terms of adoption of an integrated care model at a local level, allowing outcome measures to be evaluated.
- The **Integrated Care Programme for Prevention and Management of Chronic Disease** will facilitate the implementation of integrated care by the phased linking of CHOs and hospital groups in demonstrator projects. These will target the delivery of chronic disease management programmes and incorporating health promotion, illness prevention and self-management.
- The **Integrated Care Programme for Children** will be established. It will work with and build on the models of care already developed by the Paediatric and Neonatology National Clinical Programme. It will aim to identify and progress a number of priority projects to integrate community and hospital services to enable children to have a high standard of care at any point in their care journey.
- The **Integrated Care Programme for Maternity Care** will be guided and informed by the recommendations through the review of maternity services and the development of a national maternity strategy.

Nursing and Midwifery

- Undertake a pilot of the Framework for Staffing and Skill Requirements (phase 1), in conjunction with acute hospitals, for the nursing workforce in a range of major specialties in general and specialist adult hospital medical and surgical care settings, to test the capability of the framework to deliver on its intended outcomes. *(Held Funding DoH €2m)*
- Provide education to increase the number of nurses and midwives who may prescribe medicinal products.
- Provide education to increase the number of nurses who may prescribe x-ray (ionising radiation).
- Provide mandatory adaptation programmes for overseas nurses who have been recruited and must complete adaptation before they may register with the Nursing and Midwifery Board of Ireland.
- Provide clinical education to maximise the development of ED and AMAU nurses' skills and competence to undertake advanced clinical assessment, interpretation and treatment in a standardised range of skills to improve patient flow, in conjunction with acute services.

Detailed actions and key performance indicators supporting implementation of national clinical programmes and integrated care programmes can be seen throughout this NSP.

Operational Framework

Financial Plan

Budget 2016 v Budget 2015

The HSE budget in 2015 is currently **€12,170m.**The letter of determination, dated 27th October 2015, provides for a revenue budget in 2016 of **€12,928.5m**. This represents an increase of **€758.5m (**6.2%) year on year, of which €38.5m is provided for new service initiatives and €720m is available to maintain existing services.

In addition, a further €58.5m is being held by the DoH for further new service initiatives and will be released during the year as specific implementation plans are agreed. This will bring the total revenue budget available in 2016 to **€12,987m**. This represents an overall increase of **€817m** (6.7%) year on year, of which a total of €97m is earmarked for specific new service developments.

This is the second year in which additional budget has been made available to the health services. Following the years of austerity this additional funding is welcomed.

Budget 2016 v Costs in 2015

The full cost of providing services in 2015 is estimated to be in the region of **€12,840m** which indicates a 2015 operational deficit of approximately €550m after account is taken of additional expenditure incurred on new initiatives approved during 2015 (e.g. Delayed Discharges, Waiting Lists, ED / Winter Plan). The most significant components of the projected operational deficit include:

- **€307m (56%)** - relates to an estimated over run in 2015 on pensions (€53m) and other demand-led areas (PCRS €140m, State Claims Agency €100m and Local Demand Schemes €14m)
- **€50m (9%)** - relates to historic accelerated cash collection target– managed as per NSP 2015
- **€188m (34%)** - i.e. approximately one third relates to an estimated over run on areas that are performance managed by the HSE, including acute hospitals €150m and social care – disabilities €38m (regulatory impact primarily resulting from operation of HIQA registration / inspection process around new intellectual disability residential service regulations).

The full cost of providing services in 2015 includes elements of expenditure that are not expected to recur in 2016, the most significant of which is in respect of waiting list initiatives. If we adjust for these amounts the 2015 cost of ongoing services is estimated to be in the region of **€12,790m**. The total funding available for existing services within the 2016 allocation is **€12,890m**. This represents an increase of **€100m**, (0.8%) above the adjusted cost base in 2015, within which significant inflationary pressures will require to be managed.

As can be seen from the table below €403.9m in additional base funding has been provided within the 2016 budget and this will assist in dealing with the underlying causes of the 2015 operating deficit with the balance to be dealt with by way of additional savings and other financial measures and assumptions.

The cost of providing the existing services at the 2015 level will grow in 2016 due to a variety of factors including national pay agreements / public pay policy requirements, quality and safety requirements, new drug and other clinical non pay costs, price rises etc. A total of €316.1m has been provided towards the expected growth in costs in 2016 of existing services with the balance of 2016 expected cost growth to be dealt with by way of additional savings and other financial measures and assumptions.

In respect of all savings and other financial measures the underlying assumptions and the risks around the challenging nature of same, particularly in the acute hospital and PCRS areas, have been agreed via extensive engagements with the DoH.

The HSE will prioritise its efforts around strengthening payroll controls, reducing waste and increasing productivity in order to mitigate the continuing annual growth in health and social care costs pressures being experienced in Ireland and internationally. Thereafter to the greatest extent practical and consistent with the safe delivery of services we will deliver services at 2015 levels or at an increased level where this is supported by the funding available.

The HSE fully acknowledges the requirement to operate within the limits of the funding notified to it and will ensure this receives the very significant management focus required in 2016. Given the scale of the demographic, regulatory and other service pressures it is estimated that across the acute and community healthcare service areas there is a substantial financial risk being managed within this service plan. Particular attention in the context of the Accountability Framework will be focused in conjunction with the Hospital Groups on driving financial performance across our acute hospitals in light of the scale of the financial challenge. In addition to the performance areas there are significant financial pressures in the PCRS and other demand led areas that arise as a result of the demographic, economic and other factors. The additional revenue resource available to the HSE of €817m (€758.5m + €58.5m held by DoH) is made up as follows:

	Amount	Description (see more detail in paragraphs below)	Relates to 2015 or 2016 Costs	Existing or New Services
1.	**€403.9m**	Additional base funding	2015	Existing
2.	€118.0m	Pay funding including the implementation of the Lansdowne Road Agreement (LRA)	2016	Existing
3.	€210.6m	Non-pay funding	2016	Existing
4.	€112.5m	Full year cost of 2015 approved commitments	2016	Existing
5.	(€125.0m)	Savings and efficiency targets	2016	Existing
Sub-Total	**€316.1m**		2016	Existing
6.	€38.5m	New initiatives	2016	New
Total	**€758.5m**		**Both**	**Both**
7.	€58.5m	New initiatives – funding held by DoH to be released as implementation plans are agreed	2016	New
Grand Total	**€817.0m**		**Both**	**Both**

Separately, a provision of €399m in capital funding has been made available to the HSE in 2016. This comprises €344m for building, equipping and furnishing of health facilities and €55m for ICT.

Additional Base Funding – €404m

The additional recurring funding provided in respect of the 2015 base allocation will assist the HSE to address the unfunded costs brought forward from 2015 with the balance to be dealt with by way of savings and other financial measures. See also Table 2, Column F in appendix 1 – in summary:

- €163.9m / 41% – for areas performance managed by the HSE:
  - €100.0m Acute Hospitals
  - €45.5m Social Care (Disability Services)
  - €5.0m Social Care (Older People Services)
  - €5.0m Primary Care core services
  - €8.4m Other national services

- €240m / 59% – for Pensions and Other Demand-Led Areas:
  - €142.0m PCRS
  - €15.0m Local demand-led schemes
  - €32.0m State Claims Agency reimbursement
  - €51.0m Pensions

Pay Funding (including Lansdowne Road Agreement) – €118m

Table 2, Column G in Appendix 1 sets out the funding being provided to off-set the growth in pay costs associated with the Lansdowne Road Agreement, Labour Relations Commission recommendations and other pay pressures. It is noted that some unavoidable pay-related costs, identified as part of the estimates process, were not funded within the overall allocation. The most significant of these relate to the net cost of increments, which must be paid in line with approved public pay policy, quantified at €30m, for which no funding was received. Each division will implement measures to enable compliance with public pay policy in this regard without impacting services or giving rise to a funding deficit. The HSE will continue to engage with DoH and DPER during 2016 to seek a sustainable solution for this ongoing issue in time for implementation in 2017.

Non-Pay Funding – €211m

Table 2, Column H in Appendix 1 sets out the funding being provided to off-set a number of unavoidable non-pay cost pressures. A significant element of the total is being provided to address service cost pressures including:

- Acute hospitals – €20m has been provided for non-pay growth within the hospital system
- Disability services – €16.5m
- NHSS demographics – €14.7m funding for 2016
- PCRS - drug cost growth €68m, other cost growth €49m
- Local schemes – €10m provided for anticipated 2016 growth

Full Year Cost of 2015 Commitments – €113m

A total of €112.5m has been provided in 2016 for the cost of initiatives commenced in 2015 which will have a full year incremental cost in 2016. These include the cost of NSP 2015 initiatives €25.6m, winter plan €35.2m and delayed discharges €51.7m. A breakdown by division is provided at Table 2, Column I in Appendix 1.

Savings and Efficiency Measures – €125m

The revenue allocation for 2016, notified to the HSE in the letter of determination, is net of assumed savings and efficiency measures of €125m as follows:

- €15m – general reductions in non-pay budgets including savings to be made through the procurement process
- €110m – targeted reduction in prescribing and drug costs within the PCRS. This will involve a review of areas such as probity and the costs associated with prescribing.

The allocation of these savings targets by Division is shown in Table 2, Column J in Appendix 1.

New Initiatives – €38.5m

Table 2, Column L in Appendix 1 sets out the various elements of this funding and the related priorities. These new initiatives include the following:

- Acute services €13m – opening of newly commissioned units, maternity services, children's hospital developments and organ transplantation
- Cancer services €10m – including the implementation of a new national cancer strategy, growth in existing cancer drugs and age extension of BreastCheck for which €1.5m has been provided in 2016
- Disability services €7.25m – part year cost for provision of a day centre place for approximately 1,500 young adults
- Health and Wellbeing €2.5m – expansion of childhood immunisation schedule
- National Ambulance Service €2m – targeted performance and response improvements
- Expansion of respite beds – €1m
- Palliative care – €0.7m
- Finance reform €2m – funding to drive forward finance reform including activity based funding.
- The full year cost of these initiatives in 2017 is €82.9m. This represents an additional investment requirement of €44.4m in 2017 and approval of NSP 2016 is taken as confirmation that these initiatives can be commenced in 2016 on the basis that this additional funding will be provided in 2017. The full year costs in 2017 of these new initiatives are illustrated within Table 4, Appendix 1.

Budget Framework

	€m	€m	€m
2016 Opening Base Allocation			**12,170**
2015 Additional Base Funding			
Total 2015 Additional Base Funding		**403.9**	
2016 Existing Level of Service Funding			
Pay including Lansdowne Road Agreement (LRA)			
LRA	97.0		
PSPR and Other Pressures	10.0		
LRC Recommendations	8.0		
Pay Pressures (Other)	3.0		
Sub-total Pay including Lansdowne Road Agreement (LRA)	**118.0**		
2016 Non-Pay Funding			
Non-pay (Demographics / Drug Cost Growth / Other Pressures)	195.9		
NHSS – Demographics	14.7		
Sub-total 2016 Non-Pay Funding	**210.6**		
Full Year Cost of 2015 Commitments			
National Service Plan 2015	25.6		
ED – Winter Plan and FYC Acute NSP 2015 Developments	35.2		
Delayed Discharges	51.7		
Sub-total Full Year Cost of 2015 Commitments	**112.5**		
2016 Existing Level of Service Funding	**441.1**	**441.1**	
2016 Savings Measures			
Savings Measures – PCRS	(110.0)		
Efficiency Measures including Procurement	(15.0)		
2016 Savings Measures	**(125.0)**	**(125.0)**	

	€m	€m	€m
2016 Additional Funding Available for Existing Services			
2016 Additional Funding Available for Existing Services		**720.0**	**720**
2016 Total Funding Available for Existing Services			
2016 Total Funding Available for Existing Services			**12,890**
2016 New Initiatives			
Disability school leavers		7.3	
Expansion of respite beds		1.0	
Expansion of vaccine programme		2.5	
Opening of commissioned new units		3.5	
Maternity services		3.0	
Hospital service developments		3.0	
Paediatric service developments		3.8	
National Ambulance Service		2.0	
Cancer services		10.0	
Finance reform including Activity Based Funding		2.0	
Organ transplantation		0.5	
2016 New Initiatives		**38.5**	**39**
Total 2016 Net Determination			**12,928**

Financial tables reflect a total non-capital allocation of €12.928 billion. This excludes €58.5m of funding which is being held by the DoH for further specific initiatives.

Detailed breakdown by division is provided in Table 2, Appendix 1

Held Funding by Department of Health – €58.5m

A further €58.5m is being held by the DoH for further specific initiatives. The inclusion of this funding into the HSE's revenue allocation will be undertaken as soon as detailed plans and developments commence. These monies relate to:

- Mental Health – €35m
- Primary Care developments €13.5m – GP contract developments including extending care without fees to children up to 12 and provision for rural practices; access to diagnostics; and minor surgery
- Therapeutic services for young people, including early intervention teams and in particular speech and language therapy – €8m
- Initial implementation of the recommendations of the nursing taskforce as a pilot - €2m.

A critical service risk in 2016 is ensuring there is appropriate care pathways and effective flow through admission and discharge from our acute hospitals particularly for the very elderly and young disabled adults whose discharge can be complex and become delayed.

To address this risk the HSE will utilise €20m in expected time related savings from the €58.5m new initiatives monies held by the DoH on a once-off basis pending the securing of additional funding in the 2017 estimates process. This will maintain 2015 outturn levels of 10.437m home help hours, 15,450 people in receipt of home care packages and 313 transitional care beds delivering 109 places per week during 2016. In addition, a further €1.5m in expected time related savings will be applied, on a once off basis, to fund the advance purchase agreement for vaccines in 2016. The full year effect of these assumptions is illustrated within Table 4, Appendix 1.

The full €58.5m will be available in full for the various developments in 2017 and the relevant services can plan and commence new services in 2016 on that basis.

Health Service Reform and Achieving Better Outcomes

The Health Service Reform Programme aims to drive the delivery of person-centred, integrated models of care throughout our health and social care services. The objective is to ensure better health outcomes and improved experiences for patients and service users. In order to support this important goal, the HSE has prioritised €9m from within the 2016 allocation to progress the implementation of the Integrated Care Programmes strategy. There is an incremental cost of €9m associated with these programmes which will bring the full year cost in 2017 to €18m. Further engagement will be required with the DoH in respect of the additional 2017 funding required to secure this level of investment.

In order to further support the implementation of key quality assurance and quality improvement priorities in 2016, the HSE has made available €3m from within the 2016 allocation in respect of quality assurance and verification and quality improvement initiatives. An additional €3m investment will be required in 2017, which will bring the full year cost in 2017 to €6m.

In addition, the HSE will seek further efficiencies of €1.2m to support the hospital group and CHO structures in 2016.

The HSE has also committed to provide further support of €10m, from within existing resources, to support the system reform programme and to expand change management capacity across the system.

Approach to Financial Challenge - Financial Risk Areas

The HSE has identified a significant financial challenge in respect of maintaining existing levels of service within the net revenue allocation notified for 2016.

The key components of the HSE approach to addressing this challenge involve achieving increased efficiency, value for money and budgetary control in 2016 and include:

- **Governance** – intensify focus on budgetary control through enhanced accountability framework
- **Pay** – develop an integrated strategy on recruitment, agency conversion and workforce planning
- **Non-Pay** – implement targeted cost-containment programmes for specific high-growth categories
- **Income** – sustain and improve wherever possible the level of income generation achieved in 2015
- **Activity** – use ABF model progressively as part of the performance management process with hospitals.

All services will need to operate within the planned cost level for 2016 in order for the HSE to deliver a balanced position and there is extremely limited scope to address any overrun in one area by compensating underspends in another area.

Acute Hospitals

When account is taken of funding available to acute hospitals as a result of internally commissioned services from other divisions the indicative 2016 available funding total is €4,137.4m which is up by €126.3m / 3.1% on the most comparable figure which is the closing 2015 budget of €4,011.1m.

However the 2016 funding available is €83.5m / 2% below the €4,220.9m in costs estimated to be incurred in 2015 or €32.5m / 0.8% below if we exclude the €51m in once-off 2015 funding and costs related to the waiting list initiative.

In summary, when account is taken of the 2015 cost of services, expected cost growths and initial cost saving measures this leaves a preliminary funding shortfall of €150m to be addressed. An interim cash management based solution to the €50m historic accelerated income collection target is proposed, which reduces this funding shortfall on a once-off basis to circa €100m. This is put forward on the basis that a feasible permanent solution to this €50m issue can be agreed between the HSE and DoH during 2016, in time to be implemented in 2017.

Options to address the remaining €100m funding shortfall have been considered including aligning activity levels to the funding available, albeit this is considered as very much a last resort. In summary this view is based on the significant risks inherent in operationalising such an option and more importantly on the negative impacts for patient access to services and for staff morale.

Accordingly the acute hospital division, with support from the rest of the HSE, will take a number of further measures to control costs, reduce waste and improve efficiency aimed at minimising any impact on services. (See Table 8 on page 116).

The targets that need to be achieved in relation to these measures are very challenging and carry significant delivery risk albeit each of the measures represent areas of focus that the HSE would have intended to pursue in 2016 in any event. It is for the HSE and the Hospital Groups to ensure that appropriate management effort and attention is applied to maximising the delivery of savings measures and overall budgetary performance. Thereafter the HSE and DoH acknowledge the shared risks inherent in the extent of the savings targets and the assumptions underpinning them, which have been mutually agreed following extensive engagement in light of the alternative which is service reductions.

Note: The Hospital Care section of this plan details the activity levels to be provided in 2016.

Primary Care – Core Services

The budget allocation for primary care in 2016 presents significant challenges for the maintenance of existing levels of service for the division. A range of measures has been identified to manage services within budget, they include the following:

- Reviewing service delivery models for primary care services
- Maintaining activity in dental treatment to existing levels of service.
- The development of prioritisation protocols for the delivery of services
- The introduction of quality improvement initiatives across the division
- Further roll out of the Performance Management Framework
- Further reduction in agency costs
- Enhanced procurement and process measures to improve the management of consumables
- Adherence to the Pay Bill Framework in relation to staff replacements
- Containing activity on 2015 new developments to 2015 expenditure levels
- Containing activity in primary care core services to existing levels of service.

Primary Care Reimbursement Service (PCRS) – €2,417m available to HSE (with a further €10m held by DoH)

The PCRS budget has been set at the level indicated by the letter of determination received by the HSE.

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 DoH.

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

Thereafter demographic, economic and other variable factors, given the demand-led nature of the schemes, will dictate the actual numbers of eligible persons and the cost of their entitlements to be paid by PCRS in 2016 under each scheme. The PCRS plan for 2016 is based on a number of assumptions around demographics, economic growth and these other factors which have been agreed with the DoH following an extensive series of engagements.

As regards drug costs, the growth in costs related to existing drugs is largely a feature of the entitlements of individuals as determined by their eligibility and the demographic and other factors outlined above including prescribing practices. In relation to new drug costs, primarily high-tech drug costs, sectoral agreements and the assessment process in place to establish whether new drugs can be introduced on the basis of funding available will be a significant feature in 2016.

The PCRS budget for 2016 has been framed by reference to a series of working assumptions. These have been developed in detailed discussion with the DoH. They have been accepted as the basis on which, in respect of the PCRS, the HSE should address the statutory requirement to indicate the type and volume of services to be provided during the year to include the following:

- Persons eligible for medical cards will continue to receive them in a timely manner and in accordance with the turnaround times for processing applications as outlined in the plan.
- Appropriate measures will continue to ensure the accurate administration of the various schemes. This will involve savings being achieved from continued enhanced monitoring of claims and payments to primary care contractors.
- The medical card profile outlined in the plan (see table below and in appendix 3) reflects the funding allocated for 2016. It is jointly acknowledged that the actual level of activity will depend on the number of eligible patients availing of services.
- The savings targets in relation to drugs / medicines will be achieved in full – this is a key shared assumption that is dependent on the outcome of engagement with the pharmaceutical industry
- Overall net expenditure on High Tech drugs in 2016 is maintained at 2015 outturn levels (which includes provision for new drugs in 2016) – this is dependent on the HSE's capacity to contain approvals for new medicines to overall funded levels and the outcome of negotiations with key stakeholders.
- Efficiencies and stock management improvements in the High Tech medicines area will reduce costs.
- Savings in relation to administration costs will also be achieved.
- GMS activity is in accordance with funded levels as follows:

Schemes	Projected Outturn 2015	Activity Level 2016
GMS (medical card numbers)	1,725,767	1,675,767
GP Visit Cards	435,785	485,192*

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Expenditure in the PCRS budget will be the subject of close monitoring and assessment from the beginning of 2016. The implications of any emerging variations from the working assumptions underpinning the budget will be the subject of engagement with the DoH through the reporting and oversight arrangements which operate in relation to the NSP. In this context the HSE will indicate to the DoH the nature and extent of any interventions that it considers necessary to ensure that the available budget for PCRS is not exceeded and will seek direction in this regard.

State Claims Agency (SCA) – €128m available to HSE (up by €32m on 2015 funding level)

This relates to the cost of managing and settling claims which arose in previous years and is a statutory function of the SCA. The HSE is focused on improving the safety and quality of services on an on-going basis which should mitigate the growth in cost of future claims.

The SCA budget has been set at the level indicated by the letter of determination received by the HSE. The financial plan for 2016 is based on the assumption that in the event that cost trends in SCA costs vary from the funding level provided to the HSE this will be identified as early as possible during 2016 and will be the subject of engagement with DoH. This is on the basis that management actions in 2016 will not have any

impact on these past claims. There no capacity for the HSE to create a contingency fund to address any funding shortfall within SCA as this would immediately impact other service budgets.

Pensions – €493.1m (up by €59.6m on 2015 funding level)

Pension costs incurred within the HSE and HSE-funded agencies (Section 38) are determined by individuals' service and their eligibility under the relevant public pension scheme as provide for in relevant legislation.

These costs cannot be controlled in terms of financial performance and are difficult to predict. There is a strict requirement on the health service, as is the case across the public sector, to ring fence public pension-related funding and costs and keep them separate from mainstream service costs. The letter of allocation received by the HSE required that the overall budget for statutory and voluntary sector pensions increased by no less than €54m. The HSE has increased the amount allocated to fund pension costs in 2016 by a total of €59.6m. Pension costs and income will be monitored carefully and reported on regularly throughout the year. This plan has been prepared on the basis that, as in prior years, pension-related funding issues will be dealt with separately from the general resource available for service provision.

Overseas Treatment including Treatment Abroad Scheme and Cross Border Directive

The treatment abroad scheme relates to the provision of clinically urgent care and treatment abroad and the legislation which underpins it does not facilitate the operation of the scheme within any particular cash limit. The Cross Border Directive scheme is similar in this latter respect. The HSE will seek to ensure that these schemes continue to be managed tightly within the eligibility and other provisions set down in the legislation. Thereafter the costs incurred in 2016 are a product of the entitlement conferred by the legislation on relevant individuals who seek treatment outside Ireland.

Emergency Management

Pandemic vaccines and emergency management scenarios were previously covered by contingency funding held by the HSE. These contingency funds were utilised as part of setting out a more realistic overall budget framework in NSP 2015 and are no longer available to the HSE. Accordingly it was agreed that in the event that such costs arise in the future they will need to be addressed in separate discussion with DoH for example paediatric isolation for haemorrhagic conditions.

In this regard discussions have taken place with the DoH in respect of an Advance Purchase Agreement for vaccines. As agreed the HSE will utilise €1.5m from expected time related savings related to the €58.5m held monies for new initiatives on a once off basis. The ongoing costs of this will be dealt with by DoH as part of the 2017 estimates / service planning process.

Pay Cost Sustainability

The HSE acknowledges that it must further improve pay bill controls in 2016 and is taking action to do so. A key part of this commitment is the plan to develop an integrated strategy in respect of recruitment, agency conversion and workforce planning in 2016. Discussions to inform the 2016 approach involving the HSE, DoH and DPER are planned. It also needs to be acknowledged that there are a variety of factors, including quality and safety issues, driving upward pressure on staff numbers overall. See workforce section of this plan.

Social Care – Including Home Care, Transitional Care and Long Term Care (NHSS (A Fair Deal))

Managing the year on year growth in demand for community-based social services is one of the key challenges for older persons services in 2016. The additional funding, while welcome, does not allow the services to keep pace with the increasing demand and demographic pressures within the community. Specific pressures are evident the areas of the NHSS scheme, home support and transitional care beds, where the level of provision is directly determined by the funding available.

In the case of home care and transitional care beds the HSE will utilise €20m in expected time related savings from the €58.5m new initiatives monies held by the DoH to maintain the 2015 outturn levels of home care and

transitional care. Given the demographic pressures demand and capacity will be reviewed mid-year. This is part of our efforts to manage the risk that very elderly and young disabled adults with complex needs will be inappropriately admitted to hospital or have their discharge from acute hospitals delayed. Both of these issues can result in delayed access to emergency care and delayed admission / trolley waits for other patients.

The NHSS budget for 2016 has been set at €940m, in accordance with the letter of net non-capital expenditure received by the HSE. This represents an increase of €35m in Budget 2016 over projected expenditure in 2015. This will deliver 1,222,750 total weeks of care, supporting an average of 23,450 clients per week for 2016, representing an increase of 649 clients per week on 2015 projections.

Social Care – Disability Services

The HSE acknowledges the very significant investment in disability services in 2016 to support the full year cost of approved compliance work and emergency places commenced in 2015. The implementation of quality improvements and action plans arising from HIQA inspection reports will require to be ranked and prioritised. These priorities will need to be kept under review as further demands arise, having regard to the available funding and the relevant regulatory legislation. The HSE and HIQA have put in place a formal information sharing protocol which will enable both organisations to work within their statutory remit, while at the same time supporting the prioritisation of the highest risk areas to ensure that services are compliant, safe and effective to the greatest degree possible within the resources available.

The increasing demand for additional / emergency residential placements will be managed within the existing numbers and funding for emergency placements, with new service users being accommodated as existing placements become free and additional requirements being included in future funding submissions where they cannot be accommodated within the existing funding level.

Mental Health

The underlying cost pressures faced by mental health services (including increases to consultant pay scales, the cost of increments, unavoidable agency costs, and emergency placements) will be dealt with in 2016 from within the current base. This will be facilitated by the continued implementation of the multi-year programme for delivering improved models of care, including staffing and skill mix improvements already underway. It requires the agreed and appropriate utilisation of available development funding from 2015 and prior years to address issues such as the premia cost in medical agency and the cost of external placements, pending the development of more sustainable solutions. It has been assumed that 2016 development monies will only be released to meet the agreed additional costs of new developments continuing this multi-year programme of service improvement.

Health and Wellbeing

The implementation of service developments in 2016 will be prioritised and phased in line with the funding available. A review of water fluoridation costs with all stakeholders will conclude with Irish Water. Further discussions will be required in relation to addressing an approach to any consequent financial challenge.

Finance Indicators of Performance

Finance	Expected Activity / Target 2016
Budget Management including savings	
Net Expenditure variance from plan (within budget)	
• Pay – Direct / Agency / Overtime	0.33%
• Non-pay	0.33%
• Income	0.33%

Finance	Expected Activity / Target 2016
• Acute Hospitals private charges – Debtor Days – Consultant Sign-off	90% @ 15 days by 31/12/16
• Acute Hospitals private income receipts variance from Actual v Plan	≤ 5%
Service Arrangements / Annual Compliance Statement • % of number of Service Arrangements signed	100%
• % of the monetary value of Service Arrangements signed	100%
• % of Annual Compliance Statements signed	100%
Capital • Capital expenditure versus expenditure profile	100%
Audit	
• % of internal audit recommendations implemented by due date	75%
• % of internal audit recommendations implemented, against total number of recommendations, within 12 months of report being received	95%

Workforce Plan

Introduction

The health sector's workforce is at the core of the delivery of healthcare services working within and across all care settings in communities, hospitals and healthcare offices. The health service will continue to nurture, support and develop a workforce that is dedicated to excellence, welcomes change and innovation, embraces leadership and teamwork, fosters inclusiveness and diversity and maintains continuous professional development and learning. The People Strategy 2015–2018 has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. The strategy is underpinned by its commitment to engage, develop, value and support the workforce.

Recruiting and retaining motivated and skilled staff remains paramount for the delivery of health services delivered every day to an increasing and changing demographic population. This challenge is even greater now as the Health Reform Programme requires significant change management, organisation redesign and organisational development support.

Over the last three years, work has been ongoing to develop a robust strategic intent for HR across the wider health system to ensure there is one unified and consistent HR function, embracing statutory and voluntary providers, that will ensure HR has an operating model that is fit for purpose and aligned to the services and evolving new structures. This will ensure that the organisation and the workforce has the ability, flexibility, adaptability and responsiveness to meet the changing needs of the service while at the same time ensuring a consistent experience of HR services is delivered throughout the health system. Three areas of particular focus in 2016 will be the review of recruitment processes, HR structures and the development of a new development based 'performance management' approach. Performance indicators in relation to these areas will be developed and reported on in 2016.

Staff Engagement

An engaged and motivated workforce delivers better patient outcomes. It is only by listening to the views and experiences of staff that improvements to the health service, as a place to work, can be delivered. The messages from the first staff survey conducted in late 2014 have been identified and will need to be addressed. The next staff survey will be conducted in mid 2016.

Employee engagement is a core and central theme to the People Strategy 2015–2018 with a focus on developing mechanisms for more effective internal communications to support listening and learning across the whole sector, involving staff more in planning and decision-making and enabling them to propose and act on their ideas to improve the quality of care. This includes ensuring staff have the space to discuss their professional and career aspirations with their managers and that these engagements will inform learning and development.

The Workforce Position

Government policy on public service numbers and costs is focused on ensuring that the numbers of people employed are within the pay budgets available. It is estimated that the number of whole time equivalent posts in place at the end of 2015 will be 103,000.

There was a particular focus in 2015 on agency and overtime to reduce direct expenditure in this area and free up funding for the investment in essential posts. Workforce management in 2016 will be aligned with the allocated pay envelope, adhering to government policy on public sector numbers, pay and workforce related costs. This will be underpinned by a revised and strengthened Accountability Framework management and pay costs will continue to be managed through funded workforce plans at divisional and service delivery unit

level. Current health service staff numbers, by division, hospital group, CHO and national services (as of September 2015) are set out in Appendix 2.

Managing the Workforce: Pay and Staff Numbers Strategy

The challenge to the management of the workforce in 2016 is:

- Continuing the transition from an employment control framework driven by moratorium on recruitment to one operating within allocated pay envelopes.
- Operating strictly within allocated pay frameworks, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed.
- Strictly complying with public sector pay arrangements and policy on public sector pay costs.
- Identifying further opportunities for pay savings to allow for re-investment purposes in the health sector workforce.

Pay and Staffing Controls will be enhanced in 2016. Service Delivery Units will be required to submit monthly written assurance and exception reports in respect of 'starters and leavers'. Detailed challenges to any upward movements will be instigated with a view to eliminating further employment growth unless specifically funded in additional 2016 monies. There will be a focus on continued agency conversion and the elimination of further unfunded growth. There may be a need for targeted WTE reductions in 2016 to offset the full year costs of 2015 recruitment if operating outside of the allocated pay envelope.

The discretion now being provided in managing the workforce presents potentially greater and different management challenges. Service managers will have to focus on stretching pay expenditure to deliver optimal hourly labour costs and optimising the capacity and capability of their workforce, while strictly adhering to the pay envelope. This requires an integrated approach, with service management being supported by HR and finance. It further requires finance and HR workforce data, monitoring, and reporting to be aligned.

The 2013 Incentivised Career Break Scheme of up to three years duration concludes at the start of July 2016 and the re-integration of experienced employees, where they wish to return to public health sector employment, will be managed centrally by HBS.

Maximising labour cost reductions, efficiencies, and value for money

There is a need to further reduce the cost and reliance on agency staff. The use of agency staffing and/or overtime will be strictly controlled in 2016 to deliver the necessary savings set out in this plan.

Other tools available to work with managers to ensure the best use of people and budgets include:

- Greater use of e-rostering and time and attendance systems, which in time will need to be integrated with HR management information systems and with payroll.
- The e-Human Resource Management (e-HRM) strategy to support the effective management of the workforce and costs, being developed as part of the People Strategy, will lead in time to an integrated and unified technology platform.
- The creation of staff banks, based on geographical or service clusters, will continue to be considered.
- Skill-mix changes within and across staff disciplines will continue to ensure most appropriate and cost effective delivery of services. Options around substitution with appropriate scope of practice and oversight will also be considered.
- Review of management structures will continue.

2016 New Service Developments and Other Workforce Additions

This plan provides for specific additional funding in 2016 for new improvements and additional demographic pressures as set out in Appendix 1, which is in addition to initial pay allocations. The planning, approval, notification, management, monitoring and filling of these new posts will be in line with the previous process for approved and funded new service developments specified in national service plans. Other workforce additions, not specifically funded, will be implemented only where offset by funding redirection within allocated pay envelopes.

The Lansdowne Road Public Service Stability Agreement 2013–2018

The *Lansdowne Road Agreement*, concluded in May 2015, between government and public sector unions represents an extension of the *Haddington Road Agreement* (HRA) until 2018. A key additional factor in the agreement is a strengthened oversight and governance arrangement for dealing with matters of implementation and interpretation in respect of disputes that may arise.

The key enablers, such as additional working hours, that existed under the HRA up to now will remain for the duration of the extended agreement and will continue to assist clinical and service managers to manage their workforce through the flexibility measures contained. These enablers will support the reform, reconfiguration and integration of services and contribute to delivering a workforce that is more adaptable, flexible and responsive to needs of the services, while operating with lower pay expenditure costs and within allocated pay envelopes.

The HRA continues to provide the necessary enablers to allow for:

- Workforce practice changes
- Reviews of rosters, skill-mix and staffing levels.
- Increased use of productivity measures
- Use of redeployment mechanisms
- Greater use of shared services and combined services focused on cost effectiveness and cost efficiencies.

Workforce Planning

The DoH has committed to establishing a Workforce Planning Group in early 2016 in order to develop an Integrated Strategic Workforce Planning Framework for the health sector. The Group will address the workforce planning and development requirements contained in *Future Health*, *Healthy Ireland* and the HSE's *Corporate Plan 2015–2017*. HR will support the work of this group during 2016 and will operationalise the framework for the health sector in 2017. This will be achieved by supporting the clinical programmes, hospital groups, CHOs and central services to develop the capacity to undertake operational, programme and strategic workforce planning and workforce design. This support will be guided by relevant themes and work streams of the People Strategy 2015–2018, in conjunction with the Systems Reform Group and will involve:

- Supporting the workforce planning work streams in the dependant programmes and structures flowing from the Integrated Strategic Workforce Planning Framework.
- Developing a national workforce planning processes and structure that will support the service units in workforce planning, that will leverage the output of local and regional planning and will identify the workforce planning implications of clinical programmes, national health policy and national employment and migration policy.
- Building capacity to redesign / reconfigure services and the workforce based on best practice, evidence based models of care and anticipated future needs.

- Working with the DoH, Department of Education and Skills (DES), DJEI and other external bodies, to influence the quality and quantity of the future supply, acquisitions and deployment of healthcare workers.
- Assisting in the development and implementation of a relevant and effective resource allocation system.
- Integrating multi-discipline employee development strategies and programmes with workforce planning thereby building the internal supply.
- Providing workforce data intelligence, workforce profiles and research.

Leadership, Education and Development

In the context of a rapidly changed and evolving health service with new structures and integration of statutory and voluntary agencies it will be critical to support new emerging senior teams and to build managerial capacity. Part of this support will include implementation of a Leadership Development Programme (multi-disciplinary) across the management spectrum – with particular focus on line managers. Talent management and career mobility frameworks will be provided, and core and specialist competencies developed. These will be part of a people development planned interventions supported by coaching, mentoring and action learning. There will be a focus on building and enhancing organisational development and change management to support the reform and integration of CHOs and hospital groups. A HSE Graduate Intern Programme will be developed. Support for these initiatives will incorporate succession management and the development of talent pools across the health system. The senior leadership, clinical leadership and team leadership programmes will be adopted for newly formed clinical teams across the system.

There will be a focused emphasis on performance management and engagement at all levels in the health system with frequent manager / staff meetings in developing a culture of teamwork, communication and innovation.

It is planned to continue and expand the number of FETAC Level 5 Modules available to support staff and staff supervisors in 2016. Programmes will continue based on identified service requirements, training needs analysis and individual Personal Development Plans (PDPs) as part of the commitment to supporting employee continuous professional development needs.

Attendance Management

This continues to be a key priority area and service managers and staff with the support of HR will continue to build on the progress made over recent years in improving attendance levels. The performance target for 2016 remains at ≤ 3.5% staff absence rate.

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

The outstanding recommendations of this report will continue to be implemented in 2016 and in particular the issue of friendly flexible working arrangements will, service dependent, be supported. The negotiations on the task transfer initiative will be concluded and implementation of revised work practices shall be prioritised.

Outstanding recommendations pertaining to training, workforce planning and the consultant appointment process will be implemented in 2016.

European Working Time Directive

The HSE is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for both non-consultant hospital doctors (NCHDs) and staff in the social care sector. Key indicators of performance include:

- A maximum 24 hour shift (in relation to NCHDs only)
- Maximum average 48 hour week
- 30 minute breaks
- 11 hour daily rest / equivalent compensatory rest
- 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest.

Actions to achieve EWTD compliance in relation to NCHDs will be progressed by acute hospital and mental health services. Actions to progress EWTD compliance in relation to social care staff will be progressed by social care services.

Code of Conduct for Health and Social Care providers

This Code of Conduct, which sets out employees' and managers' responsibilities in relation to achieving an optimal safety culture, governance and performance of the organisation, was approved and endorsed by the Minister in March 2015. The HSE will implement the Code in 2016.

The People Strategy is designed to support the workforce in the pursuit of safer and better healthcare and the implementation of the Code is integral to that.

Occupational Safety and Health (OSH) at Work

In 2016 safer workplaces will be created by reviewing and revising the Corporate Safety Statement, developing key performance indicators (KPIs) in Health and Safety Management and Performance, launching a new statutory occupational safety and health training policy, and developing and commencing a national proactive audit and inspection programme. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established.

HR Indicators of Performance

HR	Expected Activity / Target 2016
Absence • % of absence rates by staff category	≤ 3.5%
Staffing Levels and Costs • % variation from funded staffing thresholds	≤ 0.5%
Compliance with European Working Time Directive (EWTD) • < 24 hour shift (Acute and Mental Health)	100%
• < 48 hour working week (Acute and Mental Health)	95%
Health and Safety • No. of calls that were received by the National Health and Safety Helpdesk during the quarter	15% increase

Corporate Goals Implementation

This section sets out key actions for national service delivery areas, grouped under five corporate goals. All actions are informed by the promotion of quality and the management of risk.

Further details of the work planned for delivery in 2016 is available in the Operational Plans which will be published January 2016

Health and Wellbeing

Introduction

Goal One of the HSE *Corporate Plan 2015–2017* is to 'promote health and wellbeing as part of everything we do'. It places the implementation of the *Healthy Ireland Framework* as a core pillar of our work and recognises the need to support staff to look after their own health and wellbeing.

	2016 NSP Budget €m	2015 Projected Outturn* €m	2015 Closing Budget €m	2016 Budget vs 2015 Projected Outturn %
Health and Wellbeing	221.7	210.3	210.3	5.4%

Full details of the 2016 budget are available in Table 2a page 113

*This includes internally commissioned services within other Divisions

To support the delivery of this goal, a *Healthy Ireland in the Health Services National Implementation Plan 2015–2017* was published in 2015. This plan outlines priorities and actions for all parts of the health service, so that we can achieve significant improvements in health and wellbeing across the population. The Health and Wellbeing Division will continue to build capacity to implement evidence-based health and wellbeing objectives in 2016 and further develop research and policy capabilities. In addition, staff in health and wellbeing will continue to ensure new accountability mechanisms, models of care and funding reforms are realising corporate commitments to rebalance health system priorities toward, chronic disease prevention and management, strategies for earlier detection of disease and the scaling up of self-care and self-management supports for individuals living with chronic disease.

2016 will see significant embedding of these priorities and agreed actions within national plans and within service specific plans, primarily across CHOs and hospital groups. Staff delivering services within the health and wellbeing services have responsibility for championing and driving this agenda in partnership with other national divisions, hospital groups and CHOs with government departments, local authorities, the community and voluntary sector, academia, the private sector and philanthropic organisations.

Implementation of all actions will be commensurate with available funding with some being prioritised and phased during 2016.

Developments and Challenges 2016

The 2016 new funding allocation of €4m will facilitate progress in relation to the following actions:

- Augment the current Primary Childhood Immunisation schedule to address agreed public health priorities. *(New Funding €2.5m)*

  The additional €2.5m new funding for vaccines allows the vaccination programme to commence in Quarter 4, 2016. Incremental funding of €7.75m in 2017 and €2.5m in 2018 will be required to fund the vaccination programme.
- Continue the implementation of age-extension for the BreastCheck Programme to eligible women aged 65–69 years. *(New Funding €1.5m)*

  Additional funding of €2.5m is required in 2017 to continue the implementation of age-extension for the BreastCheck Programme to eligible women aged 65–69 years.
- A review of water fluoridation costs with all stakeholders will conclude with Irish Water. Further discussions will be required in relation to addressing an approach to any consequent financial challenge.
- Planned health and wellbeing actions to support the clinical strategy and programme initiatives will be commensurate with available funding with delivery of some actions being prioritised and phased during 2016.

Discussions have taken place with the DoH in respect of an Advance Purchase Agreement for vaccines. As agreed the HSE will utilise €1.5m from expected time related savings related to the €58.5m held monies for new initiatives on a once off basis. The ongoing costs of this will be dealt with by DoH as part of the 2017 estimates / service planning process.

Key Priorities and Actions to Deliver on Goals in 2016

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

Healthy Ireland in the Health Services National Implementation Plan 2015–2017

- Support the development and implementation of CHO and hospital group and CHO *Healthy Ireland* plans.
- Increase the size and effectiveness of our stakeholder and partnership network to further develop joined-up approaches to improving health and wellbeing.
- Further integrate prevention, early detection and self-management supports into existing and new national clinical care programmes (continuing the four demonstrator projects – diabetes, COPD, asthma and heart failure.
- Support the development of a *Healthy Ireland* workplace framework in partnership with the DoH.
- Raise service user awareness of the importance of reducing the known and preventable key risk factors for chronic illness through support for the implementation of 'Making Every Contact Count'.
- Publish a framework and commence implementation of the National Brief Intervention Model.
- Develop a national framework and implementation plan for self-management support.
- Deliver high impact evidence-based communication and education campaigns to enable and support people to make healthier lifestyle choices.
- Reduce chronic disease by focusing on the work of national policy priority programmes in areas such as: Tobacco Free Ireland, Healthy Eating and Active Living (HEAL), Healthy Childhood Programme, Alcohol, Wellbeing and Mental Health, Positive Ageing and Sexual Health.

Tobacco Free Ireland – Working to reduce the prevalence of smoking amongst the population

- Maintain and strengthen the implementation of the HSE Tobacco Free Campus Policy.
- Build capacity amongst frontline workers to screen and support smokers to quit through the delivery of brief intervention training so they have the skills and confidence to treat tobacco addiction as a care issue.
- Maximise the impact of the QUIT campaign.
- Implement the provisions of the Tobacco Product Directive within resources.

Healthy Eating and Active Living

- Develop a three year HEAL implementation plan incorporating actions from the DoH National Obesity Policy and National Physical Activity Plan.
- Develop a model of delivery for a National Exercise Referral Framework in line with National Physical Activity Plan recommendations.
  - Increase opportunities for physical activity in partnership with other organisations such as the expansion of 'park run', with a focus on disadvantaged areas and young people.
  - Prioritise training of staff in national programmes and initiatives promoting healthy eating in infants, children and young people and their families.
- Develop and implement a HSE Healthy Food and Nutrition Policy including national clinical guideline for identification and management of under-nutrition.

Healthy Childhood

- Provide national oversight to the implementation of child health priorities (screening; immunisation; early intervention) in partnership with primary care and acute hospital services, in line with outcome one of *Better Outcomes Brighter Futures*.
- Begin the phased implementation of the revised evidence-based universal child health screening and development programme, including communication of key changes and the development of training programmes and standards to support service delivery.
- Commence the implementation of the key components of the Nurture, Infant Health and Wellbeing Programme, which will include public information and education, staff training and supports, and the development of an integrated service delivery model.
- Support the phased implementation of the action plan for breastfeeding 2015–2020 and increased participation rates.

Alcohol

- Develop a three-year alcohol implementation plan to reduce alcohol consumption and related harms incorporating actions from the National Substance Misuse report and aligned to new legislation.
- Develop and prepare the enforcement provisions of the *Public Health (Alcohol) Bill* in partnership with the DoH.
- Further progress a co-ordinated approach to prevention and education interventions through:
  - The community mobilisation on alcohol initiatives with Drug and Alcohol Task Forces.
  - The REACT award and accreditation scheme in the third level sector, which recognises and rewards an institution's efforts to reduce alcohol-related harm amongst its students.
- Increase awareness amongst the public of alcohol-related harm by building on the 2015 communication campaign.

Wellbeing and Mental Health

- Promote positive mental health and support the National Office for Suicide Prevention to implement relevant recommendations from *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015–2050* with a particular focus on mental health promotion programme activities and partnership to improve community wellbeing.

Positive Ageing

- Support the development of a national implementation plan to promote positive ageing and improve physical activity levels in partnership with social care.
- Develop and launch a national communications campaign for dementia in collaboration with a range of partners, to create better informed, positive attitudes to dementia, increase readiness in health services and communities to support people with dementia, and create better understanding of brain health in general.
- Publish the findings of the Healthy and Positive Ageing Initiative (HaPAI) surveys of people aged 55 and over across 19 local authorities to assist and inform future policy and service planning.
- Support the implementation of the Carers Strategy through the work of the multi-divisional group.

Sexual Health

- Implement priority recommendations from the National Sexual Health Strategy in partnership with relevant stakeholders.

Deliver and Expand our Screening Programmes

- Deliver breast screening to women aged 50–64 through the **BreastCheck Programme** and maximise the uptake of breast screening among the eligible population.

- Continue the implementation of age-extension for the **BreastCheck Programme** to eligible women aged 65–69 years. *(New Funding €1.5m)*
- Maximise the coverage of cervical screening among the eligible population and deliver cervical screening to the eligible cohort of women through the **CervicalCheck Programme**.
- Maximise the uptake of bowel screening among the eligible population and deliver the first year of a 2 year screening round to the eligible population 60–69 years through the **BowelScreen Programme**.
- Maximise the uptake of retinal screening among the eligible diabetic population and deliver annual screening to the eligible cohort through the **Diabetic RetinaScreen Programme**.

Immunisation Programmes

- Implement recommendations from the review of models of delivery and governance of immunisation services.
- Improve national immunisation uptake rates in partnership with primary care.
  - Implement changes to primary childhood immunisation programme and schools immunisation programme.
- Augment the current Primary Childhood Immunisation schedule to address agreed public health priorities. *(New funding €2.5m)*
- Improve influenza vaccine uptake rates amongst staff in frontline settings (acute and long-term care in the community).
- Improve influenza uptake rate among persons aged 65 and over.

Healthcare Associated Infections (HCAI)

- Review organisational approach to HCAI and antimicrobial resistance in collaboration with the Quality Improvement Division and all stakeholders to produce an updated plan.
- Encompass actions to reduce the prevalence of HCAI and antibiotic consumption rate within *Healthy Ireland* implementation plans.

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

Protect the population from threats to their health and wellbeing

- Implement the National Clinical Effectiveness Committee (NCEC) HCAI Guidelines No. 2 and No. 3 (MRSA and CDiff) and the NCEC Acute Adult Asthma Attack Guideline (No. 14 – published in November 2015).
- Provide epidemiological expertise, advice and support to key external stakeholders and provide statutory surveillance, management, investigation and control of infectious diseases.
- Provide responses and increase capacity to address public health incidents including outbreaks of infectious disease, chemical, radiation and environmental incidents.
- Implement the service contract with the Food Safety Authority of Ireland.
- Enforce HSE environmental health statutory responsibilities including the inspection test purchases and mystery shopping of establishments under the *Public Health (Sunbeds) Act 2014*.
- Address emergency management legislative requirements, in addition to interagency obligations under the Framework for Major Emergency Management and support services and functions in their planning and response to major emergencies.

Knowledge Management

- Produce data via the Health Atlas System, to support national and local population needs assessment to support services with planning, resource allocation and evaluation.

- Further develop and disseminate health and wellbeing county profiles to support health and social care services and external partners for example: Local Community Development Committees, Children and Young People's Services Committees and Age Friendly County Programmes.
- Produce an annual health information paper to inform the service planning process.
- Increase the number of formal research partnerships to build a larger, cross-sectoral agenda for health and wellbeing research.
- Progress the transition of library services to health and wellbeing services to establish a unified national library structure.

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

- Develop, implement and disseminate a Quality Profile Framework.
- Increase the number of quality KPIs developed and used in partnership with the Quality Improvement Division.
- Embed health and wellbeing indicators within HSE reform programmes and projects.
- Implement a uniform system for recording, collating and reporting complaints and compliments across Health and Wellbeing and its services.
- Include health and wellbeing indicators in the measurement of patients' / service users' needs, experiences and outcomes of care.
- Involve people in the development of programmes and initiatives to improve health and wellbeing.

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

- Develop and implement a Healthy Workplace Policy and supporting initiatives to support and encourage staff to look after their own health and wellbeing building on work this year such as calorie posting.
- Strengthen health and wellbeing management and capacity within CHOs and hospital groups.
- Provide training and support to staff to embed the concept of 'every contact counts'.
- Ensure that health education campaigns support staff to improve their own health and wellbeing.
- Promote and provide national tools for training and resource development for health literacy.
- Agree a plan to achieve 90% risk recording on the Hospital Inpatient Enquiry (HIPE) system over the next three years.
- Implement relevant recommendations arising from the employee engagement survey, the People Strategy 2015–2018, and the Public Service Agreements 2013–2018 in partnership with HR.

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

- Implement the recommendations of completed workforce plans within health promotion and improvement, public health and environmental health services.
- Identify mechanisms to incentivise the delivery of preventative activities as part of the activity based funding framework.
- Progress Phase 1 of the systems lifecycle (design, data migration, planning) in preparation for the National Immunisation and Child Health Information System (NICIS) implementation.
- Increase the proportion of patients utilising self-management supports.

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Service User Experience	
• Complaints	*System-wide. See page 119*
Safe Care	
• Serious Reportable Events	
• Safety Incident Reporting	
National Screening Service	
• BreastCheck: % women offered hospital admission for treatment within 3 weeks of diagnosis of breast cancer	> 90%
• CervicalCheck: % urgent cases offered a Colposcopy appointment within 2 weeks of receipt of letter in the clinic	> 90%
Public Health – Immunisation	
• % of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (acute hospitals and long term care facilities in the community)	40%
• % children aged 24 months who have received 3 doses of the 6 in1 vaccine	95%
• % children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	95%
Effective Care	
Health Promotion and Improvement	
• Tobacco: % of smokers on cessation programmes who were quit at one month	45%
• Child Health: % of newborn babies visited by a PHN within 72 hours of discharge from maternity services	97%
Public Health	
• 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	95%
• Immunisation: % uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	75%
Access	**Expected Activity / Target 2016**
National Screening Service	
• BreastCheck: % BreastCheck screening uptake rate	> 70%
• CervicalCheck: % eligible women with at least one satisfactory CervicalCheck screening in a 5 year period	> 80%
• BowelScreen: % of client uptake rate in the BowelScreen programme	> 45%
• Diabetic RetinaScreen: % Diabetic RetinaScreen uptake rate	> 56%
Health Promotion and Improvement – Tobacco	
• No. of smokers who received intensive cessation support from a cessation counsellor	11,500
Environmental Health Service – Food Safety	
• No. of official food control planned, and planned surveillance inspections of food businesses	33,000

Primary Care

Introduction

The development of primary care services is a key element of the overall Health Reform programme. The core objective is to achieve a more balanced health service by ensuring that the vast majority of patients and clients who require urgent or planned care are managed within primary and community based settings, while ensuring that services are:

- Safe and of the highest quality
- Responsive and accessible to patients and clients
- Highly efficient and represent good value for money
- Well integrated and aligned with the relevant specialist services.

Primary care services include primary care teams (PCTs) and general practice, schemes reimbursement, social inclusion and palliative care services. A key priority for 2016 is the continued implementation of the recommendations of *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, 2014.* There will be a continued emphasis on integrated care and accountability for primary care services. This will strengthen the Accountability Framework and outline explicit responsibilities for staff at all levels.

	2016 NSP Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m	2016 Budget vs 2015 Projected Outturn %
Primary Care	764.8	757.5	749.0	1.0%
PCRS	2,417.1	2,408.5	2,268.2	0.4%
Local Demand-Led Schemes	242.6	232.2	218.1	4.5%
Social Inclusion	127.1	127.0	128.0	0.0%
Palliative Care	72.8	71.8	71.8	1.4%
€13.5m additional funding held by DoH				

Full details of the 2016 budget are available in Table 2a page 113

Primary Care

Over the last number of years work has been underway to realise the vision for primary care services whereby the health of the population is managed, as far as possible, within a primary care setting with people very rarely requiring admission to hospital. This approach is now aligned with the *Healthy Ireland* framework, noting the importance of primary care to the delivery of health improvement gains. Primary care can play a central role in co-ordinating and delivering a wide range of integrated services in collaboration with other service areas. The PCT is the central point for service delivery which actively engages to address the medical and social care needs of the population in conjunction with a wider range of Health and Social Care Network (HSCN) services.

PCRS

The Primary Care Schemes are the means of delivery for a significant proportion of primary care services. Scheme services are delivered by over 7,000 primary care contractors e.g. GPs, pharmacists, dentists, optometrists and/or ophthalmologists.

The schemes include:

- General Medical Services (GMS) – Medical Card Scheme, including GP Visit Cards
- Drug Payment Scheme
- Long Term Illness Scheme
- Dental Treatment Services Scheme (DTSS)
- High Tech Drug Arrangements

- Primary Childhood Immunisation Scheme
- Community Ophthalmic Scheme
- Certain services under *Health (Amendment) Act 1996* and *Redress for Women Resident in Certain Institutions Act 2015*
- Methadone Treatment Scheme.

Social Inclusion

The core objective of social inclusion services is the improvement of health outcomes for the most vulnerable in society. This includes provision of targeted interventions for people from traditionally marginalised groups who experience health inequalities, have difficulties accessing services and present with multiple, complex health and support needs. Vulnerable people and communities falling within the remit of social inclusion include Irish Travellers and Roma, asylum seekers, refugees and Lesbian, Gay, Bisexual, Transgender (LGBT) service users. Issues of addiction, substance misuse, homelessness and domestic, sexual and gender based violence are overarching themes within the service user groups. Social inclusion services work with mainstream services and voluntary sectors to ensure accessibility for disadvantaged service users.

Social inclusion services are developing appropriate activity metrics to more accurately reflect the health needs and outcomes of vulnerable groups. These metrics will be aligned with the objectives of the *Healthy Ireland* implementation plan.

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment and management of pain and other physical, psychosocial and spiritual problems. In recent years, the scope of palliative care has broadened and includes not only cancer related diseases but supporting people through non-malignant and chronic illness also. A new plan involving a stakeholder representative working group is being prepared which will provide direction for palliative care services for the next three years; this will be published early in 2016. The plan is being developed in collaboration with the Clinical Programme for Palliative Care.

In 2016 engagement will continue with voluntary service providers to ensure that emerging needs and related solutions can be identified and addressed. Palliative care recognises the potential of the five Integrated Care Programmes (ICPs) to improve integration, access and outcomes and will actively support the development and implementation of the priority work streams in 2016.

Developments and Challenges in Primary Care Services in 2016

The 2016 DoH held funding allocation of €13.5m will facilitate progress in relation to:

- Extension of free GP care to children up to 12 years, subject to negotiation under the Framework Agreement.
- Improved access to diagnostics (ultrasound and x-rays) for GPs.
- Expansion of minor surgery services in primary care.

In addition, the primary care division in collaboration with the mental health and social care divisions will facilitate:

- Improved access to primary care psychology and counselling.
- Improved access to primary care speech and language therapy services.

The budget allocation for primary care in 2016 presents significant challenges for the maintenance of existing levels of service for the division, particularly so for the PCRS range of demand-led services. A range of

measures has been identified to manage the Primary Care Division services within budget, they include the following:

Core Services

- Reviewing service delivery models for primary care services
- The development of prioritisation protocols for the delivery of services
- The introduction of quality improvement initiatives across the division
- Further roll out of the Performance Management Framework
- Further reduction in agency costs
- Enhanced procurement and process measures to improve the management of consumables
- Adherence to the Pay Bill Framework in relation to staff replacements
- Containing activity on 2015 new developments to 2015 expenditure levels
- Containing activity in primary care core services to existing levels of service
- Maintaining activity in dental treatment to existing levels of service.

Local Demand-Led Schemes

- Delivering activity under local demand-led schemes to funded levels.

PCRS Assumptions

Primary Care Reimbursement Service (PCRS) – €2,417m available to HSE (with a further €10m held by DoH)

The PCRS budget has been set at the level indicated by the letter of determination received by the HSE.

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 DoH.

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

Thereafter demographic, economic and other variable factors, given the demand-led nature of the schemes, will dictate the actual numbers of eligible persons and the cost of their entitlements to be paid by PCRS in 2016 under each scheme. The PCRS plan for 2016 is based on a number of assumptions around demographics, economic growth and these other factors which have been agreed with the DoH following an extensive series of engagements.

As regards drug costs, the growth in costs related to existing drugs is largely a feature of the entitlements of individuals as determined by their eligibility and the demographic and other factors outlined above including prescribing practices. In relation to new drug costs, primarily high-tech drug costs, sectoral agreements and the assessment process in place to establish whether new drugs can be introduced on the basis of funding available will be a significant feature in 2016.

The PCRS budget for 2016 has been framed by reference to a series of working assumptions. These have been developed in detailed discussion with the DoH. They have been accepted as the basis on which, in respect of the PCRS, the HSE should address the statutory requirement to indicate the type and volume of services to be provided during the year to include the following:

- Persons eligible for medical cards will continue to receive them in a timely manner and in accordance with the turnaround times for processing applications as outlined in the plan.

- Appropriate measures will continue to ensure the accurate administration of the various schemes. This will involve savings being achieved from continued enhanced monitoring of claims and payments to primary care contractors.
- The medical card profile outlined in the plan (see table below and in appendix 3) reflects the funding allocated for 2016. It is jointly acknowledged that the actual level of activity will depend on the number of eligible patients availing of services.
- The savings targets in relation to drugs / medicines will be achieved in full – this is a key shared assumption that is dependent on the outcome of engagement with the pharmaceutical industry, prescribers and retailers.
- Overall net expenditure on High Tech drugs in 2016 is maintained at 2015 outturn levels (which includes provision for new drugs in 2016) – this is dependent on the HSE's capacity to contain approvals for new medicines to overall funded levels and the outcome of negotiations with key stakeholders.
- Efficiencies and stock management improvements in the High Tech medicines area will reduce costs.
- Savings in relation to administration costs will also be achieved.
- GMS activity is in accordance with funded levels as follows:

Schemes	Projected Outturn 2015	Activity Level 2016
GMS (medical card numbers)	1,725,767	1,675,767
GP Visit Cards	435,785	485,192*

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Expenditure in the PCRS budget will be the subject of close monitoring and assessment from the beginning of 2016. The implications of any emerging variations from the working assumptions underpinning the budget will be the subject of engagement with the DoH through the reporting and oversight arrangements which operate in relation to the NSP. In this context the HSE will indicate to the DoH the nature and extent of any interventions that it considers necessary to ensure that the available budget for PCRS is not exceeded and will seek direction in this regard.

Key Priorities and Actions to Deliver on Goals in 2016

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

Primary Care and Health and Wellbeing collaborative actions for *Healthy Ireland* implementation plan

In partnership with health and wellbeing services the following will be delivered in 2016:

- Support CHOs to develop implementation plans for *Healthy Ireland*.
- Engage with Local Community Development Committees to ensure relevant health and social care priorities are addressed.
- Implement the Healthy Workplace Policy with supporting initiatives for staff to look after their own health and wellbeing.

Implement child health programmes / initiative to improve health outcomes for children

- Implement the revised child health programme.
- Implement the Nurture - Infant Health and Wellbeing programme in primary care settings.

Improve national immunisation rates

- Improve influenza vaccination uptake rates among persons aged 65 and over.

- Improve influenza vaccine uptake rates among staff in front line settings.
- Implement recommendations of the review of models of delivery and governance for immunisation services.
- Expand the current Primary Childhood Immunisation schedule to address agreed public health priorities. *(New Funding included in Health and Wellbeing)*
- Input into the development of a National Immunisation and Child Health Information System (NICIS).

Support health promotion and improvement initiatives in primary care

- Support the implementation of the Sexual Heath Strategy.
- Support brief intervention training for staff on smoking cessation.

HCAI / Decontamination programme

- Implement the HCAI / AMR clinical care training programmes.

Primary Care Reimbursement Service

- Reimburse primary care contractors in line with health policy, regulations and within service level agreements governing administration of the health schemes.

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

Primary Care Quality and Safety

Work with the national Quality Improvement Division in supporting the roll-out of patient safety programmes

Quality Improvement / Enablement Programme

- Develop a programme to improve the quality and safety of addiction, homelessness and palliative care services.

Pressure Ulcers to Zero Collaborative

- Support the PCTs participating in the Pressure Ulcer to Zero Collaborative.
- Provide awareness training to senior public health nurses on the management and prevention of pressure ulcers within primary care.

Provide improved and additional services at primary care (PCT and Network) level

- Progress the review of GP contracts under the Framework Agreement. Negotiations between the DoH, the HSE and the IMO on a comprehensive new contractual framework with GPs will continue with a view to reaching a successful outcome during 2016.
- Extend access to free GP care to children aged up to 12 years subject to negotiations under the Framework Agreement. This service development will be implemented in the context of the new contractual framework with GPs. *(Held Funding DoH €13.5m)*
- Extend the 2015 minor surgery project to further practices and target activity transfer from acute hospitals of up to 10,000 procedures. *(Held Funding DoH €13.5m)*
- Extend direct access for GPs to ultrasound and x-ray. *(Held Funding DoH €13.5m)*
- Develop primary care psychology services including primary care counselling services for children in collaboration with mental health services. *(Held Funding DoH Mental Health €35m)*
- Implement the recommendations of the *Primary Care Eye Services Review Report.*

- Progressing Disability Services Programme for Children and Young People in collaboration with social care services*(Held DoH Funding Social Care €8m)*
- Undertake a review of the model and provision of primary care speech and language therapy services, particularly for children.
- Undertake waiting list initiatives to reduce waiting times for primary care speech and language therapy particularly for children.
- Complete a review of the operation and efficiency of the Community Intervention Team service.
- Progress the implementation of the recommendations of the GP Out of Hours Review using existing resources.

Hepatitis C Treatment Programme

- Strengthen the management and governance structures for the treatment of Hepatitis C patients.
- Establish a patient registration system for patients with Hepatitis C.
- Ensure that learning is shared nationally in a timely manner regarding best practice.

Improve access to oral health and orthodontic services

- Improve access to orthodontic treatment for children including those requiring orthognathic / oral surgery.
- Commence the process of implementation of HIQA infection control standards.
- Provide advice and information and onward early referral for oral healthcare for high risk children by undertaking a 'smiles' pilot programme targeting children aged between 0–3 years in one site.

Improve cross division service integration

- Provide an integrated response with acute services and social care services to relieve pressure in EDs, incorporating hospital admission avoidance and facilitating early discharge.
- Implement a new model of practice for the management of children with non-complex needs in primary care in collaboration with mental health and social care services.
- Participate in the multi-divisional Respite Review Group (Carers Strategy) in collaboration with social care services.
- Implement the Primary Care Education, Pathways and Research in Dementia (PREPARED) Programme through the delivery of dementia specific education to PCTs and GPs (selected sites to be agreed in January 2016) in collaboration with social care services.

Develop and progress the priority work streams of the five integrated care programmes to improve integration, access and outcomes for patients in collaboration with Clinical Strategy and Programmes

- Provide structured education programmes for patients with diabetes.
- Implement the chronic disease demonstrator projects utilising the 2015 approved posts for respiratory, heart failure and diabetes.
- Progress the implementation of the Diabetes Clinical Care Programme making best use of the existing Integrated Care Diabetes Clinical Nurse Specialists.
- Progress a study of outcomes for patients with acute asthma in collaboration with Clinical Strategy and Programmes.

Primary Care Reimbursement Service

- Process applications for eligibility within the agreed turnaround times.
- Maximise the use of data from other government agencies to confirm access for eligible persons.
- Extend the on-line medical card application system.
- Establish a service user panel to include representation from patients, GPs, pharmacists and other contracted service providers.

Implement the individual health identifier register

- Implement the plan for the roll out of individual health identifiers in 2016 in line with the *Health Identifiers Act 2014*.

Social Inclusion

Improve health outcomes for people with addiction issues

- Implement the outstanding actions in the *National Drugs Strategy* (2009–2016).
- Ensure that adults deemed appropriate for treatment for substance abuse receive treatment within one calendar month.
- Ensure that children deemed appropriate for treatment for substance abuse receive treatment within one week.
- Ensure that addiction services operate within the person-centred care planning processes of the Drugs Rehabilitation Framework.
- Finalise the response to drug-related deaths through a National Overdose Prevention Strategy.
- Audit drug services in line with the Drugs Rehabilitation Framework on care planning, assessment, key working and referrals.
- Strengthen clinical governance structures by the appointment of an Addiction Clinical Lead.

Support the implementation plan to reduce homelessness

- Support the implementation plan to reduce homelessness with particular focus on health related recommendations.
- Ensure arrangements are in place and working effectively to ensure homeless persons have access to primary care services where required.
- Work towards ensuring that no patient is discharged into homelessness from an acute setting and ensure the provision of step-down care for homeless people with chronic and enduring needs in long-term supported accommodation in collaboration with mental health services. *(Held Funding DoH Mental Health €2m of €35m)*
- Ensure the provision of in-reach services to emergency accommodation settings and long-term supported accommodation for people with high support needs.

Improve health outcomes for vulnerable groups

- Traveller and Roma health
  - Provide health information and education for travellers on diabetes and cardiovascular health.
  - Develop a Traveller and Roma Inclusion Strategy in collaboration with clinical programmes and mental health services.
  - Support an interagency initiative in two Local Authority areas – in partnership with the Local Authorities and representative groups – to improve health service delivery to the Traveller community.
- Domestic, Sexual and Gender based violence
  - Implement the recommendations of the S*trategy on Domestic, Sexual and Gender-based Violence 2015–2020* with particular attention to vulnerable or at risk communities and support for staff in recognising and responding to victims of violence.
  - Implement specific health related recommendations of the *Action Plan on Women, Peace and Security* with a focus on the listed HSE action '*Strengthen outreach to women and girls in Ireland who have been affected by conflict*'.
  - Participate in the development of an Action Plan to prevent and combat human trafficking, with associated attention to reviewing and strengthening existing care and support services for persons who have been trafficked.

- Intercultural Health
  - Develop structures and processes to provide health services under the Irish Refugee Protection Programme with associated monitoring and reporting of outcomes.

Promote implementation of an interpreting model for persons who are not proficient in English or are deaf

- Provide translation facilities to assist patients not proficient in English or deaf to access and navigate health services effectively.

Palliative Care

Improve access to adult palliative care services

- Address deficits in specialist palliative care bed numbers in Kerry (15 beds). *(New Funding included in Acute Services)*
- Extend the implementation of specialist palliative care eligibility criteria to include non-cancer patients.

Improve quality within palliative care service provision

- Strengthen palliative care services through the implementation of the *National Standards for Safer Better Healthcare.*
- Implement clinical guidelines on the management of cancer pain and the management of constipation.
- Develop and implement a suite of quality improvement measures for children's palliative care services.
- Work with the Children's Hospital Group to ensure existing children's palliative care services become fully integrated with the new structures.

Improve access to children's palliative care services.

- Provide for a palliative care consultant previously funded by Irish Hospice Foundation. *(New Funding included in Acute Services)*

Ensure palliative care services are effective, efficient and responsive to the needs of individuals and families

- Work with the Irish Hospice Foundation on the Design and Dignity Grants Scheme.
- Work with primary care services on the *Rapid Discharge Planning Pathway* to facilitate those who wish to die at home.
- Implement the recommendations from the *Palliative Care Support Beds Review.*
- Implement the specialist palliative care initiative in four designated centres for older people in the North East.
- Complete a demonstration project to develop a best practice model of palliative care for EDs.
- Work with NAS to support emergency responders to manage end of life care, enabling people to be cared for at home if appropriate.

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

Primary Care

Quality and Safety

Patient engagement and empowerment

- Engage with patients on their experience of primary care through listening sessions conducted in partnership with the Quality Improvement Division.
- Measure peoples experience within CHOs through the use of the primary care service user survey.

Governing for quality and safety

- Work with the Quality Improvement Division to foster accountability for quality within primary care through quality initiatives, i.e. provide support, training and advice to the primary care quality and safety committees.

Open disclosure programme

- Work with the Quality Improvement Division to roll out the open disclosure programme to all primary care services.

Strengthening the Primary Care Accountability Framework

- Monitor performance of health services against agreed indicators for quality and safety and the Primary Care Quality Dashboard.

Promoting safe services

- Ensure systems and structures are in place within primary care for reporting and monitoring serious reportable events (SREs) and other serious safety incidents.
- Ensure incidents in primary care are effectively managed, reported, investigated with learning shared in line with national policy.

National Standards for Safer Better Healthcare

- Support CHOs in implementing the *National Standards for Safer Better Healthcare*.
- Establish a quality support group to promote patient safety and quality improvement programmes in primary care.

Support the work of the National Clinical Effectiveness Committee

- Implement the NCEC Guidelines and Standards for Clinical Practice.

Understanding patient safety incidents

- Support the roll out of the National Incident Management System (NIMS) in primary care in conjunction with Quality Assurance and Verification and the State Claims Agency.
- Develop and produce high level incident information data from NIMS.

Audit and reviews

- Undertake audits of quality and safety in primary care to provide assurance that standards are in line with the *National Standards for Safer Better Healthcare*.

Measurement and analysis of information for quality improvement: Build capacity in the use of measurement and data for quality improvement

- Work with CHOs to further develop the primary care quality dashboard to provide one mechanism for measuring quality and safety.
- Work with the Quality Improvement Division to develop a quality profile in the primary care setting.
- Promote the development of additional quality and safety indicators.

Risk management

- Manage risk within primary care through the ongoing development of risk management processes.
- Work with other divisions to enhance the capacity and capability of staff in relation to the management of risk through education and training.

Children First

- Provide a standard system of reporting child protection and welfare concerns to the Child and Family Agency. Reports will be tracked and monitored by the Children First Office following submission of weekly / monthly reports by assigned Designated Liaison Persons (DLPs). Names and contact details for DLPs will be available to each staff member in CHOs and hospital groups.

Primary Care Reimbursement Service

Implement the recommendations of the reform programme in PCRS

- Continue the regular engagement with primary care contractor representative organisations.
- Review the content of itemised claims listings with primary care contractor representative organisations.
- Consider, in conjunction with the DoH where appropriate, further recommendations of the Clinical Advisory Group including conclusions in relation to the assessment of the burden of disease.

Develop the Community Schemes Control and Inspectorate Function in line with recommendations from the reform programme

- Develop enhanced inspection procedures.
- Increase the use of advanced data analysis to support inspection functions.

Social Inclusion

- Develop and distribute standardised problem alcohol and substance use screening and brief intervention SAOR (Support, Ask and Assess, Offer Assistance and Refer) toolkits to support Tier 1 and Tier 2 services.
- Publish a Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use for nurses and midwives in acute, primary and community settings.

Strengthen community development approaches in line with *Healthy Ireland* and other relevant initiatives

- Establish a social inclusion working group on community development, to incorporate principles in respect of addressing health inequalities, community development, community participation, social prescribing etc. with a focus on vulnerable communities. This working group will have representation from each CHO.

Enhance Community approaches to addressing HIV/AIDS

- Collaborate with HIV Ireland and other stakeholders to further develop and enhance community approaches to addressing HIV / AIDS.

Hepatitis C Strategy

- Implement the recommendations of the Hepatitis C Strategy through the development of national guidelines for Hepatitis C screening and provision of updated website information.

Palliative Care

Encourage the ongoing development of person-centred services

- Develop an integrated whole system approach to person-centred care provision.
- Undertake a health system performance and evaluation study from a person-centred perspective.
- Incorporate the experiences of service users and staff to evaluate and plan services.
- Support services to implement the *Patient Charter for Specialist Palliative Care.*
- Commence collection of key performance indicators with a quality focus.
- Commence the collection of patient / family satisfaction feedback.

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

Primary Care

Restructure the provision of GP training

- Agree a service level agreement with the ICGP on the training programme for GPs.

Quality and Safety

- Improve capacity in quality and safety within primary care by providing support to staff to develop clinical audit tools.

Implement Children First

- Promote the implementation of Children First in each CHO / hospital group.
  - Ensure each CHO / hospital group has a Children First implementation plan.
  - Ensure each CHO / hospital has a local Child Protection and Welfare Policy.
- Ensure that each staff member is aware of their social, corporate and legal responsibilities under Children First.
  - Facilitate staff (including staff of funded agencies) to undertake the Children First e-Learning programme.
  - Deliver Children First Training Programmes to meet the needs of services including out of hours and at weekends if required.

Primary Care Reimbursement Service

Engage with and inform all team members about developments

- Develop staff skills to deliver the HR improvement initiatives from the positive workplace engagements.

Implement organisation structures in line with the recommendations of the reform programme

- Align organisation structures and enhance team capacity as recommended.

Social Inclusion

- Provide LGBT health training for health service staff across three CHOs.
- Provide intercultural health training to enable staff to deliver services in a culturally competent manner. This training will be targeted at staff delivering services to asylum seekers in Direct Provision and to refugees arriving under Resettlement and Relocation programmes.
- Roll out of SAOR screening and brief intervention training to 300 staff for problem alcohol and substance use within Tier 1 and Tier 2 services. Deliver 30 SAOR trainings and complete 4 train the trainer programmes nationally.

Palliative Care

Develop the capacity of healthcare professionals to better meet the needs of patients and their families

- Progress the implementation of the *Palliative Care Competence Framework*.
- Provide training and support on the *Needs Assessment Guidance Document* and Education Module.
- Implement the *Role Delineation Framework*.
- Establish nurse prescribing within specialist palliative care.

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

Primary Care

ICT

- Roll out the primary care ICT systems to support safe and effective provision of services.

Primary Care Reimbursement Service

Assist DoH and DPER in the implementation of the Drugs Cost Strategy

- Implement relevant actions arising from the finalised strategy.

Progress the centralised administration of the Drugs Payment and the Long Term Illness Schemes

- Plan and schedule the migration to centralised administration of the scheme.

Support the work of the Medicines Management Programme (MMP) to improve quality and safety and cost effective prescribing behaviours

- Provide data and analysis as required by the programme.

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Primary Care	
Service User Experience	*System-wide. See page 119*
• Complaints	
• % of PCTs by CHO, that can evidence service user involvement as required by Action 19 of the Primary Care Strategy – A New Direction (2001)	100%
Safe Care	
• Serious Reportable Events	*System-wide. See page 119*
• Safety Incident Reporting	
Healthcare Associated Infections: Medication Management	
• Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	< 21.7
Effective Care	
Community Intervention Teams (number of referrals)	**24,202**
• Admission Avoidance (includes OPAT)	914
• Hospital Avoidance	12,932
• Early discharge (includes OPAT)	6,360
• Unscheduled referrals from community sources	3,996
Health Amendment Act: **Services to persons with state acquired Hepatitis C**	798
• Number of patients who were reviewed	
Primary Care Reimbursement Service	
Effective Care	
Medical Cards	
• % of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	90%
• % of Medical Card applications which are accurately processed by national medical card unit staff	95%

Quality	Expected Activity / Target 2016
Social Inclusion	
Effective Care	
Traveller Health	
• No. of people who received health information on type 2 diabetes and cardiovascular health	3,470
Homeless Services	
• % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	85%
Palliative Care	
Effective Care	90%
• % of patients triaged within 1 working day of referral	
• % of patients with a multi-disciplinary care plan documented within 5 working days of initial review	90%

Access	Expected Activity / Target 2016
Primary Care	
GP Activity	
• No. of contacts with GP Out of Hours service	964,770
Nursing	
• No. of new patients accepted on the caseload and waiting to be seen over 12 weeks	0
Speech and Language Therapy	
• % on waiting list for assessment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 52 weeks	100%
Physiotherapy and Occupational Therapy	
• % of new patients seen for assessment within 12 weeks	70%
• % on waiting list for assessment ≤ 52 weeks	100%
Podiatry, Ophthalmology, Audiology, Dietetics and Psychology	
Podiatry	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	75%
Ophthalmology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Audiology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Dietetics	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	70%
Psychology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Oral Health	
• % of new patients who commenced treatment within 3 months of assessment	80%
Orthodontics	
• % of referrals seen for assessment within 6 months	75%
• Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	< 5%
Primary Care Reimbursement Service	
Medical Cards	
• % of completed Medical Card / GP Visit Card applications processed within 15 days	95%

Access	Expected Activity / Target 2016
• No. of persons covered by Medical Cards as at 31st December	1,675,767
• No. of persons covered by GP Visit Cards as at 31st December	485,192*
Social Inclusion **Substance Misuse** • % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	100%
• % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	100%
• No. of clients in receipt of opioid substitution treatment (outside prisons)	9,515
• Average waiting time from referral to assessment for opioid substitution treatment	14 days
• Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced	28 days
Needle Exchange • No. of unique individuals attending pharmacy needle exchange	1,731
Palliative Care • Access to specialist inpatient bed within 7 days	98%
• Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital)	95%
• No. of patients in receipt of specialist palliative care in the community	3,309
• No. of children in the care of the children's outreach nursing team / specialist palliative care team	370

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Mental Health

Introduction

The vision for mental health services is to support the population to achieve their optimal mental health through the following key priorities which connect directly to the delivery of the HSE corporate goals:

	2016 NSP Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m	2016 Budget vs 2015 Projected Outturn %
Mental Health	791.6	774.8	794.4	2.2%
€35.0m additional funding held by DoH				

Full details of the 2016 budget are available in Table 2a page 113

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

The modern mental health service, integrated with other areas of the wider health service, extends from promoting positive mental health and suicide prevention through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness.

The ten year national policy, the *Report of the Expert Group on Mental Health Policy – A Vision for Change* (2006) is a progressive, evidence based document which proposed a new model of service delivery which would be service user-centred, flexible and community based. *A Vision for Change* and any successor policy will continue to inform the roadmap, charting the way forward for the mental health service.

The total population is growing and the population of 0–17 year olds will increase by 11,680 from 2015 to 2016, impacting on demand for Child and Adolescent Mental Health services (CAMHs). The 18–64 cohort of the population will increase by 1,290 in the same period with the biggest increase in the over 65 age group which will grow by 19,400 or 3.1% between 2015 and 2016. This has implications for increasing demand on mental health services in the period of this NSP.

Developments and Challenges 2016

The net opening budget allocation for 2016 of €791.6m, inclusive of 2015 Programme for Government (PfG) funding, plus the additional 2016 PfG funding of €35m, represents an increase of €35m (before efficiency savings) equivalent to 4.4% compared to the equivalent net closing budget figure in 2015. The provision in Budgets 2012 to 2016 of ring-fenced investment of €160m continues to develop and modernise mental health services in line with the recommendations of *A Vision for Change*. In addition to consolidation and ongoing development of services, through this previous investment, PfG funding of €35m in 2016 will provide for continued enhancement of community mental health service provision. Priority will be given to:

- The mental health division will collaborate with the primary care division on the continued development of early intervention and prevention counselling services by mental health and primary care, specifically for young people under 18 years of age.

- Continued investment in clinical programmes including development of two new clinical programmes specifically ADHD in adults and children and Dual Diagnosis of mental illness and substance misuse.
- Continued development of services for psychiatry of later life and those with mental illness and an intellectual disability.
- Development of perinatal mental health services.

A proportion of the €35m PfG funding for 2016 will be ringfenced for those counselling services for young people under 18 years mentioned above and to be developed in collaboration with HSE Primary Care. A further €2m will also be assigned, in collaboration with Primary Care, for new initiatives to address specific mental health care related needs of homeless persons in 2016.

In addition to all of the above areas, the PfG funding will also be utilised for continued development of general adult teams and child and adolescent mental health services, as well as improved 24/7 responses and liaison services. It will provide particularly for improved provision of early intervention services for adults and children and to progressively support the population to build resilience and positive mental health, as well as improved physical health.

The mental health division will collaborate with the primary care division to fully align the part of this development funding targeted for investment in improved psychological and therapeutic interventions based in primary care settings. The continued recruitment and investment in agencies and services arising from this funding will also develop specialist mental health services including forensic mental health, services for those who are homeless and mentally ill, as well as continuing to address the current service gap for low secure acute care and rehabilitation services for service users with complex needs.

This funding will also provide for the continued implementation and further development of the clinical programmes, service user and carer engagement structures at national and CHO levels, quality and service user safety improvement initiatives, as well as the implementation of the new national suicide prevention strategy, *Connecting for Life*.

Key Priorities and Actions to Deliver on Goals in 2016

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

Mental Health Strategic Priority 1: Promote the mental health of the population in collaboration with other services and agencies including reducing loss of life by suicide.

I**mplement** *Healthy Ireland in the Health Services National Implementation Plan 2015–2017* **across the organisation and services: (Actions 96–105)**

- Develop an increased focus on the health and wellbeing of the population in the delivery of mental health services, including supporting the continued rollout of the Tobacco Free Campus policy.
- Deliver health promotion and improvement programmes aimed specifically at supporting the wellbeing of staff working in mental health services towards improved implementation of a *Healthy Workplace Policy*. *(Held Funding DoH €35m)*
- Implement *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015–2020.*
  - Provide additional clinical suicide prevention services through the NGOs and develop health promotion capacity within the CHOs and mental health services.
  - The National Office for Suicide Prevention will build its monitoring and evaluation capacity to oversee the implementation of the Strategy.
  - Enhance the research and evaluation capacity of the division and extend the provision of suicide prevention initiatives and training programmes. *(Held Funding DoH €35m)*

Integrate prevention, early detection and self-management into the integrated care programmes

- Continue to develop a focus on ensuring people with severe mental illness have access to physical care, monitoring and intervention in partnership with primary care services.
- Develop early intervention and prevention services, in collaboration with primary care and NGO providers, to ensure that children and young people can access assessments and interventions, including access to counselling and psychology, at the appropriate stage to prevent and reduce escalation to secondary care mental health service and as recommended in *Healthy Ireland* and *Connecting for Life*. *(Held Funding DoH €35m)*
- Continue to develop early intervention and prevention services for adults, services in collaboration with primary care and NGO providers, to ensure timely access to counselling and psychotherapy at the appropriate stage to prevent and reduce escalation to secondary care mental health. *(Held Funding DoH €35m)*
- Implement national programmes to reduce HCAIs as part of the work to deliver quality services.

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

Mental Health Strategic Priority 2: Design integrated, evidence based and recovery focused mental health services.

Mental Health Strategic Priority 3: Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements.

Improve access to mental health services and reduce wait times

- *Forensic Mental Health Services* – implement a targeted initiative to transfer individuals currently inappropriately placed in the Central Mental Hospital (CMH) to private settings which will free up the CMH for appropriate admissions from approved centres. *(Held Funding DoH €35m)*
- Further invest in the continued provision of high observation areas in acute mental health units and specialist slow stream secure rehabilitation facilities to meet the needs of those with severe mental illness and very challenging behaviours whose needs are not adequately met. *(Held Funding DoH €35m)*
- Implement the CAMH service improvement requirements through increased community mental health team capacity, additional CAMHs liaison resources, and new CAMHs day hospital provision within the relevant capital context. *(Held Funding DoH €35m)*
- Improved 24/7 response through investment in additional liaison psychiatry services, through an enhanced community mental health services provision seven days a week and investment in the development and staffing of crisis houses. *(Held Funding DoH €35m)*

Improve access to specialist mental health services and improve service user flow

- Build on the progress in 2015 to identify and prioritise models of care including the development and implementation of standard operating procedures across the mental health services.
- Continue the implementation of the three existing clinical programmes, Assessment and Management of Self-Harm in EDs, Eating Disorders and Early Intervention in Psychosis. *(Held Funding DoH €35m)*
- Implement the two new clinical programmes in mental health addressing ADHD in adults and children and Dual Diagnosis (mental illness and substance misuse including alcohol). *(Held Funding DoH €35m)*
- Develop and increase the community mental health team capacity for general adult, psychiatry of old age and mental health and intellectual disability (MHID), services for homeless mentally ill and further develop liaison psychiatry provision including the perinatal component. *(Held Funding DoH €35m)*
- Progress the implementation of the interim CAMHs Eating Disorder Service and the development of a CAMHs Forensic Community Mental Health Team provided for in 2015 investment.

- Develop a clear strategic and operational interface between the local mental health services and the acute hospitals in the relevant catchment area.
- Commence implementation of the two-year Integrating Employment and Mental Health Support (IEMHS) Pilot Project to demonstrate how existing mental health and supported employment services can fulfil best practice Individual Placement Support (IPS) in line with commitments in the *Comprehensive Employment Strategy for People with Disabilities 2015–2024.*

Develop programmes to improve the quality and safety of mental health services for adults, children and adolescents

- Drive continued quality and patient safety improvement initiatives throughout the system.
- Put systems in place to meet legislative requirements. Assure compliance with the *Mental Health Act*, regulations, codes and rules and address areas of non-compliance.
- Respond to HSE investigation and regulatory reports in a timely and open manner.
- Implement HSE policy and guidelines, ensuring that all safety incidents are effectively managed, reported, investigated and the learning shared.
- Undertake a programme of audit to drive quality service improvements.
- Continue to support the development and implementation of national guidelines and models of care.
- Support improved influenza uptake rates for priority users and staff.

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

Mental Health Strategic Priority 4: Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services.

Enhance engagement with service users, their families and carers and involve them in the design and delivery of services

- Embed the role of service user, family members and carers at the heart of mental health service delivery nationally and at CHO level. *(Held Funding DoH €35m)*
- Complete the establishment of the Office of Service User Engagement and continue the roll out of programmes to support collaboration and partnership with service users, family members and carers. *(Held Funding DoH €35m)*
- Progress the organisational change programme to achieve recovery orientation in the mental health services. *(Held Funding DoH €35m)*
- Enhance the service user and carer engagement structures at national and CHO level in the planning and development of the mental health services.
- Work with partner organisations to reduce stigma.

Strengthen governance arrangements through the HSE's Accountability Framework to improve performance

- Continue the work of the Data Design and Optimisation Project to develop the Mental Health Quality Framework, to support the design and implementation of quality indicators, and to enhance the Performance Management Framework between the division and the CHOs in the delivery of mental health services.
- Strengthen accountability with the voluntary agencies funded by the HSE including accountability for the clinical services they are mandated to provide.

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

Mental Health Strategic Priority 5: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

- Implement the Peer Support Worker role funded in 2014/2015 within the mental health services.
- Develop appropriately skilled staff in partnership with professional bodies and third level organisations in the context of a workforce development strategy, through the development of increased capacity at third level, enhanced professional training, specialist training, continuous professional development and succession planning initiatives. *(Held Funding DoH €35m)*
- Further develop training for staff that includes a focus on service user and carers.
- Develop supports for staff to optimise their resilience, mental health and wellbeing in partnership with health and wellbeing and HR towards improved implementation of a Healthy Workplace Policy.
- Embed existing processes to engage regularly with staff through bi-annual meetings with professional groups, holding conferences, events and seminars to inform and consult with staff in planning and developing services and carrying out site visits and meetings in tandem with performance meetings with each CHO.
- Optimise the recruitment and retention of staff in areas where there are currently severe shortages, by engagement with the National Recruitment Service (NRS), and third level colleges to maximise the available skill sets in partnership with HR.
- Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of the service users.

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

Mental Health Strategic Priority 5: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

Partner with Estates in the provision of appropriate buildings so that they are fit for purpose for the mental health services

- Progress initiatives to address the significant shortage of clinical space from which community based services can be delivered. *(Held Funding DoH €35m)*
- Continue to progress the new national forensic mental health hospital with ancillary CAMHs and MHID forensic provision.
- Enhance the process to maximise the allocation of resources on an equitable basis aligned to population and deprivation.
- Refurbish existing approved centres to comply with Mental Health Commission standards and to introduce anti-ligature measures in all settings. *(Held Funding DoH €35m)*

Continue to progress the development of new programmes which will change the way services are delivered and provided by utilising the capability of digital technology and implementing the national mental health division ICT Framework

- Progress the implementation of the national mental health ICT infrastructure improvement programme.
- Progress the implementation of the national e-rostering project.
- Progress the national mental health electronic health record project. *(Held Funding DoH €35m)*
- Progress implementation of the programme management office for mental health to support service improvement.

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Service User Experience*	
• Complaints	*System-wide. See page 119*
Safe Care	
• Serious Reportable Events	
• Safety Incident Reporting	
CAMHs	
• 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%
• % 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%
Effective Care	
General Adult Community Mental Health Teams	
• % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by General Adult Community Mental Health Team	90%
• % of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Team	75%
• % of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	18%
Psychiatry of Old Age Community Mental Health Teams	
• % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	98%
• % of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	95%
• % of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	3%
CAMHs	
• % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by CAMH Teams	78%
• % of accepted referrals / CAMH re-referrals offered first appointment and seen within 12 weeks / 3 months by CAMH Teams	72%
• % of new (including re-referred) child / adolescent referrals offered appointment and DNA in the current month	10%
Access	**Expected Activity / Target 2016**
Total no. to be seen or waiting to be seen by CAMHs	
• Total no. to be seen for a first appointment at the end of each month.	2,449
• Total no. to be seen 0–3 months	1,308
• Total no. on waiting list for a first appointment waiting > 3 months	1,141
• Total no. on waiting list for a first appointment > 12 months	0

*An indicator in relation to Service User Experience is currently being developed and will be finalised in Q4 2016

Social Care

Introduction

Social care services are focused on:

- Enabling people with disabilities to achieve their full potential *living ordinary lives in ordinary places,* as independently as possible while ensuring that the voice of service users and their family is heard and that they are fully involved in planning and improving services to meet their needs.
- Maximising the potential of older people, their families and local communities to maintain people in their own homes and communities, while delivering high quality residential care when required.
- Reforming our services to maximise the use of existing resources and developing sustainable models of service provision with positive outcomes for service users, delivering best value for money.

	2016 NSP Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m	2016 Budget vs 2015 Projected Outturn %
Disability Service	1,558.2	1,498.5	1,460.5	4.0%
NHSS	940.0	905.0	873.8	3.9%
Older Persons Services	683.3	693.2	658.6	-1.4%
Home Care and Transitional Care*	20.0	-	-	0.0%
Total Available Funding – Older Persons	703.3	693.2	658.6	1.5%
€8.0m additional funding held by DoH				
Full details of the 2016 budget are available in Table 2a page 113				

*This funding is available on a once-off basis in 2016 and includes expected time-related savings from €58.5m new initiatives monies held by the DoH

Maximise Delivery of Social Care within Available Resources 2016

The social care allocation for 2016 is €3,201.5m representing an increase of €104.8m or 3.3% on the projected outturn 2015. Whilst continuing efforts will be made to reform and improve services based on existing values with service users at the centre of all decision making, there will also be a focus on the cost and sustainability of services while ensuring at all times that services are delivering best value for money for the public and service users. The additional €104.8m funding is welcome, however, the challenge for 2016 is social care's capacity to meet the increasing demand of an ageing population, together with changing needs and an increasing number of people with a disability with more complex service requirements. Demand for services continues to increase as the population of 65 years and over will increase by 3.1% between 2015 and 2016, equating to an additional 19,400 people. The population 85 years and over (which places the largest pressure on services) is growing at a rate of 4.2% between 2015 and 2016.

Improvements in services for older people will see NHSS (A Fair Deal) delivering 1,222,750 total weeks of care supporting an average of 23,450 per week, up 649 per week on 2015, together with full year implementation of 214 public short stay beds including a dedicated community hospital for Dublin at Mount Carmel Hospital. The additional funding provision received in 2015 for the delayed discharges initiative made a significant impact on delayed discharges reducing them from a high of over 800 to the November figure of 558 through the provision of additional funding to the NHSS together with additional funding for transitional care beds and home care. A critical service risk in 2016 is ensuring there is appropriate care pathways and effective flow through admission and discharge from our acute hospitals particularly for the very elderly and young disabled adults whose discharge can be complex and become delayed.

To address this risk the HSE will utilise €20m in expected time related savings from the €58.5m new initiatives monies held by the DoH to maintain 2015 outturn levels of 10.437m home help hours, 15,450 people in receipt of home care packages and 313 transitional care beds, delivering 109 places per week during 2016.

Disability services will see developments for school leavers and rehabilitation training programmes, therapy services for children through the Children's Disability Network Teams (0–18) and development of a host family initiative for respite care. There will be increasing pressure on residential and respite places as 49% of the current population of service users in residential services over the age of 35 are presenting with moderate, severe and profound disability compared to 38% in 1996 or 28.5% in 1974. A key focus across the disability sector in 2016 will be on improving compliance with national residential standards as regulated by HIQA, consolidating in 2016 the work with CHOs and providers commenced in 2015 to ensure best utilisation of the additional €62m resource provided in the NSP including the full year cost of approved emergency places.

In this context it is essential that social care services continue to reform service delivery models 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.

Services for People with a Disability

The Census 2011 reports that 13% of the population report at least one disability and one in 10 adults of working age report a disability. To respond to the projected increase in the number of people living with a disability in conjunction with the age profile and increased life expectancy of those with a disability, it is necessary for a more affordable and sustainable model of services to be put in place.

Transforming Lives – Programme to implement the recommendations of the *Value For Money and Policy Review of Disability Services in Ireland*

Building on the work undertaken to date, NSP 2016 focuses on increasing the pace of implementation of the reform programme, Transforming Lives, the programme to implement the recommendations of the *Value For Money and Policy Review of Disability Services in Ireland*. This provides the framework for the implementation of the recommendations of key reports – *A Time to Move on from Congregated Settings* in respect of residential centres, the *New Directions* programme to improve day services, and *Progressing Disability Services for Children and Young People*, which is focused on improving therapy services for children.

Accelerated implementation of Transforming Lives will see a move from institutional models of care still provided in some disability residential services to a community based person-centred model, enabling and supporting meaningful lives as chosen by people with a disability. The announcement of dedicated capital funding of €100m for disability services over the period 2016–2021, together with the establishment of a service reform fund which has been agreed between Atlantic Philanthropies, the DoH, HSE social care and mental health services and Genio will support the phased transition to person-centred models of services and supports.

Six Step Change Programme

The implementation of the national policy on safeguarding and the Six Step Programme of system wide change across social care services led by the national task force is focused on ensuring quality and safety of all services through empowering and safeguarding vulnerable people.

Developments

New funding of €7.25m has been provided to meet the costs of provision of additional day services in 2016 to benefit approximately 1,500 young people who are due to leave school and rehabilitative training programmes in 2016. In implementing this initiative, providers will be required to adhere to the principles of the *New Directions* policy.

Work is underway in reconfiguring children's disability services into geographically based Children's Disability Network Teams (early-intervention and school-aged or 0–18 teams), with 56 of the 129 teams reconfigured. Additional funding of €4m to provide 75 additional therapy posts will see the establishment of the full 129 Children's Disability Network Teams by the end of the year. This initiative is being implemented in the context of fully supporting the implementation of the Report of the Inter-departmental Group on Supporting Access to Early Childhood Care and Education Programme (ECCE) for Children with a Disability. An additional €1m is provided for the development of a host family respite initiative.

Improving Compliance with National Residential Standards as Regulated by HIQA

During 2015, while many of the residential services inspected by HIQA have been found to be compliant with the *National Standards for Residential Services for Children and Adults with Disabilities,* a number of inspections have highlighted significant issues which need to be addressed. The standard of care at some centres was unacceptably poor and fell far short of the values of caring and compassion espoused by the HSE and social care sector. In some cases full compliance will require improvements in practice, governance and leadership, while in others additional resources or reconfiguration of existing resources and service models will be required.

The move to a more community based model of person-centred service and the implementation of the Six Step change programme will support CHOs and service providers in improving compliance with the National Residential Standards as regulated by HIQA.

In recognition of the significant costs and levels of unfunded expenditure in 2015 to improve compliance, the HSE acknowledges the very significant investment in disability services of €62m in 2016 to support the full year costs of the compliance work and emergency places approved by the HSE and commenced in 2015.

In order to ensure best utilisation of this resource including the maximum impact to the benefit of service users, current and emerging demands for quality improvements in services will require to be ranked and prioritised, and these priorities will need to be kept under review as further demands arise, having regard to available funding resources. In 2016, through the consideration of action plans to improve compliance with National Standards as highlighted in HIQA reports, service providers will, in the first instance, be required to demonstrate maximum utilisation of all resources including potential for reconfiguration of existing resources and service models in line with national policy. Thereafter, proposals emerging from this process which are resource dependent will require approval from the provider's funder, at CHO or national level as appropriate. This will ensure that highest risk areas are being addressed as a priority and that full compliance is achieved in a systematic and co-ordinated way over time within the resource available.

In order to ensure the effective implementation of these arrangements, the HSE and HIQA have put in place a formal information sharing protocol, which will enable both organisations to work within their statutory remit, while at the same time ensuring that services are compliant, safe and effective to the greatest degree possible. This process will assist the HSE to ensure through work with CHOs and service providers that the highest risk centres and services are prioritised for attention, moving over time to full compliance for the sector within the resources provided.

Social care services will use the positive work underway through the Service Improvement Team to increase the efficiency and effectiveness of services and achieve greater value for money, in collaboration with the voluntary sector representative bodies and individual service providers. However, it will not be possible to meet all of these additional demands and arrangements will need to be put in place for the management of emerging waiting lists and emergency places in a fair and equitable fashion.

Services for Older People

Social care services support older people to maintain their independence and lifestyle choices, providing a range of support services so that older people can live at home or in their own communities wherever possible

or can return to their own home with support following an acute hospital stay and, if needed, can access quality residential care.

NSP 2015 included an additional budget of €23m, which allowed social care to support the implementation of the recommendations of the ED taskforce initiative, by reducing the NHSS (A Fair Deal) waiting list to 11 weeks in January 2015, as well as providing 600 additional home care packages and dedicated transitional care to specific hospitals in the greater Dublin area. The funding has enabled the opening of 65 public short stay beds in Mount Carmel Community Hospital in Dublin. During the course of the year an additional €74m was approved – €44m of this was dedicated to the NHSS (A Fair Deal) which reduced the waiting period to no more than four weeks. An additional €30m was provided to open 173 additional public short stay beds on a permanent basis, as well as approximately 240 temporary transitional care beds which currently provide 83 temporary transitional care places every week (approx. 3,600 in 2015) to 17 acute hospitals across the country, along with additional home care and home support. The impact of this work in collaboration with acute hospitals and primary care colleagues was to ensure the effectiveness of the NHSS in supporting financially those who require long stay care in a timely manner and contribute to the reduction in delayed discharges from a high of 850 to below 600. The 2016 budget allocation provides for the full year cost of the additional permanent short stay public beds provided, bringing the total public short stay bed stock to 2,005. The HSE will utilise €20m in expected time related savings from the €58.5m new initiatives money held by the DoH to maintain 2015 outturn levels of 10.437m home help hours, 15,450 home care packages and 313 transitional care beds delivering 109 places per week during 2016. The additional funding for the NHSS will support 23,450 clients on average per week, an increase of 649 per week over 2015 (22,801) with a total of 1,222,750 care weeks funded, representing an increase of 33,825 care weeks over 2015 (1,188,925).

This is the second year where additional funding has been made available within social care for older people services and this will support work in implementing ED taskforce recommendations. However, it will remain a challenge to cater for the year on year growth in demand for community-based social care services and the corresponding demographic pressures in the community.

In order to utilise the available resources to the best effect, we will continue to identify efficiencies and maximise productivity while providing our services in a safe manner. Every effort will be made through our service improvement initiatives to utilise our home care and our residential capacity in the most cost effective way, including the conclusion of the on-going consultation with staff representative bodies in relation to matching staffing levels and skill-mix to care needs.

Waiting lists will be established for home care and transitional care to manage the allocation of services in as fair a way as possible. Social care services will continue to prioritise these services to all patients requiring discharge from acute hospitals, insofar as available resources allow.

NHSS

The 2015 NSP target activity level for NHSS was 22,361 clients per week. Additional funding was provided in April 2015 as part of the €74m delayed discharge initiative to reduce the NHSS waiting list to no more than four weeks. The revised projection for 2015 is an average of 22,801 clients per week. The provision of €940m will see this level of support increase to an average of 23,450 per week for the duration of 2016. This is an increase of 649 clients per week on the 2015 projection.

	2015	2016	Change
Total Weeks of Care Provided / Forecast	1,188,925	1,222,750	33,825
Average Clients per Week	22,801	23,450	649
Average Cost per Client per Week	€761	€768	€7
Forecast	**€905m***	**€940m**	

In 2016 the Gross budget for NHSS is €1,004.9m and the Income budget is €64.9m. Therefore, the effective Net budget for 2016 is €940m.

The scheme can achieve the target of not exceeding four weeks waiting period for funding approvals to the average level of 23,450 clients per week but will not maintain this waiting period if additional clients need to be supported.

Short Stay Beds including Transitional Care

In 2016, the total short stay base in public residential care services will be 2,005, including the beds provided in 2015. Short stay residential services are currently being reviewed with regard to maximising the capacity and their potential to rehabilitate older people with care needs, to support them to remain in their own communities. This process will be finalised in 2016 and the analysis will allow for the implementation of a 'money follows the person' model to be developed, as well as identifying where any added value can be provided in the service delivery.

In addition to the short stay bed provision referred to above, transitional care beds have also been developed in previous years to support the acute hospitals in the greater Dublin area, including Our Lady of Lourdes (OLOL) Hospital, Drogheda, as community hospital type services had not been as well developed in these locations over the years. The HSE will maintain these core 73 transitional care beds delivering 26 places per week for the greater Dublin area during the year. In addition, the 240 temporary transitional care beds provided in 2015 will be continued in 2016, equating to 83 approvals per week. The total funded allocation for 2016 is 313 transitional care beds, providing 109 places per week, for the acute hospital service.

Home Care and Community Support Services

Home care will be continued at the 2015 outturn level of 10.4m home help hours and 15,450 home care packages annually. In 2016, in considering the increased demographics and in order to maximise the value of the available resource, the model of provision of home care will be reviewed to improve and streamline access as well as the quality of the service provision, and this may necessitate maintaining waiting lists for both home help and HCPs in each CHO.

Reform – Development of an Integrated Model of Care for Older People

In conjunction with the clinical strategies and programmes and colleagues in the acute hospital sector and primary care, an integrated care programme for older persons (ICPOP) is being developed and tested. The programme's primary remit is the development of 'pioneer-sites' that provide wholly integrated systems of care for older people with the creation of an evidence base that will inform the ongoing development of services for older people. Working closely with the acute hospitals, primary care and health and wellbeing services, an integrated model of care for older persons is being developed to keep older persons active and healthy for as long as possible, to avoid unnecessary acute hospital admissions, to streamline discharge following acute hospital admission and to provide home care or residential care if needed.

Safeguarding of Vulnerable Adults from Abuse

In December, 2014 the social care domain launched its national safeguarding policy *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*. This policy supports the social care service's commitment to promoting the welfare of vulnerable adults and safeguarding vulnerable adults from abuse. The policy applies to all statutory and publicly funded non-statutory service providers within social care services.

The policy outlines the importance of a number of key principles in supporting vulnerable adults to maximise their independence and safeguard them from abuse. These include promotion of human rights, a person-centred approach to care, a support for advocacy, respect for confidentiality, empowerment of individuals, and a collaborative ethos. All of these principles are promoted within a positive culture and each service has publicly declared a 'No Tolerance' approach to abuse.

The elements required to support this policy are in place, including specialist training for staff, awareness-raising for frontline staff, the development of safeguarding and protection teams in each CHO, the creation of safeguarding and protection committees in each CHO and the establishment of a national safeguarding inter-sectoral committee with multi-agency representation and an independent chair.

Key Priorities and Actions to Deliver on Goals in 2016

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

Disability Services

Promote health and wellbeing within disability services to ensure that children and adults with disabilities are enabled to live healthier lives

Accelerating implementation of *A Time to Move on from Congregated Settings*

- In line with *A Time to Move on From Congregated Settings*, 2011 and *New Directions*, 2012, there is a move from an institutional model of care to a community based person-centred model of service, enabling and supporting meaningful lives as chosen by users, within the resources available.
- Priority will be given in 2016 to targeting the transition of people from the large institutional settings to a community based model of person-centred supports. This initiative will focus particularly on those in both the Statutory and Voluntary sector with significant challenges in achieving compliance with the *National Standards for Residential Services for Children and Adults with Disabilities*.
- The capital funding of €100m for disability services recently announced, together with the additional 'ELS' funding for compliance with national standards for residential services provided for in the Letter of Determination will enable a reconfiguration of supports and the provision of accommodation required to enable the transition to the community of at least an additional 160 service users in 2016.
- Oversight of implementation will be provided through working group 2 of the Transforming Lives process.

Service reform fund

- A service reform fund established between Atlantic Philanthropies, the DoH, HSE social care and mental health services and the Genio Trust will support the phased transition to a person-centred model of services. This will provide funding for a number of innovative projects in line with the *A Time to Move on From Congregated Settings* policy and wider Transforming Lives agenda, that will facilitate individuals to transition into the community.

Older People Services

Promote the health and wellbeing of older persons facilitating them to stay active and well for as long as possible

- Progress the implementation of *Healthy Ireland in the Health Services National Implementation Plan 2015–2017* and the Positive Ageing Strategy across the delivery system and wider organisation.
- Implement actions from the Dementia Strategy implementation programme, in agreement with Atlantic Philanthropies.
- Implement a nationwide support and social media campaign for people with dementia and their carers.
- Continue to provide day care services, and other community supports either directly or in partnership with voluntary organisations, so as to ensure that older people are provided with the necessary supports to remain active and participate in their local communities.
- Develop an integrated care pathway for falls prevention and bone health and introduce in designated sites.

- Implement the Carers Strategy – through leading a multi-divisional group to progress the implementation of the *National Carers Strategy, Recognised, Supported, Empowered*. The Carers Need Assessment Tool will be tested for implementation in 2017. Collaboration with Local Authorities to support the concept of Age Friendly Cities and local Older Persons Councils will continue.
- 118 staff in older people services to receive training in brief intervention smoking cessation.

Promote the health and wellbeing of older people and persons with a disability facilitating them to stay active and well for as long as possible

- Ensure that all new disability residential houses and 20% of existing disability residential houses / units and 75% of older people services are compliant with the HSE Tobacco Free Campus Policy.
- Staff to make every service user interaction count by routinely assessing levels of physical activity of service users and to promote as much physical activity as is possible for the individual.
- Improve compliance with *Safeguarding Vulnerable Persons at Risk of Abuse*.
- Implement appropriate medication management policy across residential services.
- Ensure that IDS – TILDA and TILDA are used to inform planning and decision making in respect of health and wellbeing.
- Participate on Local Community Development Committees to maximise opportunities for older people and people with disabilities to access services that support general health and wellbeing in their local area.

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

Disability Services

Progressing Disability Services for Children and Young People (0–18s) Programme *(New Funding €4m)*

Work is underway in reconfiguring children's disability services into geographically based Children's Disability Network Teams (Early-Intervention and School-aged or 0–18 Teams), with 56 of the 129 teams reconfigured. The objective of the programme is to provide one clear referral pathway for all children (0–18s), irrespective of their disability, where they live or the school they attend. 2016 will see the completion of the full reconfiguration of 0–18s disability services into 129 Children's Disability Network Teams. In 2016 social care services will:

- Complete the process of reconfiguration of 0–18s disability services into Children's Disability Network Teams, including the provision of 75 additional WTE therapy posts through new staff appointments to reconfigured multi-disciplinary geographic based teams and through using innovative approaches to achieve targeted reductions in waiting lists for therapies.
- The programme includes the integrated development of early intervention services to facilitate the inclusion of children with a disability in mainstream preschool settings and a particular focus will be brought to this in the context of fully supporting the implementation of the Report of the Inter-departmental Group on Supporting Access to Early Childhood Care and Education Programme (ECCE) for Children with a Disability. This will be jointly developed with primary care services and the Department of Children and Youth Affairs. The provision of the additional funding of €4m under this heading will be subject to detailed service proposals being developed, and discussed and agreed with the DoH.
- Implement National Access Policy in collaboration with primary care to ensure one clear pathway of access for all children with a disability into their local services.
- Implement outcomes for Children and their Families Framework in 4 CHOs.
- Oversight of implementation will be provided through working group 2 of the Transforming Lives process.

New Directions **– reconfiguring day services including school leavers and rehabilitative training** *(New Funding €7.25m)*

In 2015, a national project group was established to develop and oversee a process to attend to the needs of school leavers and those existing rehabilitative training (RT) that require a HSE funded adult day service.

- In 2016, social care services will continue the implementation of *New Directions* which will progress an approach of individualised supports for all current users of HSE funded adult day services.
- Benchmark providers against standards framework developed in conjunction with NDA.
- Develop a CHO implementation structure to support *New Directions*.
- Develop a framework for person-centred planning.
- Provide additional day services to benefit approximately 1,500 young people who are due to leave school and rehabilitative training programmes in 2016 and ensure that this service responds in line with the principles of *New Directions*.
- Oversight of implementation will be provided through working group 2 of the *Transforming Lives* process.

Respite with host families in community settings *(New Funding €1m)*

- Respite with a host family is where a child or adult with a disability is offered a short break / holiday with a host family in the community. A combination of day and / or weekly respite will be provided, benefiting approximately 300 service users.

Rehabilitation strategy and Integrated Care Programme

- Facilitate reconfiguration of existing teams required to implement the Neuro-Rehabilitation Strategy and progress the initial mapping and scoping exercises in respect of existing services and appropriate gap analysis.
- In 2016, the Capital Plan 2016–2021 includes progressing the National Rehabilitation Hospital.

National guidelines on accessible health and social care services

- Work with services to ensure that they are examining their services for accessibility, in line with the national guidelines.

Comprehensive Employment Strategy for People with Disabilities

- Establish a working group to oversee implementation of the strategy as it applies to the HSE.

Older Persons

Home care service improvement plan

- Document and approve the model of home care – focused on how home care services (home help and home care packages) will be improved and streamlined to:
  - Make processes and services easier to navigate
  - Improve and ensure confidence in the quality of the service delivered
  - Give clients choice of approved service provider when care is not delivered directly by HSE employed staff
  - Give clients more input into the care they receive and the times they receive it.
- Develop implementation plan for the model of home care – setting out requirements for home care services for older people in the future which will apply to all funded homecare service providers over time.
- Work with DoH with regard to proposals for regulation of home care.
- Develop communication plan relating to the model of home care.
- Develop, describe and implement service delivery processes to support the above.
- Identify and manage any critical dependencies.

Home care service resource management

- Prioritise available services to need and demand to ensure that older people needing home care support can be discharged in a timely manner from hospital; a standardised process will be introduced to record waiting lists for both home help and home care packages in each CHO.

Residential care

- Complete short stay public bed project – review is ongoing of service provision and capacity of short stay residential care to maximise its potential to rehabilitate older people as part of an integrated care approach. This will include a 'money follows the person' approach to funding these services. Progress capital programme of works to ensure maximum number of public residential care units can reach compliance by end of 2021.
- Participate in the inter-departmental working group that is being established to oversee the implementation of the recommendations included in *Review of the NHSS (A Fair Deal)*.
- Implement by end of 2016, the administrative recommendations as outlined in the review.

Models of living care

- Work with statutory and relevant government departments to develop 'models of living with care' outside of the standard residential care settings including working with ISAX Project and HSE review of Boarding Out Schemes.

Integrated Care Programme for Older Persons

- The purpose of the Integrated Care Programme for Older Persons is to augment primary and secondary care services for older people in the community enabling a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older person. Given the ageing demographics there is an urgent need to build capacity in the provision of healthcare services that can meet this change in the model in both community and acute services. Work is already well established in Cork and Limerick, while programmes are being initiated in conjunction with Tallaght and Our Lady of Lourdes (OLOL) Hospitals. The priority in 2016 is developing this programme across 4 pioneer sites (CHO 7, Tallaght Hospital; CHO 8, OLOL; CHO 4, Cork University Hospital (CUH); CHO 3 University College Hospital Limerick (UCHL) which will commence the implementation of the integrated care programme in 2016. Social care services will lead the process which is multi-agency and multi-divisional.

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

Social care services have a particular requirement to develop a culture of openness, transparency and accountability. Social care is supporting the emergence of an independent voice for persons with a disability and their families and continuing to foster this same approach in older persons services through the use of advocacy groups and residents councils.

Governance and communication

- Ensure that authority and accountability for the quality and safety of services across all service areas is integrated into operational service management through appropriate leadership, governance, structures, and processes.
- Strengthen the governance arrangements under the health service Accountability Framework by measuring, monitoring and reporting on the performance of the health service in relation to the quality and safety of care, with a specific focus on identifying and addressing areas of under performance by recommending appropriate and proportionate action to ensure the improvement of services.

- Promote the reduction of risk to service users, the public and staff by implementing best practice Risk Management processes aligned with national policies.
- Improve the incident monitoring and investigation processes, creating opportunities for learning from serious incidents, including Serious Reportable Events.
- Support the work of the National Independent Review Panel.
- Build capacity to effectively manage incidents and complaints.
- Continue the implementation, control and prevention of HCAIs / Antimicrobial Resistance (AMR) in accordance with HCAI standards across all service areas including decontamination standards.
- Promote improvement in Medication Management and Prescribing in social care.
- Work with the communications lead for social care to put in place a compassionate communication and engagement strategy including plans for developing appropriate communication and engagement with service users, their families, staff, unions, advocate groups, political representatives, the media and others.

Disability Services

Service user and family engagement within the disability sector

Social care, in conjunction with Inclusion Ireland, are developing and supporting the emergence of an independent voice for persons with a disability and their families in a number of residential settings across the country.

- Work with families and services users to expand the national Volunteer Advocacy Programme, developed in 2015, in adult disability residential settings.
- Implement resident and family councils / fora in a number of disability residential centres.
- Implement a national level support structure to enable persons with a disability and their families to network and learn from developments in other areas of the country.
- Support persons with a disability and their families to engage with the disability change programme in a meaningful way.
- Continue to work with the Confidential Recipient.
- Follow on from the success of the national disability summits in 2015 and transfer learning and oversight of disability services. It is planned to hold a learning summit in June 2016 to review progress with implementation of social care's Six Step change programme through the National Task Force.

Improve compliance with National Standards for Disability Residential Centres – Quality Improvement Enablement Programme / Quality Improvement Team

- A joint initiative was launched between Social Care and the Quality Improvement Division in 2015 to support care improvements in residential services for adults with disabilities. The team have now visited the majority of the 148 houses / units provided by the statutory sector comprised of 1,054 HIQA registered beds throughout the country, and will continue to work with each house / unit in 2016 to improve the quality of disability residential services under these following six key drivers for quality improvement:
  - Leading for improvement
  - Being person-centred
  - Supporting staff to improve
  - The delivery of safe, effective, best value care
  - Measuring and learning for improvement
  - Governing for quality and safety.
- Work with the Social Care / Quality Improvement Division enablement programme to transfer learning in relation to disability residential centres between centres. The interdisciplinary quality improvement team will work with service providers on specific areas identified for improvement including governance,

leadership, risk management / risk assessment, policies, procedures, protocols and guidelines, key working and supervision.

- Share quality improvements learning and quality initiative supports, i.e. toolbox, good practices, etc. with statutory and voluntary service providers.
- Respond to the requirement to take immediate, medium and longer term actions to respond to HIQA concerns and recommendations arising from inspection findings of disability residential services, including the overall plan to implement a sustainable model of person-centred community based service.

Administrative arrangements around dormant accounts – persons with a disability fund

- The HSE including social care services will work with POBAL and also with and on behalf of the DoH in administering the disability measures awarded funding in 2015 and in developing proposals for the 2016 disability measures.

Older Persons

Enhance patient / service user advocacy services

- Work alongside SAGE, the National Advocacy Service for Older Persons, and the new proposed National Advocacy Body, in 2016 Social Care to strengthen existing advocacy services for older persons.

Improved service user engagement

- Ensure that all service users and their families are aware of the role of the Confidential Recipient.
- Continue to support the establishment of Residents' Councils for elderly residential care services.
- Continue to implement the National Quality Standards for Residential Care Settings – Older People Services.
- Ensure effective implementation of recommendations arising from inspections by HIQA.
- Continue to self-evaluate and implement quality improvement plans to support person-centred care in public residential services.

Older Persons and Disability Services

Safeguarding vulnerable adults – continuing the implementation process

In 2016, in order to continue to promote the welfare of vulnerable adults and safeguard them from abuse, social care services will:

- Develop an I.T. based logging and tracking system in relation to safeguarding concerns within each CHO area. This will allow safeguarding and protection teams to track safeguarding concerns and support the establishment of an anonymised database to aid statistical analysis.
- Continue training of designated officers and awareness-raising of frontline staff at an accelerated pace in 2016. By the end of Quarter 2, all designated officers will have received formal training and, by year end, a minimum of 8,000 frontline staff will have attended an awareness-raising programme on safeguarding.
- Complete a checklist by the end of Quarter 1 to assure compliance of all social care funded agencies policies and procedures with the national policy.
- Explore, proposals and options in relation to commissioning research related to safeguarding vulnerable adults through the National Inter-Sectoral Safeguarding Committee
- Explore options for an awareness campaign on promoting the rights and independence of vulnerable adults through the National Inter-Sectoral Safeguarding Committee.
- Develop a practice handbook for use by all staff, in relation to safeguarding and in line with the policy
- Commence a formal review of the policy by the end of Quarter 4, 2016.

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

The social care division will support the implementation of the People Strategy 2015–2018 by driving implementation through a number of key areas including leadership, employee engagement and learning and development

Leadership

- Support the development of leaders at CHO level to provide direction and purpose, and connect with all staff and teams through open and ongoing communication and engagement as a core leadership activity.
- Support the development of leaders' capacity to engage effectively with service users, work with other relevant health service areas and connect with local communities to enhance patient pathways and patient experiences.
- These actions will be achieved through the delivery of individual CHO leadership development programmes.

Quality improvement through staff engagement

- Support the work undertaken by national HR to create a culture of staff engagement in service design and delivery, which will be achieved by ongoing consultation and workshops on the CHO reform programme.
- Continue to improve the current partnership arrangement with HR and the Quality Improvement Division to identify, use and share learning from staff engagement initiatives, through the Quality Enablement Programme, quality improvement team and service improvement teams.

Employee engagement

- Prioritise effective communication as a core enabler of employee engagement in partnership with communications.
- Create an environment where front line workers are afforded the opportunity to provide constructive feedback on service delivery through regular staff team meetings and national workshops.
- Support staff to act as advocates for service users and enable their participation in decision making regarding care planning and solution focused approaches through the advocacy work being undertaken by Inclusion Ireland within the social care services.
- The social care division is committed to multi-disciplinary team working at the core unit of service delivery through the establishment of Children's Disability Network Teams in partnership with voluntary providers to improve the overall service delivery.

Learning and development approach

- In partnership with HR, work with professional bodies and staff representative associations to develop continuous professional development responses that support improved performance.
- Explore with voluntary providers opportunities to develop on the job experiential learning through job rotation and shadowing.

Public residential care workforce plan

- Implement, following reaching agreement through the auspices of the Labour Relations Commission, proposals regarding the matching of staffing levels and skill-mix to care needs requirements across all public residential care services.

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

Paybill Management and Control – National Framework 2015

The 2015 Framework clearly states the overall requirement for each Chief Officer to remain within their notified budget and the recruitment of staff must not breach that requirement in the current year, nor build in unsustainable levels into the following year. There is an absolute requirement for each CHO and sub-element to have a fully funded workforce plan developed in line with their allocated pay envelope and this should drive all recruitment decisions.

There is a clear expectation from social care services, that each Chief Officer will fully utilise the 2015 Framework and delegation to eliminate and/or reduce the use of agency and overtime within their CHO. The Chief Officers will be required to clearly demonstrate for both HSE direct provision and S38 agencies the actions taken by them to progress this and provide evidence of same.

Social care will finalise and implement the agreement in relation to staffing requirements of public residential care services in older people.

The Service Improvement Team, Disabilities will build on the baseline analysis completed in 2015 across five section 38 Intellectual Disability agencies which has delivered phase 1 comparative analysis in terms of top line activity, outputs, cost, quality and outcomes. In 2016, the deliverables will be an enhanced understanding for CHOs and voluntary organisations of capacity to meet existing, new and changing levels of support requirements, capacity to provide quality and safe services and capacity to meet the requirements of the reform programme in a sustainable manner for the benefit of the people who require the access to supports and services. The outcome from both of these initiatives will be cascaded throughout the CHOs to assist them to maintain compliance with the Paybill Management Framework.

Disability Services

Transforming Lives – The programme to implement the recommendations of the VFM and Policy Review of Disability Services

Person-centred model of services and supports This working group is supporting the implementation of strategic aims, 3, 6 and 7 of the *National Implementation Framework*, addressing in 2015 the priority actions included in the Social Care Operational Plan – Disability Services.

- Report on the volume and nature of future service needs.
- Baseline evaluation criteria and evaluating too (aligned to DPER criteria) to assess projects / services within 'listing'.
- Evaluation report on 'listed' services.
- Report of future capacity required.

People with disabilities and community involvement This working group is supporting the implementation of strategic aims 3 and 7 of the National Implementation Framework, addressing in 2015 the priority actions included in the Social Care Operational Plan – Disability Services.

An important focus of the work of this group is to build on the existing national and local consultative processes so as to develop a model, which meets the changing needs of the health service and will be fit for purpose to support the new model of service delivery envisaged in *Future Health*. The intention is to maximise the potential of local communities to support people with disabilities and their families within their own area and to develop both the informal and formal social networks which have the capacity to support the new service models.

- Develop a participation framework which describes how to engage with and enable persons with disabilities, carers, families and the wider community to have a meaningful role and voice in service design and delivery.

- Oversee implementation of Participation Framework.

Quality and standards This working group is enhancing the quality and safety of services for people with a disability and improving their service experience through putting in place a Quality Framework and Outcomes Measurement Framework.

- Design a Quality Framework for disability service and associated self audit.

Management and information systems This working group supports the implementation of strategic aims 4 and 5 of the National Implementation Framework, addressing in 2016 the priority actions included in the Social Care Operational Plan – Disability Services.

- Plan for implementation of assessment tool.

Governance and service arrangements

- Social care services will develop a strong national capability to ensure effective governance and accountability in respect of S38 and S39 Agencies.

Service Improvement Team (SIT)

- In 2016 the Service Improvement Team, will commence a comparative analysis of a further 45 organisations (both section 38 and section 39) based on significant learnings garnered to date from the analysis of the top five section 38 organisations, which linked funding provided to activity, outputs, cost, quality and outcomes.
- The deliverables will include an enhanced understanding for CHOs and organisations of capacity to meet existing, new and changing levels of support requirements, capacity to provide quality and safe services and capacity to meet the requirements of the reform programme in a sustainable manner for the benefit of the people who require the access to supports and services.
- Specific focus on resource allocation and cost models will take place during 2016 the output of which will inform the choice of a standardised assessment tool for disability services through the *Transforming Lives* process.

European Working Time Directive

The social care division is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for staff in the social care sector. Key indicators of performance in each case include:

- Maximum average 48 hour week.
- 30 minute breaks.
- 11 hour daily rest / equivalent compensatory rest.
- 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest.
- A maximum 24 hour shift (in relation to NCHDs only).

Actions to achieve EWTD compliance in relation to social care staff will commence in 2016 linked to the implementation of the reform programme in social care.

Older Persons

Introduction of the Single Assessment Tool (SAT)

- Progress the implementation of the IT enabled standardised assessment of health and care needs of older people through the implementation of the Single Assessment Tool project. Phased implementation is planned with an initial focus on access to long term care, resulting in a minimum of 50% of NHSS application assessed using SAT by the end of 2016. Implementation for applications to home care services will follow resulting in a minimum of 25% of HCP applications assessed using SAT by the end of 2016.

Assisted technology

- Consider the potential contribution that new assistive technologies can make to the support of older people in their own homes and communities.
- In this regard, mainstream the innovative approach of the '5 step programme' for people with dementia and specifically the 'show house' located in Clonmel that provide a display of new assistive technologies.

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Service User Experience	*System-wide. See page 119*
• Complaints	
• % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum / Service User Panel or equivalent for Disability Services / Older Persons Services.	100%
Safe Care	
• Serious Reportable Events	*System-wide. See page 119*
• Safety Incident Reporting	
Safeguarding	
• % of Preliminary Screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan.	100%
• % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy.	100%
• % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in 9.2 of the policy.	100%
• % compliance with inspected outcomes following HIQA inspection of Disability Residential Units	75%
Effective Care	
• In respect of agencies in receipt of €3m or more in public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL, CARF or PQASSO	100%

Access	Expected Activity / Target 2016
Disability Services	
Progressing Disability Services for Children and Young People (0–18s) Programme	
• No. of Children's Disability Network Teams Established	100% (129 of 129)
Day Services	
• % of school leavers and RT graduates who have been provided with a placement	100%
Disability Act **Compliance**	
• % of assessments completed within the timelines as provided for in the regulations	100%
Personal Assistance (PA)	
• No. of PA Service hours delivered to adults with a physical and / or sensory disability	1.3m
Home Support Service	
• No. of home support hours delivered to persons with a disability	2.6m
Congregated Settings	
• Facilitate the movement of people from congregated to community settings	160
Respite Services*	
• No. of day only respite sessions accessed by people with a disability	35,000
• No. of overnights (with or without day respite) accessed by people with a disability	180,000

Access	Expected Activity / Target 2016
Transforming Lives – VfM Policy Review	
• Deliver on VfM Implementation priorities.	100%
Service Improvement Team Process	
• Deliver on Service Improvement priorities.	100%
Older Persons Services	
Home Care Packages	
• Total no. of persons in receipt of a HCP	15,450
• Intensive HCPs – Total no. of persons in receipt of an Intensive HCP	130
Home Help Hours	
• No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	10.4m
Nursing Homes Support Scheme (NHSS)	
• No. of people being funded under NHSS in long-term residential care during the reporting month	23,450
Public Beds	
• No. of NHSS beds in Public Long Stay Units	5,255
Service Improvement Team	
• Deliver on Service Improvement priorities.	100%

*The introduction of an expanded range of KPIs in respect of respite, with more appropriate reporting of day and overnight respite, results in a combined target of 215,000 for 2016

Pre-Hospital and Emergency Care

Introduction

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.

	2016 NSP Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m	2016 Budget vs 2015 Projected Outturn %
NAS	151.4	144.1	144.1	5.1%

Full details of the 2016 budget are available in Table 2a page 113

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 that the emergency call is received, continues through to the safe treatment, transportation and handover of the patient to the clinical team at the receiving hospital or ED.

The NAS responds to over 300,000 ambulance calls each year, employs over 1,600 staff across 100 locations and has a fleet of approximately 500 vehicles. In conjunction with its partners the NAS transports approximately 40,000 patients via an 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.

NAS has completed major reform in the last three years and is now developing a strategic plan (Vision 2020) for the next five years. This cohesive plan incorporates key findings from reviews completed in 2014 (*internal HSE review to support performance improvement and the Health Information and Quality Authority (HIQA) review of pre-hospital emergency care services in Ireland)* and in 2015 *(National Capacity Review of pre-hospital emergency care services in Ireland and a review of the provision of pre-hospital emergency care services in Dublin).*

Immediate risks identified in the HIQA review relating to governance arrangements and quality of clinical care will be addressed by:

- Implementing the electronic patient care record and clinical audit programme
- Strengthening governance arrangements for services in Dublin with Dublin City Council
- Improving public and patient engagement with the expansion of the Community First Responder (CFR) Programme.

The NAS will continue to engage proactively in the delivery of the integrated care programmes with relevant stakeholders in the seven hospital groups and nine CHOs.

Developments and Challenges 2016

Funding of €5.2m to sustain the existing level of service will assist in funding current payroll and equipment cost pressures. Staffing numbers remain a concern and this funding will help support overtime in order to minimise the impact on service levels, while more staff are recruited and trained. The priority in 2016 will be maintaining current response times as a result.

Development priorities addressed are the training of more paramedics, implementing mobile terminal data terminals in emergency ambulances, initiating the first phase of an alternative care pathway, expanding Community First Responder Schemes and assisting in the delivery of a children's ambulance service. These will be phased in during 2016 with a cost of €2m and a full year cost of €3.6m.

Key Priorities and Actions to Deliver on Goals in 2016

The NAS Vision 2020 strategic plan is set in the context of the *Corporate Plan 2015–2017* and the *National Standards for Safer Better Healthcare*. Through Vision 2020, a service delivery model will be developed that provides care in the most appropriate place and where performance is measured to a greater extent on the quality and clinical outcome of care received by patients. The first tier of the strategic plan will be implemented in 2016 with target dates and owners assigned.

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

Improve engagement with patients and service users

- Deliver important staff initiatives with the implementation of a HR strategy.

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

Improve operational performance and outcome for patients

- Implement improved response times in targeted areas with the recruitment of additional staff. *(New funding €1.2m)*
- Expand the Community First Responder Scheme, improving response times in targeted areas. *(New funding €0.3m)*
- Assist in the delivery of a dedicated children's ambulance service for routine, urgent and end of life journeys. *(New funding €0.2m)*
- Implement an alternative care pathway i.e. Hear and Treat Model. *(New funding €0.1m)*
- Work with acute hospital services to reduce ED handover delays thereby improving ambulance turnaround times.

Enhance clinical competencies and governance arrangements to improve quality of care and patient safety

- Implement and further develop clinical audit to support a patient safety culture.
- Introduce an electronic patient care record in all emergency ambulances.

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

Improve engagement with patients and service users and play an active role in improving the health needs of the population

- Implement a new complaints and compliments management process.
- Strengthen the quality and risk management systems within the NAS.
- Ensure a compassionate approach continues to be embedded in the culture of the organisation and as per the National Open Disclosure Policy.
- Establish a patient forum.
- Develop a set of performance measures that reflect the balance between time and clinical based targets.

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

Provide a flexible, safe, responsive and effective service to meet planned alternative models of patient care

- Build on relations with staff and staff representative groups, through an approach which is fostered on mutual understanding, trust and openness.
- Promote a culture of meaningful staff engagement.
- Implement an Education and Competency Assurance Plan, ensuring the continued development of staff.

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

Deploy the most appropriate resources safely, quickly and efficiently

- Support service associated costs associated with the national roll out of digital radio communications, including mobile data terminals. *(New funding €0.2m)*
- Continue the development of the Computer Aided Dispatch system with integration of a suite of management reporting systems enhancing patient care and service delivery.
- Develop and implement NAS eHealth Strategy to deliver initiatives including single national manpower management and payroll systems.
- Procure additional fleet to ensure reliability, improve patient care and response times in compliance with policy.

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Service User Experience	
• Complaints	*System-wide PIs. See page 119*
Safe Care	
• Serious Reportable Events	
• Safety Incident Reporting	
Effective Care	
Clinical Outcome	
• Return of spontaneous circulation (ROSC) at hospital in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using the Utstein comparator group calculation	40%
Audit	
• National Emergency Operations Centre (NEOC)* – % of control centres that carry out Advanced Quality Assurance Audits (AQuA)	100%
• National Emergency Operations Centre (NEOC)* – % Medical Priority Dispatch System (MPDS) Protocol Compliance	90%

Access	Expected Activity / Target 2016
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%
• % of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	80%
• % of ECHO calls which have a resource allocated within 90 seconds of call start	85%

Access	Expected Activity / Target 2016
• % of DELTA calls which have a resource allocated within 90 seconds of call start	85%
Intermediate Care Service	
• % of all transfers provided through the Intermediate Care Service	80%
Ambulance Turnaround Times	
• % of ambulance turnaround delays escalated where ambulance crews were not cleared nationally in 60 minutes (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	100%

*Tallaght and Ballyshannon Control Centres

Hospital Care

Introduction

The hospitals in Ireland are now organised into seven groups. Each Group Chief Executive has full legal authority to manage the group delegated to them under the *Health Act 2004* in line with NSP2016 and subject to budgets being allocated to group level. In this context each group will produce an operational plan for 2016. The groups will set out for their hospitals the services they can deliver for the funding provided as part of their operational plans for 2016.

The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the accountability framework of the HSE. All targets and performance criteria adopted in the service plan will be reported through this framework.

	2016 Available Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m
Acute Hospitals	4,053.5	4,134.8	3,925.0
National Cancer Screening Service	17.8	17.5	17.5
Clinical Strategy and Programmes	10.0	10.7	10.7
National Cancer Control Programme	54.4	54.3	54.3
Other	1.7	3.6	3.6
Total Available Funding*	**4,137.4**	**4,220.9**	**4,011.1**
Percentage Difference			**-2.0%**

Full details of the 2016 budget are available in Table 2a page 113

*Includes once-off allocation of budget which is available from the divisions listed above

Impact of Demographics on Hospitals

The demand for acute hospital services continues to increase in line with a growing and ageing population.

Demographic changes will see the population increase by 1% in 2016 over 2015 which amounts to 32,500 people.

Health needs increase as people get older and people over 65 years of age more frequently require hospital care and present with complex needs. The number of people in the over 65s age group is expected to increase by 3.1% or 19,400 people in 2016 when compared to 2015 and there will be 2,900 additional people over 85 years of age.

Developments and Challenges 2016

This plan aspires to deliver an equivalent volume of activity as that delivered in 2015. It is acknowledged that the financial challenge in this plan is significant. It will require very substantial cost control and cost reduction by the groups and hospitals. The focus will be on controlling the total pay and non pay costs as well as maximising income. The specific challenges in meeting the financial and activity targets will be clearer when the group operational plans have been prepared and evaluated. The plan prioritises delivering safe care at the 2015 volumes. This emphasis is driving the financial challenge.

In summary, when account is taken of the 2015 cost of services, expected cost growths and initial cost saving measures this leaves a preliminary funding shortfall of €150m to be addressed. An interim cash-management based solution to the €50m historic accelerated income collection target has been proposed which reduces this funding shortfall on a once-off basis to circa €100m. This is put forward on the basis that a feasible permanent solution to this €50m issue can be agreed between the HSE and DoH during 2016, in time to be implemented in 2017.

Options to address the remaining €100m funding shortfall have been considered including aligning activity levels to the funding available, albeit this is considered as very much a last resort. In summary, this view is

based on the significant risks inherent in operationalising such an option and more importantly on the negative impacts for patient access to services and for staff morale.

Accordingly the acute hospital division, with support from the rest of the HSE, will take a number of measures to control costs, reduce waste and improve efficiency aimed at minimising any impact on services (see Table 8 on page 116).

The targets that need to be achieved in relation to these measures are very challenging and carry significant delivery risk albeit each of the measures represent areas of focus that the HSE would have intended to pursue in 2016 in any event. It is for the HSE and the Hospital Groups to ensure that appropriate management effort and attention is applied to maximising the delivery of savings measures and overall budgetary performance. Thereafter the HSE and DoH acknowledge the shared risks inherent in the extent of the savings targets and the assumptions underpinning them, which have been mutually agreed following extensive engagement in light of the alternative which is service reductions.

This is considered preferable in light of the alternative which is service reductions.With regard to inpatient activity it is recognised that the imperative is to continue to shift to day case activity in terms of enabling good access at the most efficient cost. The planned work undertaken by the system will give priority to urgent and complex cases. In terms of activity we will also seek to optimise existing capacity through reducing length of stay and shifting care to appropriate settings including primary care.

Having regard to the available funding, it is expected that:

- Day case activity will be delivered at 100% of 2015 levels including up to 10,000 cases to be provided within primary care.
- Inpatient activity target is to deliver 2015 levels.
- Emergency inpatient activity will be delivered at 100% of 2015 levels.
- OPD activity will be funded at 100% of 2015 levels.
- The target for % of adults waiting < 15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 90% compliance against this target. The projected compliance for 2016 is 95%
- The target for % of adults waiting < 8 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 66% compliance against this target. The projected compliance for 2016 is 70%.
- The target for % of children waiting <15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 95% compliance against this target. The projected compliance for 2016 is 95%.
- The target for % of children waiting < 20 weeks for elective procedure (inpatient and cay case) was 100% in 2015 and it is expected that the outturn for 2015 will be 55% compliance against this target. The projected compliance for 2016 is 60%.
- The target for % of people waiting <15 months for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 90%. The projected compliance for 2016 is 100%.
- The target for % of people waiting < 52 weeks for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 85%. The projected compliance for 2016 is 85%.

Risks to the delivery of Acute Hospitals plan within funding available

- Capacity to cap the introduction of drugs and medical devices including transcatheter aortic valve implantations (TAVIs).
- Capacity to maintain and collect income
- Capacity to achieve pay and non-pay cost control at the level required while demographic impacts drive demand for services.

- Ability to contain activity to 2015 levels
- Delayed discharges are not reduced to and maintained at <500 during 2016
- Service risks related to limited capacity in ICU.

In the context of developing ABF as the funding model for the HSE the plan is also seeking to align activity with cost. Hospital services will be analysed on a diagnosis related groups (DRG) basis which will provide a truer assessment of real performance in 2016. This form of analysis is used internationally to understand the complexity and cost of hospital inpatient and day case activity. The budgets of each group and their hospitals will reflect the affordable activity level to be provided and the cost associated there with. This will be presented using the DRG tools available to the HSE.

The WTEs employed by the acute sector fell significantly during the years of austerity and by June 2015 have recovered to within 620 of the whole time equivalent numbers at that time. The specific staff levels will be identifed in the operational plans of the hospitals groups. The range of adjustment will vary depending upon the outurn for each group in 2015. Where hospitals are achieving a balanced financial position for 2015 current staff numbers may be affordable.

Children's Hospital Development

The detailed resource plan on specific deliverables required in 2016 in relation to meeting the programme to design the new Children's Hospital and satellite centres and to integrate the three children's hospitals in time to open the satellite centres, is dependent on the level of funding in 2016. The resource requirements of the Children's Hospital group are currently being reviewed in order to ensure that the project delivers against agreed timelines and this will be the subject of further dialogue with both the DoH and the Children's Hospital Group.

The key objectives of acute hospital services for 2016 include:

- Sustain access to urgent and planned care by increasing efficiencies, streamlining processes and maximising capacity in hospitals.
- Implement integrated care pathways for patients with COPD, asthma, heart failure and diabetes in the context of the Integrated Programme for Prevention and Management of Chronic Disease.
- Improve patient access and experience by the provision of integrated care in collaboration with social care, primary care and mental health services.
- Provide high level co-ordination of maternity, gynaecology and neonatal services across the country by the establishment of the Women and Infants Health Programme.
- Commence implementation of the Maternity Strategy.
- Embed robust governance structures within the hospital groups in line with the HSE Accountability Framework.
- Build effective managerial and clinical networks within hospital groups which will provide direct support to the smaller hospitals in the groups in particular.
- Develop and improve capacity for quality and patient safety within hospital groups through the establishment of a defined patient safety and quality framework that will address patient advocacy, complaints, incident management and response, learning systems and service improvement.
- Continue the establishment of the hospital groups on an administrative basis in 2016, in advance of legislation.
- Phased implementation of Activity Based Funding Model with the use of the HIPE data to determine the volume of cases required to be undertaken by each hospital group in 2016.
- The National Cancer Control Programme (NCCP) will work with the DoH and other stakeholders in the implementation of the National Cancer Strategy 2016-2025. The NCCP will continue to lead on

service developments in cancer and performance monitoring against agreed KPIs across all eight designated cancer centres.

Clinical Strategy and Programmes will progress the establishment, enablement and delivery of integrated care through five integrated care programmes – prevention and management of chronic disease, older people, patient flow, children and maternity care.

Priorities and Actions to Deliver on Goals in 2016

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

Implement *Healthy Ireland in the Health Services National Implementation Plan 2015–2017* **across all hospital groups**

- Promote healthy lifestyle for patients and staff, reduce incidence of disease and support best management of chronic diseases such as diabetes, COPD and coronary heart disease through the development of hospital group *Healthy Ireland* implementation plans.
- Increase the number of hospital frontline staff trained in brief intervention.
- Promote increased uptake of seasonal flu vaccination by hospital staff.
- Support implementation of calorie posting in all hospital groups.
- Support the expansion of BreastCheck from 65–69 years and develop the BowelScreen Programme in 2016 to support a two year screening round by 2017. *(New funding €1.5m included in Cancer €10m)*
- Develop haemachromatosis model of care using an integrated approach to condition management, in collaboration with primary care services.

Implement programmes to reduce healthcare associated infections

- Ensure compliance with targets of healthcare associated infections / AMR with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms, underpinned by the implementation of HIQA *National Standards for the Prevention and Control of Healthcare Associated Infections*.
- Commence monitoring of key performance indicators on the number of patients colonised with multi-drug resistant organisms (MDRO) that cannot be isolated in single rooms or cohorted, with dedicated toilet facilities as per national MDRO policy.

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

Improve access to planned care in acute hospitals for an inpatient or day case procedure and in outpatient services and improve access to diagnostic tests for outpatients

- Monitor and report chronological scheduling for routine inpatient and day case procedures including waiting lists for a range of diagnostic procedures.
- Improve performance in relation to scheduled care by ensuring active management of waiting lists for inpatient and day case procedures by strengthening operational and clinical governance structures in hospital groups.
- Continue to roll-out the outpatient reform programme with an emphasis on the new minimum dataset, improved pathways of care and efficiency measures through the outpatient services performance improvement programme.
- Reorganise hospital group services with an increased focus on small hospitals managing routine urgent or planned care locally and more complex care managed in the larger hub hospitals.

- Activity targets for each of the hospital groups will be set out in the Acute Services Divisional Operational Plan.
- Optimise capacity by reducing length of stay in line with the surgical programme targets and increasing day of surgery rates
- Shift care to the most appropriate setting including increased day surgery rates and redirection of minor operations from hospitals to primary care

Improve access to urgent care in acute hospitals with reduction in numbers of patients waiting over 6 hours for admission or discharge in EDs

- Improve performance in relation to unscheduled care by continuing to implement the ED Task Force report recommendations in conjunction with group management teams and community healthcare counterparts. A National Implementation Group comprising the Directors of the key divisions will drive and oversee the implementation process.
- Develop a performance indicator which will monitor time taken for clinical handover of patients in ED that will be based on the National Ambulance Handover Protocol for the Handover of Ambulance Patients in EDs and differentiates between completion of clinical handover and the time ambulance crew are available for next call, in conjunction with NAS.
- Implement the Irish Hospital Redesign Programme in Limerick University Hospital in 2016 and continue to implement the programme in Tallaght Hospital, which has been established to improve healthcare delivery in Irish hospitals, using a redesign approach in conjunction with the integrated programme for patient flow.
- Continue implementation of the winter initiative aimed at alleviating pressures on the hospital system over the winter period enabling achievement of the targeted reduction in trolley waits.
- Continue to flex bed capacity within hospitals in order to address seasonal pressures, effectively manage demand and capacity to improve PET times.

Continue to implement the acute hospital reform programme and enhance service developments

- Develop self-audit schedules and follow-up action plans for NEWS and IMEWS in each of the hospital groups.
- Commence monitoring of PEWS implementation in all hospitals with paediatric services.
- A gap analysis of the implementation of the Sepsis Guideline across all acute hospitals is to be undertaken by the hospital group sepsis leads led by the Sepsis Clinical Programme.
- Undertake **national maternity service improvements** in line with HIQA recommendations and other relevant reviews, and commence implementation of the National Maternity Strategy once published. *(New funding Maternity Services €3m)*
  - Complete and publish monthly Safety Statements by all Maternity Units.
  - Implement the Maternity Charter which will be informed by the Maternity Strategy.
  - Establish the National Women and Infants Health programme that will lead on the implementation of the Maternity Strategy.
  - Implement the midwifery workforce planning study (Birthrate Plus).
  - Appoint Directors of Midwifery to all maternity units.
  - Through the Women and Infants Health Programme lead in the planning and development of the provision of equitable access to antenatal anomaly screening in all Maternity Units in the context of emerging clinical maternity networks.
  - Progress plans for the relocation of Dublin Maternity Hospitals and University of Limerick Maternity Hospital.
  - Develop and establish clinical maternity networks across all hospital groups.
  - Establish the Coombe Portlaoise maternity network with the appointment of consultant neonatologists, obstetricians, perinatal pathologist, perinatal psychologist and quality and patient safety manager.

  - Progress maternity service developments in South Tipperary General Hospital as recommended in the Flory Report.
  - Develop bereavement specialist teams in all maternity units.
  - Implement Phase 1 of the Maternal and Newborn Clinical management System at Kerry General Hospital, Cork University Hospital, National Maternity Hospital and Rotunda Hospital.
- Improve integrated care pathways for those patients that require access to long-term care and to primary care services in order to reduce the number of delayed discharges through developing a system wide approach in conjunction with national Clinical Strategy and Programmes and the CHOs.
- Continue to develop an improved organ donation and transplantation infrastructure with a view to achieving target donation and transplant rates.

Improve access to Cancer Services *(New funding €10m – see other initiatives under goals 1, 2 and 5)*

- Improve rapid access services for patients where there is a high index of suspicion of prostate or lung cancer.
- Improve access for patients attending Symptomatic Breast Disease services who are triaged as non-urgent within a 12 week timeframe.
- Support improvements in diagnosis, medical oncology, radiation oncology, surgery and multi-disciplinary care for cancer through recruiting additional clinical staff.
- Develop evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery and treatments for patients with cancer.
- Commission the two additional linear accelerators in St. Luke's Hospital to increase capacity.
- Contribute to Altnagelvin radiation oncology service, as per Ministerial commitment to this cross border initiative to meet needs of patients in North West. *(€0.725m)*
- Support the National Cancer Control Programme's Systemic Therapy programme in providing improved access to cancer drugs. *(Cancer Drugs €7m)*

National Speciality Services Developments *(Included in New funding in Hospital Service Developments €3m)*

- Continue development of the stroke telemedicine service in order to support rapid diagnosis and treatment at smaller hospitals with support from specialist centres.
- Continue the development of Paediatric Scoliosis Services in Our Lady's Children's Hospital to address ongoing capacity deficits.
- Continue to develop the National Rare Diseases Office that will act as a national point of reference for enquiries relating to services, diagnostics and clinical trials and linked to recognised online information databases. The office will be supported to develop potential Centres of Expertise to help meet national capacity criteria and European Standards.
- Continue to develop the adult metabolic service in the Mater Misericordiae University Hospital for the transition of adolescents from paediatric services.
- Support the phased implementation of the policy on Trauma Networks for Ireland within existing resources.
- Continue the development of the bilateral cochlear implant service with the recruitment of key support staff.
- Continue the provision of orphan drugs for patients with metabolic conditions.
- Develop a detailed implementation plan for targeted hip ultrasound screening programme for infants at increased risk of developmental dysplasia of hip (DDH).

Blood and Organ Policy *(Funding €0.623m – Organ Transplantation €0.5m; Hospital Developments €0.123m)*

- Increase in staff for haemophilia services in Cork University Hospital in order to meet service demands.
- Recruit clinical psychologist in Our Lady's Children's Hospital to support patients attending with benign haematology conditions.
- Recruit additional co-ordinator for Organ Donation and Transplant Ireland service.
- Transition of the pancreatic transplant programme from Beaumont Hospital to St. Vincent's University Hospital will continue in 2016.

Children's Hospital developments *(New funding €3.75m)*

- Develop a general paediatric consultant-delivered service to ensure greater efficiencies in acute care delivery and scheduled care following the review of paediatric and neonatology services and framework for future development in line with the national model of care for Paediatrics and Neonatology.
- Develop All Island Paediatric Cardiology Service in conjunction with health partners in Northern Ireland and congenital cardiac service in Mater Hospital.
- Develop services for Duchene's Muscular Dystrophia in the Children's Hospital Group.
- Implement the ongoing reform programme across the Children's Hospital Group.
- Provide funding for palliative care consultant previously funded by Irish Hospice Foundation.
- Improve access and commence integration of services in the Children's Hospitals Group through additional resources (as part of the transition of services to the satellite centres in relation to ENT, dermatology, radiology, emergency medicine, and spina bifida services).
- Continue to develop the Forensic Medicine Service for children in the Children's Hospital Group.
- Support additional new theatre capacity for orthopaedics and trauma due for completion mid 2016.

Ensure timely and equitable access to services by enhancing capacity within acute hospitals and facilitating expansion of role of care professionals to provide the best care within available resources in acute hospitals

- Increase the number of Advanced Nurse Practitioners to support consultants in cancer services. *(€0.298 New funding included in Cancer Services €10m)*
- Support phase 1 pilot of the framework on staffing and skill-mix for nursing related to general and specialist medical and surgical care in acute hospitals.
- Facilitate the opening of new Units including the Endoscopy Unit at Roscommon General Hospital, Wexford General Hospital Delivery Suite, St. Luke's Hospital Kilkenny Acute Floor including ED, AMU, and Oncology Unit on a phased basis. *(New funding included in Commissioned New Units to Open €3.5m)*
- Monitor the number of nurses registered to prescribe medicinal products and ionising radiation in response to service need.

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

- Continue to implement the *Standards for Safer Better Healthcare* in acute hospitals.
- Embed the hospital group structures within acute hospital services and support the completion of strategic plans for each of the seven hospital groups.
- Use learning from the employee survey to shape organisational values and ensure that the opinions of acute hospital staff are acknowledged.
- Promote the implementation of *Children First Guidelines* in each hospital group.

- Continue the implementation of the National Clinical Guideline – No. 5 Communication (Clinical Handover) in Maternity Services, No. 6 Sepsis Management and the Communication (Clinical Handover) Guideline in acute and children's hospital services.

Improve Patient Experience by improving knowledge of patients' requirements and communicating better with the users of acute services.

- Implement plans to build the capacity and governance structures needed to promote a culture of patient partnership across acute services and use patient insight to inform quality improvement initiatives and investment priorities which will include the completion of Patient Experience Surveys in all acute hospitals on a phased basis within available resources.

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

Acute Hospitals Services HR Strategy

- Achieve full compliance with the European Working Time Directive.
- Implement actions agreed under the *Public Service Agreements 2013–2018* through which change is achieved and is a central element of the strategy for recovery and a sustainable future for acute hospital services.
- Ensure that health education campaigns will include specific information and supports to help staff improve their own health and wellbeing
- Implement the Healthy Workplace Policy and support initiatives to encourage staff to look after their own health and wellbeing.
- Implement the People Strategy 2015–2018 within acute hospitals.
- Support improved capacity within acute hospitals by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals.

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

- Move to the next phase of transition to an Activity Based Funding model for hospital activity with the initial focus on inpatient and day cases.
- Ensure compliance with the Pay-bill Management and Control Framework within acute hospitals services.

Use information systems and applications to improve knowledge management within acute hospitals to inform practices, integrate systems, improve information sharing and gather and improve best practice.

- Procure and roll-out a National Medical Oncology Clinical Information System to support the care of medical oncology and haemato-oncology patients, including the provision of systemic anti-cancer therapy, in cancer centres, satellite centres and other locations where patients are receiving systemic anti-cancer treatment, to improve quality, safety and access to patients. *(New funding €0.477m included in Cancer €10m)*

Continue to support the roll-out and application of clinical quality assurance systems including:

- National Surgical Clinical Programme to monitor and measure surgical activity across all hospitals using the National Quality Assurance Information System (NQAIS).

- Acute Medicine Clinical Programme in developing NQAIS to test and monitor medical activity across all hospitals and set standards.
- Continued roll out of the NQAIS-NAHM (National Audit of Hospital Mortality) Module to all hospital groups.
- Radiology Clinical Programme in NQAIS radiology system.

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Service User Experience	
• Complaints	*System-wide PIs. See page 119*
Safe Care	
• Serious Reportable Events	
• Safety Incident Reporting	
• % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	100%
• % of maternity units / hospitals with implementation of IMEWS	100%
• % of hospitals with implementation of IMEWS for pregnant patients	100%
• % maternity units which have completed and published Maternity Patient Safety Statements at Hospital Management Team each month	100%
Healthcare Associated Infections (HCAI)	
• Rate of MRSA blood stream infections in acute hospital per 1,000 bed day used	< 0.055
• Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5
Colonoscopy / Gastrointestinal Service	
• % of people waiting < 4 weeks for an urgent colonoscopy	100%
Effective Care	
Stroke	
• % of patients with confirmed acute ischaemic stroke who receive thrombolysis	9%
• % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	50%
Acute Coronary Syndrome	
• % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	85%
Re-admission	
• % emergency re- admissions for acute medical conditions to the same hospital within 28 days of discharge	10.8%
• % of surgical re-admissions to the same hospital within 30 days of discharge	< 3%
Surgery	
• % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%
• % day case rate for Elective Laparoscopic Cholecystectomy	> 60%
• % of elective surgical inpatients who had principal procedure conducted on day of admission	75%
Emergency Care and Patient Experience Time	
• % of all attendees at ED < 24 hours	100%
• % of patients 75 years or over who were admitted or discharged from ED within 9 hours	100%
Average Length of Stay	
• Medical patient average length of stay	7.0
• Surgical patient average length of stay	5.2
• ALOS for all inpatient discharges excluding LOS over 30 days	4.3

Quality	Expected Activity / Target 2016
Symptomatic Breast Cancer Services	
• Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer.	> 6%
Lung Cancers	
• Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer.	> 25%
Prostate Cancers	
• Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of prostate cancer.	> 30%

Access	Expected Activity / Target 2016
Discharge Activity	
• Inpatient	640,140
• Day case	851,831
• Dialysis – Day case	181,890
• Total inpatient and day case	1,673,861
Outpatients	
• No. of new and return outpatient attendances	3,242,424
• Outpatient attendances – New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	1:2
Inpatient, Day Case and Outpatient Waiting Times	
• % of adults waiting < 15 months for an elective procedure (inpatient and day case)	95%
• % of adults waiting < 8 months for an elective procedure (inpatient and day case)	70%
• % of children waiting < 15 months for an elective procedure (inpatient and day case)	95%
• % of children waiting < 20 weeks for an elective procedure (inpatient and day case)	60%
• % of people waiting < 15 months for first access to OPD services	100%
• % of people waiting < 52 weeks for first access to OPD services	85%
Colonoscopy / Gastrointestinal Service	
• % of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	70%
Emergency Care and Patient Experience Time	
• % of all attendees at ED who are discharged or admitted within 6 hours of registration	75%
• % of all attendees at ED who are discharged or admitted within 9 hours of registration	100%
• % of ED patients who leave before completion of treatment	< 5%
Delayed Discharges	
• No. of bed days lost through delayed discharges	< 183,000
• No. of beds subject to delayed discharges	< 500
Acute Medical Patient Processing	
• % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	75%
Symptomatic Breast Cancer Services	
• No. of patients triaged as urgent presenting to symptomatic breast clinics	16,800
• % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals.	95%
• % 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%
Lung Cancers	
• No. of patients attending the rapid access lung clinic in designated cancer centres	3,300

Access	Expected Activity / Target 2016
• **%** of patients attending the lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres.	95%
Prostate Cancers	
• No. of patients attending the rapid access prostate clinics in cancer centres	2,600
• % of patients attending the prostate rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre.	90%
Radiotherapy	
• % of patients undergoing radical treatment who commenced treatment within 15 working days of being deemed ready to be treated by radiation oncologist (palliative care patients not included).	90%

Supporting Service Delivery

Supporting Service Delivery

Introduction

Implementation of the NSP is dependent on a number of key enablers which support service delivery. In conjunction with front line services, the provision of a modern and efficient healthcare system is enabled by essential support services. These services include Human Resources (HR), Finance, Communications, Internal Audit, the Office of the Chief Information Officer and Health Business Services (HBS).

Human Resources

HR provides strategic and operational HR support, direction, advice and interventions to the service delivery units of the health sector as set out in the People Strategy 2015–2018. The strategy has the following five priorities:

- Investing in leadership and team development
- Engaging and building trust with employees
- Addressing workforce planning and recruitment with greater pace and transparency
- Investing in learning opportunities
- Using ICT to improve data use, avoid duplication of data and paper based systems.

This strategy has been developed in recognition of the vital role of the workforce in delivering safer and better healthcare, with a commitment to engage, develop and value the workforce in order to deliver the best possible care and services to the people who depend on them.

Finance

Finance provides strategic and operational financial support, direction and advice to the various streams of the HSE in achieving the organisational goals of providing high quality, integrated health and personal social services. The objectives of the finance team are to manage the finances of the HSE, to support enhanced accountability and value for money and to develop a standardised financial management framework for the organisation.

Communications

Communications develops and manages the HSE's internal and public communications function, advises and supports each of the HSE's service areas and corporate services and provides support as required to the developing CHOs and hospital groups. Additional communication supports for a number of areas, including integrated programmes and eHealth, will be funded by the relevant national divisions in 2016 and managed by agreement on their behalf by national communications.

Internal Audit

The HSE's Accountability Framework is supported by the overall work of Internal Audit. Through its audit reports, recommendations to strengthen controls and other work, Internal Audit provides assurance to the Director General, the HSE Directorate and the HSE Leadership Team on the adequacy and degree of adherence to HSE's procedures and processes. Implementation by management of Internal Audit recommendations is an essential part of the HSE's governance mechanism.

Office of the Chief Information Officer

The Office of the Chief Information Officer published the *Knowledge and Information Plan* in 2015 building on the e-Health Vision for Ireland. This plan supports the delivery of innovative, safe and high quality healthcare with an emphasis on co-ordinating all of the care an individual may need, wherever it is delivered, with

particular focus on the knowledge and information requirements of patients and clinicians.

The *Knowledge and Information Plan* will enable the provision of a seamless and information-rich experience to patients, care providers and the system as a whole through all stages of care:

- Prevention of illness
- Access and entry to care
- Diagnosis, treatment and evaluation of treatment effectiveness
- Timely transfer to most appropriate settings, and maintenance of care plans and persons' health.

The *Knowledge and Information Plan* outlines how to transform the organisation and will be supported by the **ICT Capital Plan**.

Further dialogue on improving the revenue / capital balance of funding for ICT will be undertaken during 2016 to ensure appropriate resources are available across health to enable this delivery.

Health Business Services

Implementation of the *Health Business Services Strategy 2014–2016* is continuing on target through 43 detailed actions.

A range of common support business services are now delivered on a shared basis. This allows operational services to focus management attention on core service provision. In line with best practice for shared services, a strong governance model is in place with oversight provided by the HSE Directorate through its subcommittee on HBS Governance.

A priority in 2016 will be to further develop the Customer Relationship Management (CRM) strategy which was first introduced during 2015. A critical element of the HBS business model are the Business Partnership Arrangements (BPAs) which have been developed for the CHO areas, hospital groups and Tusla. These will be further developed and enhanced during 2016.

HBS ensures that services provided are in line with National EU Directives, legislation and regulation. HBS aims to eliminate duplication of effort, improve quality and consistency of services and achieve value for money. This will require further investment in both people and technologies.

The HSE's construction **Capital Plan** is €344m in 2016 and will be prudently managed to remain within this capital envelope. All projects being progressed which are not in construction on 1st January 2016 will be progressed to pre-tender stage and construction works will only be tendered if it is clear that funding is available to allow for completion of the project. The allocations for the Ambulance Replacement Programme, the Equipment Replacement Programme and the social care HIQA compliance programmes will be increased in 2016.

Key Priorities and Actions to Deliver on Goals in 2016

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

- Develop a Staff Health and Wellbeing Strategy to support staff in managing their own health and wellbeing and improve work performance, job satisfaction and attendance levels.
- Provide training to improve knowledge about what keeps people healthy and support people to be healthier.
- Enhance occupational safety and health support and advice to support managers in developing working environments conducive to the delivery of safer better healthcare.
- Develop a *Healthy Ireland* Plan for HBS staff and functions.

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

- Provide professional expertise and advice to service managers to support the provision of improved service delivery across all services.
- Support staff to act as advocates for service users and enable their participation in decision making on care planning and solution focused approaches.

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

- Improve governance and performance through the implementation of the Accountability Framework.
- Provide and publish information on performance to support managers and ensure transparency.
- Support a culture that is honest, compassionate, transparent, reputable and accountable.
- Empower staff through availability of protocols and supports to raise concerns and take action if they perceive risks to service users, colleagues or themselves.
- Enable easy access to health service information and content, so that people can find and use the services they need.
- Develop the HSE's National Infoline into a multi-platform public information service for the health service. Up to €0.2m will be provided for this in 2016 by way of a charge across the relevant divisions.
- Develop an Irish Language Scheme implementation plan in collaboration with relevant CHOs and hospital groups.
- Conduct and complete a comprehensive programme of audits within the HSE and agencies funded by HSE and provide assistance in support of other divisions.
- Track implementation status of audit recommendations and report to senior management for necessary action.
- Conduct special investigations including fraud related topics as and when required.

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

Implement the People Strategy 2015–2018 by driving implementation through a number of key areas including leadership and culture, employee engagement, learning and development, workforce planning, evidence and knowledge, performance, partnering and human resource professional services:

- Develop and implement workplans to support the operationalisation of the People Strategy.
- Develop a Leadership and Management Development Strategy and delivery plan aligned with the People Strategy.
- Create a national leadership development academy comprising leaders from across the system to lead, influence and develop leadership practice and succession management.
- Develop a Staff Engagement Strategy underpinned by the values of Care, Compassion, Trust and Learning.
- Involve staff in planning and decision-making and enable them to propose and act on their ideas to improve the quality of care.
- Conduct an annual Employee Survey and take actions based on findings.
- Establish HR user groups to ensure greater connectivity with service delivery units and partners across the health service.

- Develop a learning and development plan with an agreed funding stream that builds individual and organisation capacity and knowledge.
- Put in place Personal Development Plans.
- Work with professional bodies and staff representative associations to develop continuous professional development responses that support improved performance.
- Develop coaching and mentoring as key leadership and line management support in facilitating improved performance.
- Develop a talent management framework which supports employees along their career path and maximises their contribution to the organisation.
- Ensure each staff member and team are clear regarding role, professional responsibilities, reporting relationship and fit within the organisation.
- Support the implementation of the finance operating model as set out in the Finance Reform Programme.
- Progress the development of funded workforce plans.
- Enable and develop communications staff and those working across all services by providing first rate communications advice, training and support.
- Support the delivery of a programme to improve communication skills in health leaders.
- Develop the skills required to enhance the patient experience and support multi-disciplinary team working.
- Support managers in recognising good and poor performance and provide them with the skills to give constructive feedback.

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

HR

- Implement a revised performance management system.
- Ensure leaders and staff, at all levels, comply with professional, regulatory and quality standards and are accountable for service targets.
- Develop a Workforce Planning Framework to attract and retain cutting edge talent and deliver on organisational objectives.
- Develop the knowledge and skills to undertake high quality workforce planning including future scanning to respond to changing needs in healthcare.
- Develop streamlined HR data gathering, reporting processes and systems to meet the requirements of the Accountability Framework and to provide managers with the required HR workforce metrics and business intelligence in a timely manner to enable good decision making.
- Work with finance and HBS to integrate and align HR and finance reporting.
- Develop eHMR Strategy in collaboration with ICT and HBS.
- Use HR and workforce data to assist in service redesign and support service modernisation with revised clinical pathways, shared service arrangements, practice changes and models of service.

Finance

- Continue to improve our corporate reporting and budgeting capacity and the planning and performance support we provide to our services.
- Continue to implement the Finance Operating Model as set out in the Finance Reform Programme including progressing the procurement of a new national integrated financial management and procurement system. This includes finance people, processes and technologies to support our CHOs and hospital groups. *(New funding €2m provided to progress the Finance Reform Programme including Activity Based Funding)*

- Implement Activity Based Funding (ABF) in acute hospital services for inpatient and day case work in line with the ABF implementation plan agreed with the DoH and published in 2015. This involves converting from block grants to ABF revenue streams, including transition adjustments and work on developing an ABF system for outpatients.
- Support services to make practical improvements in controls and compliance including through the work of the National Financial Controls Assurance Group (NFCAG).
- Continue to develop our central capacity and expertise to forecast and analyse pay, income and non-pay across all services at national level. This includes supporting the integration of pay and staffing data, control of pay and staffing numbers and the improved generation and collection of private charges income within acute hospitals.
- Develop a framework for community costing that is aligned with Activity Based Funding principles.
- Establish how best to use funding models to promote integrated care.
- Support the development of a commissioning framework for health services.
- Strengthen accountability with the voluntary agencies funded by the HSE.
- Continue to support the implementation of major capital, technological and service development projects.

Through the Office of the Chief Information Officer develop new programmes which will change the way services are delivered and provided by utilising the capability of digital technology including:

- Deliver the Individual Health Identifier (IHI) to a number of areas including the national epilepsy electronic patient record (EPR), a GP practice management system, one hospice system and the national maternity and newborn clinical management system.
- Complete the roll out of e-Referrals to all hospitals to improve communication between primary care and secondary care, reduce risk to patients and begin work on new specialist referrals.
- Publish the Open Data strategy and commence consultation with primary care services.
- Mobilise the programme to acquire and implement a National Electronic Health Record solution set.
- Roll out a range of key therapeutic and support systems including laboratories, radiology, maternal and newborn, national ambulance services and mental health.
- Commence implementation of e-Pharmacy by building a single drug file for Ireland covering 80% of all drugs, ensure e-Script support is in place and provide support for innovation hub e-Prescription work.
- Commence ePrescribing in the community in conjunction with primary care services
- As part of the Digital Children's Hospital establish the ICT programme to enable the satellite centres and commence the national PAS implementation for the Children's Hospital Group.
- Develop cancer IT by procuring and implementing the National Medical Oncology Information System for systemic anti-cancer treatment.
- In collaboration with primary care services, develop primary care technology in a number of areas including building the national audiology system, completing the rollout of Healthmail to remaining GPs, implementing a limited pilot for a summary care record and expanding Healthlink capability to hospitals in the South enabling electronic transfer of LAB results to GP practices.
- Establish a memorandum of understanding with the Irish College of GPs and practice system vendors for support of Healthlink and new developments that aid integrated care and universal GP cover (under 6s and under 12s, asthma and diabetes cycles of care).

In addition, there are approximately 33 significant service improvement projects which will be advanced in 2016, including the implementation of integrated SAP HR and Payroll System in HSE South. In general these are focused upon service excellence and, in particular, keeping all the existing systems and infrastructure functioning as well as providing helpdesk support to all HSE staff.

The ICT Capital Plan has been developed to ensure that these focus areas are prioritised from a resource and delivery perspective. Ongoing alignment of the ICT Capital Plan with health service priorities will continue to be monitored and improved via the ongoing monthly dialogue involving DPER, DoH and the HSE.

Ensure the continued delivery and development of HBS shared services for CHOs, hospital groups, NAS, Corporate Divisions and Tusla

- Embed and adapt the HBS customer relationship model.
- Ensure day to day delivery of existing HBS services – estates, procurement, ERPS, transactional HR and finance – while continuing to drive significant reform in line with HBS strategy objectives.
- Continue to facilitate and support the transfer of function to the Office of Government Procurement (OGP) and implement the next phase of the National Distribution Centre.
- Maximise the delivery of compliance in procurement sourcing.
- Develop recruitment services in line with the HSE Recruitment Strategy.
- Develop technological solutions to support recruitment, pensions management and CRM.
- Progress key HBS finance initiatives in electronic invoicing, income reporting, online payslips and the payroll rationalisation strategy.
- Deliver HBS services in compliance with regulation, legislation and national and EU directives.
- Ensure that HBS estates supports the implementation of *Healthy Ireland* in delivering best health outcomes and improving people's experience of using services.
- Deliver the **Capital Plan** and ensure prudent management of the capital allocation.
- Progress a number of projects including the Children's Hospital, the National Forensic Mental Health Hospital, the National Radiation Oncology Programme, the relocation of the National Maternity Hospital and the continuing investment in primary care centres, mental health infrastructure and achieving HIQA compliance in all long stay residential facilities.

Appendices

Appendix 1: Financial Tables

Table 1: Income and Expenditure Allocation 2016

	Pay €m	Non-Pay €m	Gross Budget €m	Income €m	Net Budget €m
Direct Service Provision					
Acute Hospitals Division	**3,463.6**	**1,568.7**	**5,032.2**	**(978.7)**	**4,053.5**
National Ambulance Service	**111.9**	**39.8**	**151.7**	**(0.2)**	**151.4**
Health and Wellbeing Division	**107.9**	**120.9**	**228.8**	**(7.1)**	**221.7**
Primary Care Division					
Primary Care	523.9	269.2	793.1	(28.3)	764.8
Social Inclusion	37.1	90.5	127.6	(0.6)	127.1
Palliative Care	37.7	44.7	82.4	(9.6)	72.8
Primary Care Division Total	**598.7**	**404.4**	**1,003.1**	**(38.5)**	**964.7**
Mental Health	**643.1**	**169.1**	**812.2**	**(20.5)**	**791.6**
Social Care					
Disabilities	637.4	1,027.5	1,664.9	(106.7)	1,558.2
Nursing Homes Support Scheme (NHSS)	-	1,004.9	1,004.9	(64.9)	940.0
Older Persons	635.9	415.5	1,051.4	(368.2)	683.3
Social Care Total	**1,273.3**	**2,447.9**	**3,721.2**	**(539.7)**	**3,181.5**
National Cancer Control Programme	**16.5**	**55.0**	**71.5**	**(0.0)**	**71.5**
Clinical Strategy and Programmes	**16.4**	**38.3**	**54.8**	**(0.8)**	**54.0**
Quality Improvement Division	**2.5**	**5.7**	**8.1**	**(0.2)**	**8.0**
Quality Assurance and Verification	**2.0**	**1.1**	**3.2**	**-**	**3.2**
Other National Divisions / Services	**152.7**	**159.3**	**312.0**	**(3.6)**	**308.4**
Direct Service Provision Total	**6,388.5**	**5,010.4**	**11,398.8**	**(1,589.4)**	**9,809.4**
Pensions and Demand-Led Services					
Pensions	**665.1**	**0.0**	**665.1**	**(172.0)**	**493.1**
Pension Levy	**0.0**	**-**	**0.0**	**(170.9)**	**(170.8)**
State Claims Agency	**-**	**128.0**	**128.0**	**-**	**128.0**
Primary Care Reimbursement Scheme	**13.0**	**2,526.8**	**2,539.8**	**(122.7)**	**2,417.1**
Local Demand-Led Schemes	**-**	**242.6**	**242.6**	**-**	**242.6**
Overseas Treatment	**0.1**	**8.9**	**9.1**	**-**	**9.1**
Pensions and Demand-Led Services Total	**678.2**	**2,906.4**	**3,584.6**	**(465.6)**	**3,119.0**
Net Determination	**7,066.7**	**7,916.7**	**14,983.4**	**(2,055.0)**	**12,928.4**

Note: The pay, non pay and income split is illustrative and subject to change during the operational planning process

Table 2: Financial Allocation 2016

	2015 NSP Budget €m	2015 Movement €m	2015 Closing Budget €m	2015 Once-Off Funding Returned €m	2016 Opening Budget €m	2015 Additional Base Funding €m	2016 Pay Funding €m	2016 Non-Pay Funding €m	Full Year Cost of 2015 Commit-ments €m	2016 Savings Measures €m	Additional VfM / Efficiency Savings €m	2016 New Initiatives €m	2016 NSP Budget €m
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L	Column M
Direct Service Provision													
Acute Hospitals Division	**3,999.9**	**11.2**	**4,011.1**	**(86.1)**	**3,925.0**	**100.0**	**27.7**	**20.0**	**32.7**	**(9.9)**	**(55.1)**	**13.1**	**4,053.5**
National Ambulance Service	**144.0**	**0.1**	**144.1**	**0.1**	**144.2**		**0.3**	**3.7**	**1.5**	**(0.1)**	**(0.2)**	**2.0**	**151.4**
Health and Wellbeing Division	**201.2**	**(9.2)**	**192.0**	**18.3**	**210.3**		**0.1**	**4.4**	**3.4**	**(0.1)**	**(0.4)**	**4.0**	**221.7**
Primary Care Division													
Primary Care	747.6	1.4	749.0	0.1	749.1	5.0	1.1	9.0	4.8	(2.8)	(1.3)		764.8
Social Inclusion	125.7	2.3	128.0	(0.9)	127.1		0.1			(0.0)	(0.2)		127.1
Palliative Care	71.9	(0.1)	71.8	(0.0)	71.8		0.5			(0.0)	(0.1)	0.7	72.8
Primary Care Division Total	**945.2**	**3.6**	**948.8**	**(0.8)**	**948.0**	**5.0**	**1.7**	**9.0**	**4.8**	**(2.9)**	**(1.6)**	**0.7**	**964.7**
Mental Health	**756.8**	**37.6**	**794.4**	**(2.0)**	**792.4**		**1.7**			**(1.3)**	**(1.2)**		**791.6**
Social Care													
Disabilities	1,459.3	1.2	1,460.5	0.7	1,461.1	45.5	20.6	16.5	8.0	(0.2)	(1.6)	8.3	1,558.2
Nursing Homes Support Scheme	873.8	0.0	873.8	0.0	873.9			26.8	39.3				940.0
Older Persons	655.2	3.4	658.6	(0.9)	657.7	5.0	3.7	0.4	19.2	(0.2)	(2.6)		683.3
Social Care Total	**2,988.3**	**4.6**	**2,992.9**	**(0.2)**	**2,992.7**	**50.5**	**24.4**	**43.7**	**66.5**	**(0.4)**	**(4.1)**	**8.3**	**3,181.5**
National Cancer Control Programme	**15.1**	**(7.7)**	**7.4**	**54.5**	**61.9**	**0.0**	**0.0**		**1.2**	**(0.1)**	**(0.0)**	**8.5**	**71.5**
Clinical Strategy and Programmes	**30.1**	**0.1**	**30.2**	**14.7**	**44.9**		**0.0**		**0.1**	**(0.0)**	**9.0**		**54.0**
Quality Improvement Division	**7.2**	**(0.3)**	**6.9**	**0.3**	**7.3**		**0.0**		**0.3**		**0.4**		**8.0**
Quality Assurance and Verification	**0.6**	**(0.0)**	**0.6**	**(0.0)**	**0.6**		**0.0**				**2.6**		**3.2**
Other National Divisions/Services	**297.1**	**(9.5)**	**287.6**	**2.3**	**289.9**	**8.4**	**2.7**	**2.8**	**2.0**	**(0.2)**	**0.7**	**2.0**	**308.4**
Historic Accelerated Income Target	**(50.0)**	**-**	**(50.0)**	**-**	**(50.0)**						**50.0**		**-**
Direct Service Provision Total	**9,335.5**	**30.7**	**9,366.1**	**1.0**	**9,367.2**	**163.9**	**58.7**	**83.6**	**112.5**	**(15.0)**	**0.0**	**38.5**	**9,809.4**

	2015 NSP Budget €m	2015 Movement €m	2015 Closing Budget €m	2015 Once-Off Funding Returned €m	2016 Opening Budget €m	2015 Additional Base Funding €m	2016 Pay Funding €m	2016 Non-Pay Funding €m	Full Year Cost of 2015 Commit-ments €m	2016 Savings Measures €m	Additional VfM / Efficiency Savings €m	2016 New Initiatives €m	2016 NSP Budget €m
	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L	Column M
Pensions and Demand-Led Services													
Pensions	434.5	(1.0)	433.5	-	433.5	51.0	8.6						493.1
Pension Levy	(220.9)	(0.8)	(221.6)	-	(221.6)		50.8						(170.8)
State Claims Agency	96.0	-	96.0	-	96.0	32.0							128.0
Primary Care Reimbursement Scheme	2,268.1	0.1	2,268.2	(0.1)	2,268.1	142.0		117.0		(110.0)			2,417.1
Local Demand-Led Schemes	217.8	0.3	218.1	(0.4)	217.6	15.0		10.0					242.6
Overseas Treatment		9.6	9.6	(0.5)	9.1								9.1
Pensions and Demand-Led Services Total	2,795.5	8.3	2,803.7	(1.0)	2,802.7	240.0	59.3	127.0		(110.0)			3,119.0
Net Determination	12,131.0	38.9	12,169.9	(0.0)	12,169.9	403.9	118.0	210.6	112.5	(125.0)	0.0	38.5	12,928.4

- Financial tables reflect a total non-capital allocation of €12.928 billion for 2016. This excludes €58.5m of funding which is being held by the DoH for further specific initiatives. This held funding relates to the following specified areas: Primary Care Reimbursement Service (PCRS) - €10m, Primary Care - €3.5m, Mental Health - €35m, Therapy services for young people - €8m and Nursing Taskforce pilot - €2m.
- 2016 Savings Measures – Financial tables include a total efficiency savings target of €15m in addition to €110m savings within PCRS.
- Additional VFM / Efficiency Savings – Financial tables include a provision of €13.2m to fund Integrated Care Programmes (€9m), Quality Improvement and Assurance initiatives (€3m) and support for CHOs and hospital groups (€1.2m).
- National Divisions / Services - Includes national functions such as Human Resources, Finance, HBS, Health Repayment Scheme, Office of the Chief Information Officer and other Corporate Functions.
- Lansdowne Road Agreement (LRA) – Financial tables include LRA pay funding which has been allocated to each division.
- An enhanced process for planning and prioritising communications programmes and campaigns is being introduced in 2016. This will affect all divisions involved in communications campaigns aimed at the general public. Budgetary responsibility for campaigns will rest with divisions in 2016. Funding transfers are not yet reflected in financial tables and will subsequently be reflected in 2016.
- The 2016 NSP Budget is stated prior to the allocation of once off funding for internally commissioned services. This funding relates to National Cancer Screening Services, the National Cancer Control Programme and other funding streams. These Divisions may vary funding levels in 2016 on the basis of service delivery. The projected impact of this once off funding on divisional budgets in 2016 is illustrated on Table 2a
- 2015 Movement (Column B) - the movements indicated in Column B above primarily relate to €35m Mental Health funding (which was held by the DoH in the first instance in 2015), once-off budgetary movements during 2015 (primarily between the National Cancer Control Programme, National Cancer Screening Service, Clinical Strategy and Programmes and the Acute Division) and adjustments relating to the Revised Estimates Volume (REV).

Table 2a: Financial Allocation 2016

	2016 NSP Budget €m	2016 Once-Off Funding to be Applied €m	2016 Available Funding €m	2015 Projected Spend €m	Diff. 2016 Available Budget vs 2015 Projected Spend €m	Diff. 2016 Available Budget vs 2015 Projected Spend %
	Column A	Column B	Column C	Column D	Column E	Column F
Direct Service Provision						
Acute Hospitals Division	**4,053.5**	**83.9**	**4,137.4**	**4,220.9**	**(83.5)**	**-2.0%**
National Ambulance Service	**151.4**		**151.4**	**144.1**	**7.3**	**5.1%**
Health and Wellbeing Division	**221.7**	**(17.8)**	**203.9**	**192.0**	**11.9**	**6.2%**
Primary Care Division						
Primary Care	764.8	(0.4)	764.4	757.5	6.9	0.9%
Social Inclusion	127.1		127.1	127.0	0.0	0.0%
Palliative Care	72.8		72.8	71.8	1.0	1.4%
Primary Care Division Total	**964.7**	**(0.4)**	**964.2**	**956.3**	**8.0**	**0.8%**
Mental Health	**791.6**		**791.6**	**774.8**	**16.9**	**2.2%**
Social Care						
Disabilities	1,558.2		1,558.2	1,498.5	59.7	4.0%
Nursing Homes Support Scheme (NHSS)	940.0		940.0	905.0	35.0	3.9%
Older Persons	683.3		683.3	693.2	(9.9)	-1.4%
Social Care Total	**3,181.5**		**3,181.5**	**3,096.7**	**84.8**	**2.7%**
National Cancer Control Programme	**71.5**	**(54.4)**	**17.0**	**9.0**	**8.1**	**90.3%**
Clinical Strategy and Programmes	**54.0**	**(10.0)**	**44.0**	**31.2**	**12.8**	**41.2%**
Quality Improvement Division	**8.0**		**8.0**	**6.9**	**1.1**	**15.8%**
Quality Assurance and Verification	**3.2**		**3.2**	**0.6**	**2.6**	**468.7%**
Other National Divisions / Services	**308.4**	**(1.3)**	**307.1**	**296.5**	**10.6**	**3.6%**
Direct Service Provision Total	**9,809.4**	**(0.0)**	**9,809.4**	**9,728.9**	**80.5**	**0.8%**
Pensions and Demand-Led Services						
Pensions	**493.1**		**493.1**	**485.5**	**7.6**	**1.6%**
Pension Levy	**(170.8)**		**(170.8)**	**(220.2)**	**49.3**	**-22.4%**
State Claims Agency	**128.0**		**128.0**	**195.6**	**(67.6)**	**-34.5%**
Primary Care Reimbursement Scheme	**2,417.1**		**2,417.1**	**2,408.5**	**8.6**	**0.4%**
Local Demand-Led Schemes	**242.6**		**242.6**	**232.2**	**10.4**	**4.5%**
Overseas Treatment	**9.1**		**9.1**	**9.6**	**(0.5)**	**-5.3%**
Pensions and Demand-Led Services Total	**3,119.0**		**3,119.0**	**3,111.1**	**7.9**	**0.3%**
Net Determination	**12,928.4**	**(0.0)**	**12,928.4**	**12,840.0**	**88.4**	**0.7%**

Table 3: 2016 Existing Level of Service Funding

	€m
Pay including Lansdowne Road Agreement (LRA)	
LRA	97.0
PSPR and Other Pressures	10.0
LRC Recommendations	8.0
Pay Pressures (Other)	3.0
Sub-total Pay including Lansdowne Road Agreement (LRA)	**118.0**
2016 Non-Pay Funding	
Non-pay (Demographics / Drug Cost Growth / Other Pressures)	195.9
NHSS – Demographics	14.7
Sub-total 2016 Non-Pay Funding	**210.6**
Full Year Cost of 2015 Commitments	
National Service Plan 2015	25.6
ED – Winter Plan and FYC Acute NSP 2015 Developments	35.2
Delayed Discharges	51.7
Sub-total Full Year Cost of 2015 Commitments	**112.5**
2016 Existing Level of Service Funding	**441.1**

Table 4: New Initiatives

	2016 €m	2017 €m	2017 Incremental Funding Requirement €m
Disability school leavers	7.3	14.0	6.8
Expansion of respite beds	1.0	1.0	-
Expansion of vaccine programme*	2.5	10.3	7.8
Opening of commissioned new units	3.5	7.3	3.8
Maternity services	3.0	9.3	6.3
Hospital service developments	3.0	4.1	1.1
Paediatric service developments	3.8	5.8	2.1
National Ambulance Service	2.0	3.6	1.6
Cancer services	10.0	16.4	6.4
Finance reform including Activity Based Funding	2.0	9.2	7.2
Organ transplantation	0.5	1.9	1.4
Sub-total 2016 New Initiatives	**38.5**	**82.9**	**44.4**
Cost Pressures / Other Initiatives			
Integrated care programmes	9.0	18.0	9.0
Quality and assurance initiatives	3.0	6.0	3.0
Home care and transitional care**	-	20.0	20.0
Advance purchase agreement - vaccines**	-	1.5	1.5
Sub-total Cost Pressures / Other Initiatives	**12.0**	**45.5**	**33.5**
Grand Total	**50.5**	**128.4**	**77.9**

*The incremental cost of the vaccine programme is €2.5m in 2018

** These initiatives will be funded on a once-off basis in 2016

Table 5: 2016 Savings Measures

	€m
Savings Measures – PCRS	(110.0)
Efficiency Measures including Procurement	(15.0)
2016 Savings Measures	**(125.0)**

Table 6: Additional VFM / Efficiency Savings

	€m
Integrated care programmes	9.0
Quality and assurance initiatives	3.0
Support for CHOs and hospital groups	1.2
Total	**13.2**

Table 7: Nursing Homes Support Scheme (NHSS)

	€m	€m
2016 Opening Base Allocation		873.9
Non-pay	12.1	
NHSS – Demographics	14.7	
Delayed discharges	39.3	66.1
Total Net Budget		**940.0**

Gross Budget		1,004.9
Income		(64.9)
Total Net Budget		**940.0**

In 2016 the Gross budget for NHSS is €1,004.9m and the Income budget is €64.9m. Therefore the effective Net budget for 2016 is €940m

Table 8: Acute Hospitals 2016

			Measures to address shortfall – range: stretch to best case	
Opening 2015 Funding Shortfall – Before savings measures proposed	**€m**		**From €m**	**To €m**
Current 2015 funding level	4,011.1			
Winter Plan 2015 funding	9.0			
Provision of 2015 deficit funding in 2016	100.0			
Funding relevant to 2015 spend	4,120.0			
Projected 2015 spend (excluding €51m)	4,170.0			
Opening 2016 funding shortfall / measures to address	**50.0**		**32.6**	**43.5**
2016 Clinical + Non-Clinical Cost Pressures before savings measures proposed	**€m**		**From €m**	**To €m**
Approved but unfunded 2016 pay rate increase and increments paid in line with public pay policy	23.6		15.5	21.9
Clinical and Non Clinical non-pay cost growth 2016 based on trends over the period 2012-2015 (€73.5m net of €20m funding received)	53.5		47.0	53.5
Full year costs in 2016 of 2015 service developments	7.5		6.5	7.5
Service related 2016 cost pressures	25.4		22.0	25.4
Procurement Savings target 2016 (€15m HSE budget cut – Acute portion)	9.9		8.9	9.9
Additional VFM / Efficiency Targets 2016	5.1		4.8	5.1
Historic accelerated income collection – impact in 2016	50.0		45.0	50.0
Total identified 2016 Clinical + Non Clinical Cost Pressures before savings / other measures	**175.0**		**149.7**	**173.3**
Total Funding Shortfall before savings and other proposed measures	**225.0**		**182.3**	**216.8**

To be addressed by additional measures to be identified during 2016	**€8.2m (0.2%) to €42.7m (1.0%)**

Appendix 2: HR Information

All information in tables has been rounded to nearest WTE

HSE / Section 38 Agencies

Service	WTE Dec 14	WTE Sep 15	Projected Outturn Dec 2015
HSE	**63,046**	**65,105**	**65,585**
Voluntary Hospitals	22,572	23,102	23,272
Voluntary Agencies (Non-Acute)	13,709	14,039	14,143
Section 38 Agencies	**36,281**	**37,141**	**37,415**
Total	**99,327**	**102,245**	**103,000**

Divisional breakdown

Division	WTE Dec 14	WTE Sep 15	Projected Outturn Dec 2015
Acute Services	49,742	51,669	52,050
Mental Health	9,191	9,316	9,385
Primary Care	10,103	10,294	10,370
Social Care	24,831	25,366	25,553
Health and Wellbeing	1,237	1,261	1,271
Ambulance Services	1,623	1,662	1,674
Corporate and HBS	2,599	2,677	2,697
Total	**99,327**	**102,245**	**103,000**

Divisional breakdown by staff category (as at September 2015)

Division / Staff Category	Medical / Dental	Nursing	Health and Social Care Professionals	Management / Admin	General Support Staff	Patient and Client Care	Total	Projected Outturn Dec 2015
Acute Services	7,141	20,071	6,538	7,908	5,711	4,299	**51,669**	52,050
Mental Health	750	4,641	1,182	786	897	1,059	**9,316**	9,385
Primary Care	962	2,677	2,433	2,832	438	953	**10,294**	10,370
Social Care	198	7,290	3,407	1,699	2,093	10,678	**25,366**	25,553
Health and Wellbeing	156	43	592	399	14	58	**1,261**	1,271
Ambulance Services	1			60	18	1,583	**1,662**	1,674
Corporate and HBS	25	128	26	2,167	322	9	**2,677**	2,697
Total	**9,232**	**34,852**	**14,178**	**15,850**	**9,493**	**18,640**	**102,245**	**103,000**

Hospital Group and CHO	WTE Dec 14	WTE Sep 15	Projected Outturn Dec 2015
Children's Hospital Group	2,783	2,833	2,854
Dublin Midlands Hospital Group	9,368	9,571	9,642
Ireland East Hospital Group	9,987	10,527	10,605
RCSI Hospital Group	7,618	8,071	8,130
Saolta Healthcare University Hospital Group	7,858	8,049	8,108
South / South West Hospital Group	8,992	9,253	9,321
University of Limerick Hospital Group	3,109	3,334	3,358
National Services	27	32	32
Acute Services	**49,742**	**51,669**	**52,050**
CHO 1: Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan	4,603	4,649	4,684
CHO 2: Galway, Roscommon, Mayo	4,421	4,576	4,609
CHO 3: Clare, Limerick, North Tipperary/East Limerick	3,726	3,742	3,769
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork	6,112	6,256	6,302
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford	4,042	4,126	4,156
CHO 6: Wicklow, Dun Laoghaire, Dublin South East	4,165	4,199	4,230
CHO 7: Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West,	5,510	5,657	5,698
CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath	5,402	5,446	5,486
CHO 9: Dublin North, Dublin North Central, Dublin North West	5,861	5,950	5,994
Other Services	282	377	380
CHO Services	**44,125**	**44,976**	**45,308**
Health and Wellbeing	**1,237**	**1,261**	**1,271**
Ambulance Services	**1,623**	**1,662**	**1,674**
Corporate and HBS	**2,599**	**2,677**	**2,697**
Total	**99,327**	**102,245**	**103,000**

Appendix 3: National Performance Indicator Suite

System-Wide

System-Wide				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Budget Management including savings **Net Expenditure variance from plan (within budget)** Pay – Direct / Agency / Overtime	M	≤ 0%	To be reported in Annual Financial Statements 2015	0.33%
Non-pay	M	≤0%		0.33%
Income	M	≤ 0%		0.33%
Acute Hospitals private charges – Debtor Days – Consultant Sign-off	M	New PI 2016	New PI 2016	90% @ 15 days by 31/12/16
Acute Hospitals private income receipts variance from Actual v Plan	M	New PI 2016	New PI 2016	≤ 5%
Capital Capital expenditure versus expenditure profile	Q	New PI 2016	New PI 2016	100%
Audit % of internal audit recommendations implemented by due date	Q	New PI 2016	New PI 2016	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received	Q	New PI 2016	New PI 2016	95%
Service Arrangements / Annual Compliance Statement % of number of Service Arrangements signed	M	100%	100%	100%
% of the monetary value of Service Arrangements signed	M	100%	100%	100%
% of Annual Compliance Statements signed	A	100%	100%	100%
HR % absence rates by staff category	M	3.5%	4.19%	≤ 3.5%
% variation from funded staffing thresholds	M	New PI 2016	To be reported in Annual Report 2015	≤ 0.5%
EWTD < 24 hour shift (Acute and Mental Health)	M	100%	96%	100%
< 48 hour working week (Acute and Mental Health)	M	100%	78%	95%
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	New PI 2016	New PI 2016	15% increase
Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	M	75%	75%	75%
Serious Reportable Events % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	M	New PI 2016	New PI 2016	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	62%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	New PI 2016	New PI 2016	90%

System-Wide				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	New PI 2016	To be set in 2016

Health and Wellbeing

Health and Wellbeing				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
National Screening Service **BreastCheck** No. of women in the eligible population who have had a complete mammogram	M	New PI 2016	New PI 2016	149,500
% BreastCheck screening uptake rate	Q	New PI 2016	New PI 2016	> 70%
% women offered hospital admission for treatment within 3 weeks of diagnosis of breast cancer	Bi-annual	New PI 2016	New PI 2016	> 90%
CervicalCheck No. of unique women who have had one or more smear tests in a primary care setting	M	271,000	260,000	255,000
% eligible women with at least one satisfactory CervicalCheck screening in a 5 year period	Q	New PI 2016	New PI 2016	> 80%
% urgent cases offered a Colposcopy appointment within 2 weeks of receipt of letter in the clinic	M	New PI 2016	New PI 2016	> 90%
BowelScreen No. of clients who have completed a satisfactory BowelScreen FIT test	M	New PI 2016	New PI 2016	106,875
% of client uptake rate in the BowelScreen programme	Q	New PI 2016	New PI 2016	> 45%
Diabetic RetinaScreen No. of Diabetic RetinaScreen clients screened with final grading result	M	78,300	78,300	87,000
% Diabetic RetinaScreen uptake rate	Q	New PI 2016	New PI 2016	> 56%
Environmental Health No. of tobacco sales to minors test purchase inspections carried out	Q	480	460	384
No. of establishments inspected under the *Public Health (Sunbeds) Act*	Q	400	400	200
No. of official food control planned, and planned surveillance inspections of food businesses.	Q	33,000	35,882	33,000
Tobacco No. of smokers who received intensive cessation support from a cessation counsellor	M	9,000	11,000	11,500
% of smokers on cessation programmes who were quit at one month	Q	New PI 2016	New PI 2016	45%
Healthy Eating Active Living No. of people who have completed a structured patient education programme for diabetes	M	New PI 2016	New PI 2016	2,200
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	95%	93.5%	95%
% of newborn babies visited by a PHN within 72 hours of discharge from maternity services	Q	97%	97.4%	97%
% of babies breastfed (exclusively and not exclusively) at first PHN visit	Q	56%	53.5%	56%
% of babies breastfed (exclusively and not exclusively) at 3 month PHN visit	Q	38%	34.6%	38%

Health and Wellbeing				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Immunisations and Vaccines				
% children aged 24 months who have received 3 doses of the 6in1 vaccine	Q	95%	95.0%	95%
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	Q	95%	92.7%	95%
% of first year girls who have received two doses of HPV vaccine	A	80%	85%	85%
% of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (acute hospitals)	A	40%	23.4%	40%
% of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (long term care facilities in the community)	A	40%	25.7%	40%
% uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	A	75%	60%	75%
Public Health				
No. of infectious disease (ID) outbreaks notified under the national ID reporting schedule	Q	614	680	660

Primary Care

Primary Care				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Community Intervention Teams (no. of referrals)	M	**26,355**	**18,600**	**24,202**
Admission avoidance (includes OPAT)		1,196	651	914
Hospital Avoidance	M	14,134	10,788	12,932
Early discharge (includes OPAT)	M	6,375	3,980	6,360
Unscheduled referrals from community sources	M	4,650	3,181	3,996
Health Amendment Act: **Services to persons with state acquired Hepatitis C**				
No. of patients who were reviewed	Q	820	22	798
Healthcare Associated Infections: Medication Management				
Consumption of antibiotics in community settings (defined daily doses per 1,000 population)		< 21.7	25.7	< 21.7
Service User Experience				
% of PCTs by CHO, that can evidence service user involvement as required by Action 19 of the Primary Care Strategy – A New Direction (2001)	Q	New PI 2016	New PI 2016	100%
GP Activity				
No. of contacts with GP Out of Hours Service	M	959,455	964,770	964,770
Nursing				
No. of new patients accepted on the caseload and waiting to be seen over 12 weeks	M	New PI 2016	New PI 2016	0
Physiotherapy				
% of new patients seen for assessment within 12 weeks	M	80%	83%	70%
% on waiting list for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
Occupational Therapy				
% of new patients seen for assessment within 12 weeks	M	80%	76%	70%
% on waiting list for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
Speech and Language Therapy				
% on waiting lists for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%

Primary Care

Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Podiatry, Ophthalmology, Audiology, Dietetics and Psychology				
Podiatry				
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	75%
Ophthalmology				
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting lists for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%
Audiology				
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%
Dietetics				
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment less ≤ 12 weeks	M	New PI 2016	New PI 2016	70%
Psychology				
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%
Oral Health				
% of new patients care who commenced treatment within 3 months of assessment	M	New PI 2016	New PI 2016	80%
Orthodontics				
% of referrals seen for assessment within 6 months	Q	75%	74%	75%
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	Q	< 5%	8%	< 5%

Primary Care Reimbursement Service

Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
% of completed Medical Card / GP Visit Card applications processed within the 15 days	M	90%	90%	95%
% of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	M	90%	90%	90%
% of Medical Card applications which are accurately processed by national medical card unit staff	M	New PI 2016	New PI 2016	95%
No. of persons covered by Medical Cards as at 31st December	M	1,722,395	1,725,767	1,675,767
No. of persons covered by GP Visit Cards as at 31st December	M	412,588	435,785	485,192*

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Social Inclusion

Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Substance Misuse				
% of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q	100%	97%	100%
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	M	100%	89%	100%

Social Inclusion				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
No. of clients in receipt of opioid substitution treatment (outside prisons)	M	9,400	9,413	9,515
Average waiting time from referral to assessment for Opioid Substitution Treatment	M	New PI 2016	New PI 2016	14 days
Average waiting time from Opioid Substitution assessment to exit from waiting list or treatment commenced	M	New PI 2016	New PI 2016	28 days
Needle Exchange No. of unique individuals attending pharmacy needle exchange	Q	1,200	1,731	1,731
Homeless Services % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	Q	85%	72%	85%
Traveller Health No. of people who received health information on type 2 diabetes and cardiovascular health	Q	3,470	2,228	3,470

Palliative Care				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Inpatient Units – Waiting Times Access to specialist inpatient bed within 7 days	M	98%	98%	98%
Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital)	M	95%	87%	95%
No. of patients in receipt of specialist palliative care in the community	M	3,248	3,178	3,309
No. of children in the care of the children's outreach nursing team / specialist palliative care team	M	320	359	370
% patients triaged within 1 working day of referral	M	New PI 2016	New PI 2016	90%
% of patients with a multi-disciplinary care plan documented within 5 working days of initial review	M	New PI 2016	New PI 2016	90%

Mental Health

Mental Health				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
General Adult Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by General Adult Community Mental Health Team	M	90%	92%	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Team	M	75%	74%	75%
% of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	M	18%	22%	18%
Psychiatry of Old Age Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	M	99%	98%	98%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	M	95%	94%	95%

Mental Health				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	M	2%	3%	3%
CAMHs 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.	M	95%	71%	95%
% of bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of bed days used by children in mental health acute inpatient units	M	New PI 2016	New PI 2016	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	M	78%	78%	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	M	72%	72%	72%
%. of new (including re-referred) child / adolescent referrals offered appointment and DNA in the current month	M	10%	12%	10%
Total no. to be seen or waiting to be seen by CAMHs Total no. to be seen for a first appointment at the end of each month.	M	2,632	2,509	2,449
Total no. to be seen 0-3 months	M	1,153	1,138	1,308
Total no. on waiting list for a first appointment waiting > 3 months	M	1,479	1,371	1,141
Total no. on waiting list for a first appointment waiting > 12 months	M	0	203	0

Social Care

Social Care				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Disability Services **Progressing Disability Services for Children and Young People (0-18s) Programme** No. of Children's Disability Network Teams established	M	New PI 2016	New PI 2016	100% (129 of 129)
Quality % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum / Service User Panel or equivalent for Disability Services	Q	New PI 2016	New PI 2016	100%
Safeguarding % of Preliminary Screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan	Q	New PI 2016	New PI 2016	100%
% of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy	Q	New PI 2016	New PI 2016	100%
% of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy	Q	New PI 2016	New PI 2016	100%
% compliance with inspected outcomes following HIQA inspection of Disability Residential Units	Q	New PI 2016	New PI 2016	75%
Quality In respect of agencies in receipt of €3m or more in public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL or CARF	Bi-annual	100%	100%	100%

Social Care				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Disability Act **Compliance** % of assessments completed within the timelines as provided for in the regulations	Q	100%	34%	100%
Day Services % of school leavers and RT graduates who have been provided with a placement	Q3	100%	100%	100%
Respite Services * No. of day only respite sessions accessed by people with a disability	Q	New PI 2016	New PI 2016	35,000
No. of overnights (with or without day respite) accessed by people with a disability	Q	190,000	182,710	180,000
Personal Assistance (PA) No. of PA Service hours delivered to adults with a physical and / or sensory disability	Q	1.3m	1.4m	1.3m
Home Support Service No. of Home Support Hours delivered to persons with a disability	Q	2.6m	2.7m	2.6m
Congregated Settings Facilitate the movement of people from congregated to community settings	Q	150	112	160
Transforming Lives - VfM Policy Review Deliver on VfM Implementation priorities.	Bi-annual	New PI 2016	New PI 2016	100%
Service Improvement Team Process Deliver on Service Improvement priorities.	Bi-annual	New PI 2016	New PI 2016	100%
Older Persons Services **Quality** % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Older Persons Services.	Q	New PI 2016	New PI 2016	100%
Safeguarding % of Preliminary Screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan	Q	New PI 2016	New PI 2016	100%
% of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy	Q	New PI 2016	New PI 2016	100%
% of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy	Q	New PI 2016	New PI 2016	100%
Service Improvement Team Process Deliver on Service Improvement priorities.	Bi-annual	New PI 2016	New PI 2016	100%
Home Care Packages Total no. of persons in receipt of a HCP including delayed discharge initiative HCPs	M	13,800	15,450	15,450
Intensive HCPs: Total no. of persons in receipt of an Intensive HCP	M	190	130	130
No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	M	10.3m	10.4m	10.4m
No. of people in receipt of home help hours (excluding provision of hours from HCPs)	M	50,000	47,795	47,800
No. of persons funded under NHSS in long term residential care	M	22,361	23,450	23,450
No. of NHSS beds in Public Long Stay Units.	M	5,287	5,288	5,255
No. of short stay beds in Public Long Stay Units	M	1,840	2,005	2,005
Average length of stay for NHSS clients in Public, Private and Saver Long Stay Units	M	3.2 years	3.1 years	3.2 years
% of population over 65 years in NHSS funded beds (based on 2011 Census figures)	M	4%	4%	4%

*The introduction of an expanded range of KPIs in respect of respite, with more appropriate reporting of day and overnight respite, results in a combined target of 215,000 for 2016

Pre-Hospital and Emergency Care

National Ambulance Service				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
% of all transfers provided through the Intermediate Care Service	M	70%	80%	80%
Return of spontaneous circulation (ROSC) at hospital in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using the Utstein comparator group calculation	Q	40%	37%	40%
Emergency Response - % of Clinical Status 1 ECHO incidents responded to by a patient carrying vehicle in 18 minutes 59 seconds or less.	M	80%	78%	80%
Emergency Response - % of Clinical Status 1 DELTA incidents responded to by a patient carrying vehicle in 18 minutes 59 seconds or less.	M	80%	67%	80%
National Emergency Operations Centre (NEOC)* - % of control centres that carry out Advanced Quality Assurance Audits (AQuA)	M	100%	100%	100%
National Emergency Operations Centre (NEOC)* - % Medical Priority Dispatch System (MPDS) Protocol Compliance	M	New PI 2016	New PI 2016	90%
% of ambulance turnaround delays escalated, where ambulance crews were not cleared nationally in 60 minutes (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	M	100%	72%	100%
% of ECHO calls which have a resource allocated within 90 seconds of call start	M	New PI 2016	New PI 2016	85%
% of DELTA calls which have a resource allocated within 90 seconds of call start	M	New PI 2016	New PI 2016	85%

*Tallaght and Ballyshannon Control Centres

Hospital Care

Acute Services (Acute Hospitals and National Clinical Care Programmes)				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Discharge Activity*				
Inpatient	M	643,748	640,140	640,140
Day case	M	824,317	861,831	851,831
Dialysis – Day case	M	176,374	171,890	181,890
Total inpatient and day case	M	1,644,439	1,673,861	1,673,861
Shift of day case procedures to Primary Care	M	New PI 2016	New PI 2016	Up to 10,000
Emergency Care				
New ED attendances	M	1,104,131	1,102,680	1,102,680
Return ED attendances	M	84,042	94,948	94,948
Other emergency presentations	M	89,276	94,855	94,855
Inpatient Admissions				
No. of inpatient emergency admissions	M	451,157	443,948	443,948
Elective inpatient admissions	M	99,973	102,463	102,463
Outpatients				
No. of new and return outpatient attendances	M	3,189,749	3,242,424	3,242,424
Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	M	New PI 2016	New PI 2016	1 : 2

Acute Services (Acute Hospitals and National Clinical Care Programmes)				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Births				
Total no. of births	M	66,705	65,977	65,977
Inpatient, Day Case and Outpatient Waiting Times				
% of adults waiting < 15 months for an elective procedure (inpatient and day case)	M	100%	90%	95%
% of adults waiting < 8 months for an elective procedure (inpatient and day case)	M	100%	66%	70%
% of children waiting < 15 months for an elective procedure (inpatient and day case)	M	100%	95%	95%
% of children waiting < 20 weeks for an elective procedure (inpatient and day case)	M	100%	55%	60%
% of people waiting < 15 months for first access to OPD services	M	100%	90%	100%
% of people waiting < 52 weeks for first access to OPD services	M	100%	85%	85%
Colonoscopy / Gastrointestinal Service				
% of people waiting < 4 weeks for an urgent colonoscopy	M	100%	100%	100%
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	M	100%	52%	70%
Emergency Care and Patient Experience Time				
% of all attendees at ED who are discharged or admitted within 6 hours of registration	M	95%	67.8%	75%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	M	100%	81.3%	100%
% of ED patients who leave before completion of treatment	Q	< 5%	< 5%	< 5%
% of all attendees at ED < 24 hours	M	100%	96%	100%
% of patients 75 years or over who were admitted or discharged from ED within 9 hours	M	New PI 2016	New PI 2016	100%
Acute Medical Patient Processing				
% of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	M	95%	65.5%	75%
Ambulance Turnaround Times				
% of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	M	New PI 2015	New PI 2015	95%
Healthcare Associated Infections (HCAI)				
Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used	Q	< 0.057	0.054	< 0.055
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	Q	< 2.5	2.1	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	Bi-annual	83	86.4	80
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	Bi-annual	25	28	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	Bi-annual	90%	87.2%	90%
Activity Based Funding (MFTP) model				
HIPE Completeness – Prior month: % of cases entered into HIPE	M	> 95%	93%	> 95%
Average Length of Stay				
Medical patient average length of stay (contingent on < 500 delayed discharges)	M	5.8	7.2	7.0
Surgical patient average length of stay	M	5.1	5.5	5.2
ALOS for all inpatient discharges excluding LOS over 30 days	M	4.3	4.6	4.3
Stroke				
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	Q	9%	12.1%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	Q	66%	53.7%	50%
Acute Coronary Syndrome				
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Q	85%	83%	85%
% of reperfused STEMI patients (or LBBB) who get timely PPCI	Q	80%	68.4%	80%

Acute Services (Acute Hospitals and National Clinical Care Programmes)				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	M	70%	69.4%	75%
% day case rate for Elective Laparoscopic Cholecystectomy	M	> 60%	38.3%	> 60%
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	M	95%	84.5%	95%
Re-admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	M	9.6%	10.8%	10.8%
% of surgical re-admissions to the same hospital within 30 days of discharge	M	< 3%	2.0%	< 3%
Medication Safety No. of medication incidents (as provided to the State Claims Agency) in acute hospitals reported as a % of bed days	Q	New PI 2015	0.12%	≤0.12%
Patient Experience % of hospital groups conducting annual patient experience surveys amongst representative samples of their patient population	A	100%	Not yet reported in 2015	100%
Delayed Discharges No. of bed days lost through delayed discharges	M	New PI 2016	225,250	< 183,000
No. of beds subject to delayed discharges	M	New PI 2016	577	< 500
HR – Compliance European Working Time Directive compliance for NCHDs - < 24 hour shift	M	100%	98%	100%
European Working Time Directive compliance for NCHDs - < 48 hour working week	M	100%	75%	95%
National Early Warning Score (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	Q	100%	100%	100%
% of all clinical staff who have been trained in the COMPASS programme	Q	> 95%	63.6%	> 95%
Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with implementation of IMEWS	Q	100%	100%	100%
% of hospitals with implementation of IMEWS for pregnant patients	Q	100%	78%	100%
Clinical Guidelines % of maternity units / hospitals with implementation of the guideline for clinical handover in maternity services	Q	New PI 2016	New PI 2016	100%
% of acute hospitals with implementation of the guideline for clinical handover	Q	New PI 2016	New PI 2016	100%
National Standards % of hospitals who have commenced second assessment against the NSSBH	Q	New PI 2016	New PI 2016	95%
% of hospitals who have completed first assessment against the NSSBH	Q	95%	80%	100%
% maternity units which have completed and published Maternity Patient Safety Statements at Hospital Management Team each month	M	New PI 2016	New PI 2016	100%
No. of nurses prescribing medication	A	New PI 2016	New PI 2016	100
No. of nurses prescribing ionising radiation (x-ray)	A	New PI 2016	New PI 2016	55

*Full detail of activity targets for inpatient and day cases will be provided in terms of volume of cases and complexity weighted units in hospital group Operational Plans

Acute Services (National Cancer Control Programme)				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Symptomatic Breast Cancer Services				
No. of patients triaged as urgent presenting to symptomatic breast clinics	M	16,000	16,800	16,800
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals	M	95%	96%	95%
% 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)	M	95%	82%	95%
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer	M	> 6%	11%	> 6%
Lung Cancer				
No. of patients attending the rapid access lung clinic in designated cancer centres	M	3,000	3,300	3,300
% of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	M	95%	86%	95%
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer	M	> 25%	29%	> 25%
Prostate Cancer				
No. of patients attending the rapid access clinic in cancer centres	M	2,500	2,600	2,600
% of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres	M	90%	62%	90%
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of prostate cancer	M	> 30%	38%	> 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)	M	90%	84%	90%

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that were completed in 2014 / 2015 but not operational, projects due to be completed and operational in 2016 and also projects due to be completed in 2016 but not operational until 2017

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
PRIMARY CARE									
CHO 1: Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan									
Derrybeg/Bunbeg, Co. Donegal	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
CHO 2: Galway, Roscommon, Mayo									
Castlebar, Co. Mayo	Primary Care Centre, by lease agreement.	Q4 2016	Q4 2016	0	0	0.00	0.00	0	0.00
CHO 3: Clare, Limerick, North Tipperary/East Limerick									
Windmill Court, Garryowen, Limerick City	Primary Care Centre, by lease agreement.	Q4 2016	Q4 2016	0	0	0.00	0.00	0	0.00
Borrisokane, Co. Tipperary	Extension of primary care facility.	Q4 2016	Q4 2016	0	0	0.28	0.46	0	0.00
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork									
Charleville, Co Cork	Primary Care Centre, by lease agreement (includes a mental health primary care centre).	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0.00
St. Finbarr's Hospital, Cork	Audiology services, ground floor, block 2.	Q2 2016	Q3 2016	0	0	0.80	1.50	0	0.00
Ballyheigue, Co. Kerry	Primary Care Centre, refurbishment of existing health centre.	Q1 2016	Q2 2016	0	0	0.10	0.14	0	0.00
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
Tipperary Town	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Carnew, South Wicklow	Primary Care Centre, by lease agreement.	Q1 2016	Q2 2016	0	0	0.00	0.00	0	0.00
CHO 7: Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West,									
Kilnamanagh/Tymon, Dublin	Primary Care Centre, by lease agreement.	Q3 2016	Q4 2016	0	0	0.00	0.00	0	0.00
Springfield, Tallaght, Dublin	Primary Care Centre, by lease agreement.	Q3 2016	Q4 2016	0	0	0.00	0.00	0	0.00
Tus Nua, Kildare Town	Primary Care Centre, by lease agreement.	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0.00
Celbridge, Co. Kildare	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Blessington, Co. Wicklow	Primary Care Centre, by lease agreement.	Q2 2016	Q2 2016	0	0	0.00	0.00	0	0.00
CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath									
Ballymahon, Co. Longford	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Mullingar, Co. Westmeath	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
PRIMARY CARE *(contd.)*									
CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath *(contd.)*									
Kells, Co. Meath	Primary Care Centre, by lease agreement.	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0.00
Tullamore, Co. Offaly	Refurbishment of vacated original hospital (Scott's) buildings to replace rented accommodation in the Tullamore area. A wide range of community health services will be provided from this building.	Q4 2016	Q1 2017	0	0	2.00	14.73	0	0.00
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Corduff, Co. Dublin	Primary Care Centre, to be developed on HSE owned site.	Q1 2016	Q2 2016	0	0	2.58	7.36	0	0.00
Blanchardstown, Co. Dublin	Refurbishment of Roselawn Health Centre to complete the provision of primary care services in the Corduff/Blanchardstown network.	Q4 2016	Q4 2016	0	0	0.25	0.25	0	0.00
Balbriggan, Co. Dublin	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Grangegorman, Dublin	Primary Care Centre, to be developed on site in Grangegorman.	Q3 2016	Q4 2016	0	0	6.50	12.00	0	0.00
	Relocation of Eve Holdings to Grangegorman Villas (1-5).	Q4 2016	Q4 2016	0	0	0.25	0.75	0	0.00
St. Ita's Hospital, Portrane	Upgrade and refurbishment of 123 Block. This will facilitate the provision of Coolock Primary Care Centre, a European Institute of Innovation and Technology Centre and accommodate services currently in rented accommodation and accommodate staff currently in Coolock Health Centre.	Q2 2016	Q2 2016	0	0	2.00	4.30	0	0.00
MENTAL HEALTH									
CHO 1: Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan									
Community Mental Health Unit, Donegal	Refurbishment of Rowanfield House to provide a community mental health unit for the area.	Q1 2015	Q1 2016	0	0	0.00	1.98	0	0.00
CHO 2: Galway, Roscommon, Mayo									
St. Bridget's, Ballinasloe, Co. Galway	Reconfiguration of admissions building (ground floor) to accommodate Beds (x16) from St. Brendan's CNU, St. Joseph's disability day centre and to provide accommodation for a rehabilitation team (POL Project).	Q1 2016	Q2 2016	0	16	0.30	1.50	0	0.00
Loughrea, Co. Galway	Refurbishment of a section of the recently vacated St. Brendan's Community Hospital to provide accommodation for the community mental health team and day hospital.	Q2 2016	Q3 2016	0	0	0.20	1.20	0	0.00
Gort Glas, Ennis, Co. Clare	Refurbishment (at front of St. Joseph's Hospital) to provide a mental health day centre.	Q3 2016	Q4 2016	0	0	0.70	1.50	0	0.00
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork									
Killarney, Co. Kerry	Provision of a combined challenging behaviour and mental health residential unit to facilitate the relocation of remaining residents from St. Finan's Hospital (*Vision for Change*).	Q3 2015	Q4 2015 / Q1 2016	0	40	1.11	13.00	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
MENTAL HEALTH *(Contd.)*									
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork *(contd.)*									
Kerry General Hospital, Tralee, Co. Kerry	Upgrade and extension to the acute mental health unit to include a 4 bed closed observation unit.	Q4 2014	Q1/Q2 2016	0	4	0.00	2.00	0	0.00
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Clonskeagh, Dublin	Development of an acute day hospital in St. Brock's on the Clonskeagh Hospital campus.	Q3 2016	Q4 2016	0	0	0.35	0.65	0	0.00
CHO 7: Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West,									
Cherry Orchard, Dublin	Child and adolescent residential Unit (Linn Dara).	Q4 2015	Q1 2016	14	8	0.60	12.48	0	0.00
Brú Chaoimhín, Dublin	Refurbishment of Unit 4, to accommodate adult day mental health services.	Q4 2015	Q1 2016	0	0	0.20	1.60	0	0.00
CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath									
Our Lady of Lourdes Hospital, Drogheda, Co. Louth	New acute mental health unit.	Q1 2015	Q1 2016	0	45	0.30	12.90	0	0.00
St. Fintan's, Portlaoise, Co. Laois	Alvernia House refurbishment to accommodate Child and Adolescent Mental Health Unit, primary care centre expansion, Irish Wheelchair Association and other disability service facilities.	Q4 2015	Q1 2016	0	0	0.17	4.67	0	0.00
CHO 9: Dublin North, Dublin North Central, Dublin North West									
St. Ita's Hospital, Portrane, Co. Dublin	Stabilisation work to listed building, including repairs to roofs, windows, paraphet walls and heating systems (*will not impact on operational status)	Q1 2016	*N/A	0	0	0.40	2.20	0	0.00
SOCIAL CARE – Services for Older People									
CHO 1: Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan									
Virginia Healthcare Unit, Co. Cavan	Refurbishment and upgrade (to achieve HIQA compliance).	Q2 2015	Q1 2016	0	50	0.08	3.74	0	0.00
St. Mary's Hospital, Castleblaney, Co. Monaghan	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2015	Q1 2016	0	71	0.20	5.86	0	0.00
Ballinamore Community Nursing Unit (CNU), Co. Leitrim	Refurbishment and upgrade (to achieve HIQA compliance).	Q3 2014	Q4 2015/Q1 2016	0	21	0.20	6.00	0	0.00
CHO 2: Galway, Roscommon, Mayo									
Plunkett CNU, Boyle, Co. Roscommon	Refurbishment and upgrade (to achieve HIQA compliance).	Q2 2016	Q3 2016	0	38	1.20	1.60	0	0.00
Áras Mhathair Poil CNU, Castlerea, Co. Roscommon	Refurbishment and upgrade (to achieve HIQA compliance).	Q3 2016	Q3 2016	0	30	0.80	1.10	0	0.00
MacBride CNU, Westport, Co. Mayo	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2015	Q1 2016	0	29	0.20	1.00	0	0.00
Dalton CNU, Claremorris, Co. Mayo	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2015	Q1 2016	0	29	0.20	1.00	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
SOCIAL CARE – Services for Older People *(Contd.)*									
CHO 2: Galway, Roscommon, Mayo *(contd.)*									
St. Augustine's CNU, Ballina, Co. Mayo	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2016	Q4 2016	0	33	0.60	1.20	0	0.00
Áras MacDara, CNU, Carraroe, Co. Galway	Refurbishment and upgrade (to achieve HIQA compliance).	Q1 2016	Q2 2016	0	47	0.85	1.55	0	0.00
CHO 3: Clare, Limerick, North Tipperary/East Limerick									
Raheen CNU, Tuamgraney, Co Clare	Refurbishment and upgrade (to achieve HIQA compliance).	Q3 2016	Q4 2016	0	8	1.00	2.00	0	0.00
Regina House CNU, Kilrush, Co Clare	Refurbishment and upgrade (to achieve HIQA compliance).	Q2 2016	Q3 2016	0	4	0.60	1.00	0	0.00
Ennistymon CNU, Co Clare	Refurbishment and upgrade (to achieve HIQA compliance).	Q2 2016	Q3 2016	0	8	0.90	1.60	0	0.00
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork									
Bandon Community Hospital, Co. Cork	Extension and refurbishment (phase 1) - upgrade of existing beds.	Q4 2016	Q4 2016	2	25	3.00	3.60	0	0.00
Bantry General Hospital, Co. Cork	Refurbishment and upgrade (to achieve HIQA compliance).	Q3 2016	Q4 2016	0	24	2.00	2.50	0	0.00
Dunmanway Community Hospital, Co. Cork	Refurbishment and upgrade (to achieve HIQA compliance).	Q3 2016	Q4 2016	0	23	1.00	1.20	0	0.00
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
Dungarvan Community Hospital, Co. Waterford	Refurbishment and upgrade (to achieve HIQA compliance) – phase 2	Q2 2016	Q3 2016	0	72	0.60	0.60	0	0.00
CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath									
St. Vincent's CNU, Mountmellick, Co. Laois	Refurbishment and upgrade (to achieve HIQA compliance) – phase 1	Q1 2016	Q1 2016	0	25	0.11	1.66	0	0.00
St. Joseph's Care Centre, Longford	Refurbishment and upgrade (to achieve HIQA compliance) – phase 1	Q1 2016	Q1 2016	0	28	0.60	1.00	0	0.00
Offalia House, Edenderry, Co. Offaly	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2016	Q4 2016	0	30	1.90	2.60	0	0.00
St. Oliver Plunkett Hospital, Dundalk, Co. Louth	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2015	Q1 2016	0	63	0.40	4.07	0	0.00
St. Joseph's CNU, Trim, Co. Meath	Refurbishment and upgrade (to achieve HIQA compliance) – phase 6	Q4 2016	Q1 2017	0	58	0.75	0.85	0	0.00
CHO 9: Dublin North, Dublin North Central, Dublin North West									
St. James's Hospital, Dublin – (Mercer Institute for Successful Ageing)	Relocation of 31 existing beds within the main hospital and 116 existing beds within the new (MISA) building.	Q1 2016	Q2/Q3 2016	0	147	3.02	31.70	0	0.00
Bellevilla CNU, Co. Dublin	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2016	Q4 2016	0	50	2.00	4.30	0	0.00
ACUTE SERVICES									
RCSI Hospital Group									
Beaumont Hospital, Dublin	Provision of renal dialysis unit.	Q4 2016	Q1 2017	0	44	8.00	11.95	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
ACUTE SERVICES *(Contd.)*									
RCSI Hospital Group *(contd.)*									
Beaumont Hospital, Dublin	Renal transplant unit (phase 1); upgrade and refurbishment of St. Damien's ward, extension of histocompatability and immunogenics laboratories and equipping of Theatre 12.	Q4 2015	Q1 2016	0	24	0.50	5.80	0	0.00
Ireland East Hospital Group									
Cappagh National Orthopaedic Hospital, Dublin	Provision of a recovery unit to serve the theatre department (co-funded with Cappagh).	Q1 2016	Q1 2016	0	0	0.10	1.00	0	0.00
Midland Regional Hospital, Mullingar, Co. Westmeath	Emergency Department (ED), phase 2b (stage 2).	Q1 2016	Q2 2016	0	0	0.30	3.56	0	0.00
St. Luke's General Hospital, Kilkenny	Redevelopment (phase 1) to include a new ED, medical assessment unit (MAU), day service (including endoscopy) including medical education unit, (co-funded by the Royal College of Surgeons of Ireland and the University of Limerick).	Q3 2015	Q2 2016 (phased opening)	10	12	2.50	26.00	0	0.00
	Conversion of day ward into a 12 bed inpatient ward [Winter capacity initiative]	Q1 2016	Q1 2016	12	0	0.10	0.10	0	0.86
Wexford General Hospital	Provision of an early pregnancy assessment unit, a foetal assessment unit and a urodynamics laboratory (co-funded by the Friends of Wexford Hospital)	Q4 2016	Q4 2016	0	0	0.10	0.10	0	0.00
	Upgrade and replacement of fire detection and alarm systems, emergency lighting and passive fire protection works. This project includes the fit-out of the vacated old ED as a decant ward to allow these works proceed.	Q4 2015	Q1 2016	0	0	0.15	5.24	0	0.00
Dublin Midlands Hospital Group									
Midland Regional Hospital, Portlaoise Co. Laois	Redevelopment (phase1), acute medical unit, day services.	Q2 2016	Q3 2016	0	20	2.10	5.50	0	0.00
Midland Regional Hospital, Tullamore, Co. Offaly	Provision of a replacement MRI and additional ultrasound.	Q4 2016	Q1 2017	0	0	2.05	2.57	0	0.00
Tallaght Hospital – AMNCH	Provision of an extended oncology/haematology day unit and relocate service from Burkitt Ward (16 beds back in use). Also link partially vacated Beech Ward to Lynn Ward creating 11 additional adult beds [co-funded from Winter capacity initiative].	Q4 2015	Q1 2016	16	11	0.4	1.20	0	1.90
Children's Hospital Group									
National Children's Hospital, Dublin	Enabling works for National Children's Hospital being delivered as part fit-out of the shelled out area to accommodate the National Centre for Hereditary Coagulation Diseases.	Q4 2016	Q4 2016	0	0	2.00	2.70	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
ACUTE SERVICES *(Contd.)*									
Children's Hospital Group *(contd.)*									
National Children's Hospital, Dublin	Enabling works being delivered as part of the Mercer Institute for Successful Ageing (MISA) project including accommodation for rheumatology and heptology.	Q4 2016	Q4 2016	0	0	3.70	6.85	0	0.00
Our Lady's Children's Hospital, Crumlin, Dublin	Provision of a catheterisation laboratory unit.	Q3 2016	Q4 2016	0	0	1.14	5.60	0	0.00
	Provision of an additional interim orthopaedic theatre as part of the catheterisation laboratory project.	Q3 2016	Q4 2016	0	0	1.90	2.40	0	0.00
South / Southwest Hospital Group									
Cork University Hospital	Reconfiguration of existing paediatric outpatients department (OPD) to provide additional isolation facilities in adjacent ward; provision of new paediatric OPD and medical education facility (funded by University College Cork); dedicated leukaemia and cystic fibrosis units within this development.	Q3 2016	Q4 2016	0	6	3.00	5.12	0	0.00
	Extension and refurbishment of existing pathology laboratory to facilitate management services tender [blood science project].	Q4 2016	Q4 2016	0	0	1.00	2.20	0	0.00
South Infirmary Victoria University Hospital, Cork	Refurbishment and upgrade of accommodation to facilitate relocation of ophthalmic surgery from Cork University Hospital.	Q3 2016	Q4 2016	0	0	0.70	2.19	0	0.00
St. Mary's Orthopaedic Hospital, Cork	Upgrade existing ward to facilitate the relocation of OPD, Mercy University Hospital to OPD, St. Mary's Orthopaedic Hospital.	Q3 2016	Q4 2016	0	0	0.70	1.00	0	0.00
University Hospital, Waterford	New decontamination facility for the day unit (endoscopy).	Q2 2016	Q3 2016	0	0	1.00	1.44	0	0.00
	Provision of replacement interventional (angiography) radiology room.	Q1 2016	Q2 2016	0	0	0.50	1.00	0	0.00
Kerry General Hospital, Tralee, Co. Kerry	Extension and refurbishment of existing pathology laboratory to facilitate management services tender [blood science project].	Q3 2016	Q4 2016	0	0	0.30	0.70	0	0.00
Mercy University Hospital, Cork	Provision of 18 transitional care beds [Winter capacity initiative].	Q4 2015	Q4 2016	0	0	0.20	1.00	0	0.90
Bantry General Hospital, Co. Cork	Provision of a MAU to enable reconfiguration of acute hospital services.	Q4 2015	Q1 2016	0	0	0.10	1.15	0	0.00
South Tipperary General Hospital	Provision of 4 additional ED treatment places [Winter capacity initiative].	Q4 2015	Q1 2016	0	0	0.10	0.40	0	0.15
	Extension of the radiology department to accommodate a CT (purchased) and future MRI.	Q3 2016	Q3 2016	0	0	1.46	1.96	0	0.00
Saolta Hospital Group									
Sligo Regional Hospital	Upgrade of boiler plant and boiler room.	Q4 2016	Q4 2016	0	0	1.70	2.30	0	0.00
	New Medical Education Centre.	Q3 2015	Q12016	0	0	0.15	2.40	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
ACUTE SERVICES *(Contd.)*									
Saolta Hospital Group *(contd.)*									
Sligo Regional Hospital	Upgrade of building fabric (roofs, windows, etc) and fire compartmentation works.	Phased 2016	Phased 2016	0	0	0.40	1.26	0	0.00
Galway University Hospital	Interim emergency ward to replace 17 beds lost due to the construction of the clinical ward block and the creation of 18 additional beds within vacated areas to address service difficulties.	Q4 2015/Q1 2016	Q1 2016	18	17	0.70	2.20	0	0.00
Galway University Hospital *(contd.)*	New clinical block to provide replacement ward accommodation. Initial phase is provision of a 75 bed block.	Q4 2016	Q1 2017	0	75	10.00	17.60	0	0.00
Letterkenny General Hospital, Co. Donegal	New medical education centre.	Q1 2016	Q2 2016	0	0	0.30	2.00	0	0.00
	Restoration and upgrade of the critical care unit, haematology and oncology units, damaged in 2013 flood (part-funded by Insurance).	Q4 2016	Q1 2017	0	0	2.00	2.70	0	0.00
	Restoration and upgrade of central staff changing facility, damaged in 2013 flood.	Q4 2016	Q4 2016	0	0	1.51	2.11	0	0.00
	Restoration and upgrade of mortuary damaged in 2013 flood (part-funded by Insurance).	Q4 2016	Q1 2017	0	0	0.00	0.23	0	0.00
	Restoration and upgrade of underground service duct (and services) damaged in 2013 flood.	Q4 2016	Q4 2016	0	0	0.01	2.46	0	0.00
	Restoration and upgrade of laboratory department damaged in 2013 flood.	Q4 2015	Q1 2016	0	0	0.22	1.84	0	0.00
Mayo General Hospital, Castlebar, Co. Mayo	Expansion of existing endoscopy suite to provide a new decontamination facility, also works to main concourse including replacement lift.	Q4 2016	Q4 2016	0	0	1.50	1.80	0	0.00
Roscommon County Hospital	Provision of endoscopy unit.	Q4 2015	Q1 2016	0	2	0.26	5.48	0	0.00
University of Limerick Hospital Group									
Ennis Hospital, Co. Clare	Redevelopment of Ennis General Hospital (phase 1) to include fit out of vacated areas in existing building to accommodate physiotherapy and pharmacy and development of a local (minor) injuries unit.	Q4 2016/Q1 2017 (phased)	Q1 2017 (phased)	0	50	0.45	1.19	0	0.00
University Hospital, Limerick	Construction and fit out of renal dialysis unit over ED.	Q3 2016	Q4 2016	13	11	1.50	7.20	0	0.00
	Acute MAU and OPD reconfiguration. Ward 1B reverts to a 29 bed ward and the acute MAU will be accommodated in the (old) Ward 6A.	Q4 2016	Q1 2017	5	0	0.50	1.00	0	0.00
	Clinical education and research centre (co-funded with University of Limerick).	Q4 2016	Q4 2016	0	0	2.80	11.20	0	0.00
	Equipping of Leben building - breast unit, dermatology, stroke and cystic fibrosis OPD.	Q4 2015	Q1/Q2 2016	0	0	1.00	4.50	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
NATIONAL CANCER CONTROL PROGRAMME									
St. Luke's Hospital, Dublin	Provision of interim facilitates, (phase 2 – radiation/oncology project).	Q2 2016	Q3 2016	0	0	3.58	7.00	0	0.00
Altnagelvin Hospital, Londonderry	Provision of additional radiation oncology facilities (part funded by the National Development Plan).	Q3 2016	Q4 2016	0	0	8.00	19.00	0	0.00

Accountability Framework

Our Values
Care Compassion Trust Learning

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Accountability Framework

Performance Accountability Framework
for the Health Services

2016

CONTENTS

The Accountability Framework 2016

The HSE's **Accountability Framework** was introduced in 2015 and has been further enhanced and developed for 2016. It sets out the means by which the HSE and in particular the National Divisions, Hospital Groups and CHOs, will be held to account for their performance in relation to **Access** to services, the **Quality and Safety** of those Services, doing this within the **Financial resources** available and by effectively harnessing the efforts of its overall **Workforce**.

The introduction of an Accountability Framework as part of the HSE's overall governance arrangements is an important development. The key components of the Performance Accountability Framework 2016 are as follows:

- Strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group CEOs and the CHO Chief Officers.
- Formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers.
- A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance.
- The continuation of the national level management arrangements for the CHO Chief Officers
- The continuation of the **National Performance Oversight Group** with delegated authority from the Director General to serve as a key accountability mechanism for the Health Service and to support the Director General and the Directorate in fulfilling their accountability responsibilities.
- Accountability arrangements will be put in place in 2016 between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Operational Business Plans.

All of the above elements, together with the other arrangements that are in place, are described in this document.

Introduction and Executive Summary

Overview

The HSE is the statutory body with responsibility for the delivery of health and personal social services within the resources allocated to it by the Minister. In discharging its public accountabilities, the HSE has in place a Governance Framework covering corporate, clinical and financial governance. While the HSE's primary accountability is to the Minister for Health, it also has a range of other accountability obligations to the Oireachtas, Oireachtas Committees and to its Regulators.

The HSE regularly reviews its Governance arrangements and in the context of the new health service structures currently being implemented through the 7 Hospital Groups and 9 Community Healthcare Organisations (CHOs), the HSE is further strengthening its **Accountability Framework** to bring greater clarity in relation to accountability obligations at each level of the organisation.

Accountability and the National Service Plan 2016

The HSE recognises that continually strengthening accountability and good governance within the HSE is of critical importance. In 2015 the Minister requested that the HSE develop and implement a robust **Accountability Framework** which would make explicit the responsibilities of managers and which would describe in detail the means by which the health service, and in particular Hospital Groups (HGs) and Community Healthcare Organisations (CHOs), would be held to account for their efficiency and control in relation to service provision, patient safety, finance and HR. In addition, it required the National Service Plan 2015 to '*include specific targets (across the balanced scorecard of quality, access, finance and HR), timelines for achievement, escalation processes and actions to be taken on foot of underperformance*'.

The HSE developed and implemented an Accountability Framework in 2015 in line with the Ministers request. In the second half of 2015 a review of the operation, effectiveness and application of the Accountability Framework was commissioned and has been concluded. The learning from this and recommendations arising will be taken on board during 2016 as appropriate.

The Letter of Determination for 2016 requested that the National Service Plan should detail how the HSE intends to develop and build on the Framework in 2016 including the changes that are required to improve the process and, in particular, the intervention and support processes in place to address areas of underperformance.

Areas for development and improvement during 2016 include:

- The implementation of Improvement Leads and Improvement Teams
- Partnering of a high performing hospital or service with a poorer performing service as a 'buddy' arrangement to provide advice and support
- Inclusion of a clearly defined timeframe for improvement over the reporting year for services that fail to improve
- Differentiated approach to underperformance in respect of finance
- The application of sanctions for persistent underperformance

As part of the Performance Accountability Framework 2015 an enhanced Escalation and Intervention Framework and process was developed for implementation during 2016. The HSE's Escalation and Intervention Framework sets clear thresholds for

intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels which are described in section 4.

Introduction to the Accountability Arrangements

The **Accountability Framework 2016** is described in this document. It sets out the means by which the HSE and in particular the National Divisions, Hospital Groups, CHOs and the National Ambulance Service, will be held to account for their performance in relation to **Access** to services, the **Quality and Safety** of those Services, doing this within the **Financial resources** available and by effectively harnessing the commitment and expertise of its overall **Workforce**.

The key components of the Accountability Framework set out in this document are:

Section 1: Accountability levels

Section 2: Accountability Suite (Plans, Agreements and Reports)

Section 3: Accountability processes

Section 4: Escalation and Intervention Framework 2016

Section 1: Accountability levels

There are five main levels covered by this Accountability Framework. These are the accountability of the:

- HSE through the Directorate to the Minister
- Director General to the Directorate
- National Directors to the Director General, (including National Directors for Support functions, Finance, HR and Health Business Services)
- Hospital Group CEOs and CHO Chief Officers to the relevant National Directors
- Service Managers and the CEOs of Section 38 and Section 39 agencies to Hospital Group CEOs and CHO Chief Officers

Section 2: Accountability Suite (Plans, Agreements and Reports)

The **National Service Plan** is the contract between the HSE and the Minister, against which the HSE's performance is measured. A National **Performance Report** is produced on a monthly basis which is provided to the Minister for Health and subsequently published. An **Annual Report** is also produced.

A key feature of the Accountability Framework is the formal **Performance Agreements**. They will be updated to reflect the 2016 National Service Plan. These Agreements will be in place at two levels.

- The first level will be the **National Director Performance Agreement** between the Director General and each National Director. (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service).
- The second level will be the **Hospital Group CEO Performance Agreement** and **CHO Chief Officer Performance Agreement** which will be with the National Director Acute Hospitals and relevant National Directors for community services respectively.

National Directors will be accountable for the delivery of their Divisional component of the National Service Plan. This will be reflected in the Performance Agreement. The Performance Agreement will in addition focus on a number of key priorities contained

in the Service Plan or Operational Plan. These priorities will be captured in a **Balanced Score Card** which will ensure accountability for the four dimensions of **Access** to services, the **Quality and Safety** of those services, doing this within the **Financial resources** available and by effectively harnessing the commitment and expertise of its overall **Workforce**. The Balanced Score Card will set out both quantitative and qualitative measures.

The Agreement will also set out the core performance expectations, accountability arrangements and escalation and intervention measures that will be put in place. A consistent approach to these arrangements will continue during 2016 at each accountability level.

During 2016 accountability arrangements will also be put in place between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Operational Business Plans.

Section 3: Accountability processes

One of the key features of this Accountability Framework is the continuation of the **National Performance Oversight Group** which is the principal performance accountability mechanism in the HSE. The arrangements for the National Performance Oversight Group are set out in Section 3. The main outputs from this Group are:

- Scrutiny of the Monthly **National Performance Report** for submission to the Director General
- A formal **Escalation Report** in relation to serious performance issues to the Director General by the Deputy Director General which is published as part of the monthly Performance Report.

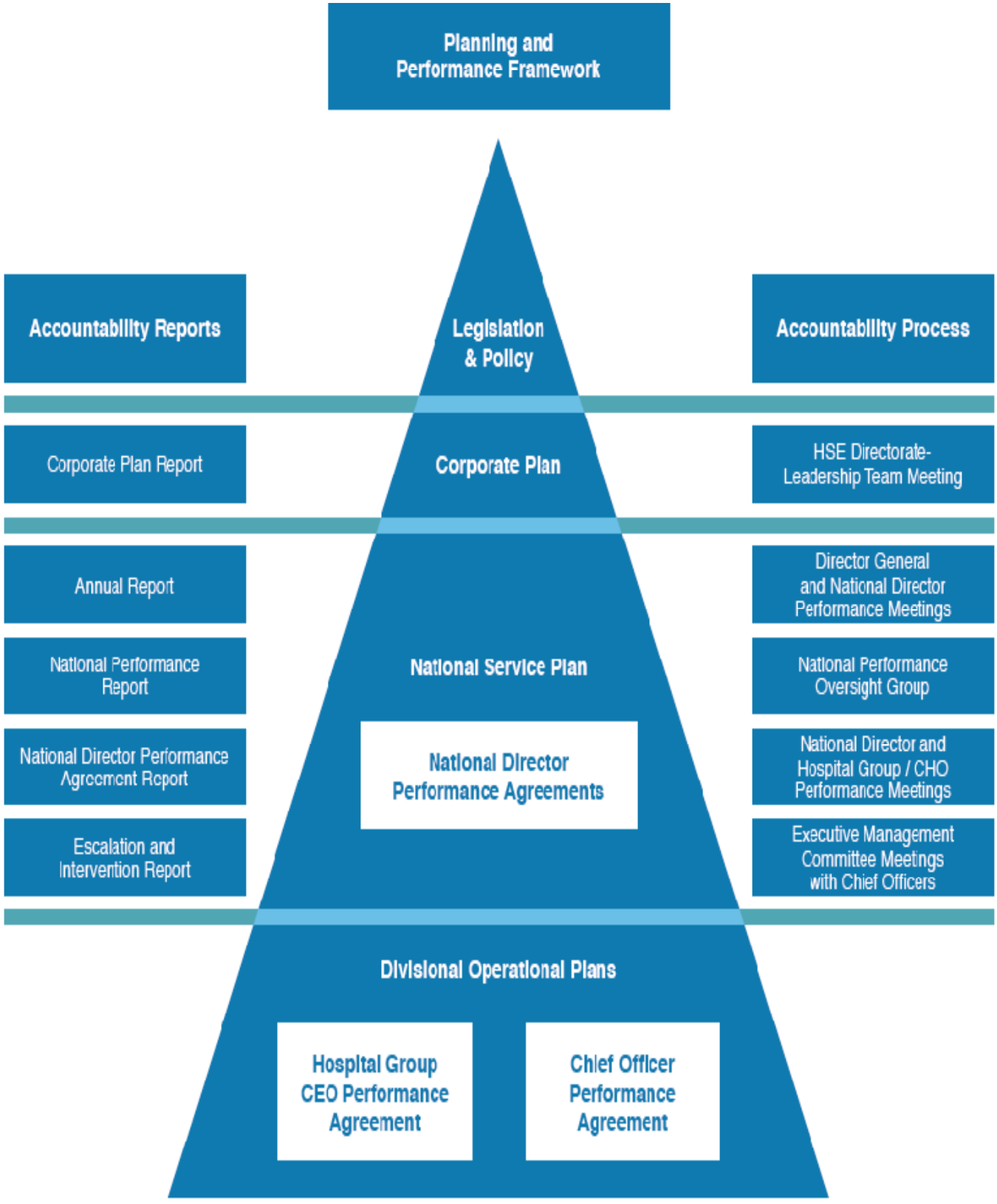
The monthly Performance Management processes between the Director General and National Directors and between National Directors and Hospital Group CEOs and CHO Chief Officers will be further strengthened in 2016.

Section 4: Escalation and Intervention Framework 2016

One of the most important elements of the HSE's strengthened accountability arrangements is a requirement that Managers at each level ensure that any issues of underperformance are identified and addressed at the level where they occur. Where there are issues of persistent underperformance in any of the quadrants of the Balanced Score Card, the HSE will implement an enhanced **Escalation and Intervention Framework** and process as part of its Accountability Framework. The process will include the:

- Responsibilities at each level for performance and escalation.
- The thresholds and tolerances for underperforming services at each level.
- The type of supports, interventions and sanctions to be taken at each level of escalation.

HSE Accountability Framework 2016



Section 1. Accountability levels

The five levels of accountability (i.e. who is calling who to account) set out in the Framework are described below.

Level 1 Accountability:	■ The HSE's accountability through the Directorate[1] to the Minister for Health
Level 2 Accountability:	■ The Director General's accountability to the Directorate
Level 3 Accountability:	■ National Directors accountability to the Director General
Level 4 Accountability:	■ Hospital Group CEOs accountability to National Director Acute Hospitals. ■ CHO Chief Officers accountability to National Directors for Community Services
Level 5 Accountability:	■ Service Managers accountability to the relevant Hospital Group CEO or CHO Chief Officer. ■ Section 38 and Section 39 funded agencies accountability to the relevant Hospital Group CEO or CHO Chief Officer.

Section 2. Accountability suite (Plans, Agreements and Reports)

2.1 Overview

Plans

There are a number of documents that form the basis of the Accountability Framework.

- The **Corporate Plan 2015-2017** is the 3 year strategic Plan for the Health Service.
- The **National Service Plan** sets out prospectively the performance commitments of the HSE. It describes the type and volume of services which will be provided within the funding provided by Government. This Plan serves as the Contract between the HSE and the Minister for Health, against which the performance of the HSE is measured.
- **Operational Plans** are prepared for each of the HSE's service Divisions. These detailed plans, together with the Divisional component of the **National Service Plan** are the basis against which the performance of each National Director and their Division are measured and reported.

Performance Agreements

During 2016 the monitoring and management of these plans will be further strengthened through the formal **Performance Agreements** which explicitly link accountability for the delivery of the HSE's Plans to managers at each level of the organisation.

- The **National Director Performance Agreement** will be between the Director General and National Directors. (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service).
- The **Hospital Group CEO Performance Agreement** will be between the National Director Acute Hospitals and each Hospital Group CEO.

[1] Section 7 of the Health Service Executive (Governance) Act 2013 establishes the Directorate as the governing body of the HSE. The Directorate is accountable to the Minister for the performance of its functions and those of the HSE and the Director General accounts to the Minister on behalf of the Directorate through the Secretary General of the Department of Health. The current members of the Directorate are the Director General, the Deputy Director General, the Chief Financial Officer and the National Directors for Acute Hospitals, Primary Care, Social Care, Mental Health and Health and Wellbeing services.

- A single CHO **Chief Officer Performance Agreement** (covering all community services Divisions) will be put in place between the four National Directors for Primary Care, Social Care, Mental Health and Health and Wellbeing and each of the CHO Chief Officers.
- *Performance Agreements at each level, while linked to specific Divisions and service organisations, will also set out expectations in relation to integration priorities and cross boundary working.*

The Executive Management Committee (EMC) for Community HealthCare, comprising the four National Directors (i.e. Primary Care, Social Care, Mental Health, Health and Wellbeing) established in 2015 will continue in its current form in 2016. During 2015 the National Director for Social Care was appointed by the Director General to chair the Committee. These arrangements will remain in place in 2016 and be updated as relevant.

It is at this Forum that each CHO Chief Officer is held to account and the Committee is expected to oversee community services performance in a coordinated way. Individual National Directors and their teams will continue to have ongoing interactions with the CHO Chief Officers and their teams in the normal course of the business of each Division. In this context National Directors will continue to hold their Divisional meetings with each CHO in discharging their delegated accountability.

CHO Chief Officers will continue to have a single reporting relationship to the chair of the Executive Committee who is their line manager and to whom they will be accountable for the delivery of all services in their areas.

Performance reports

The HSE will also continue to retrospectively account for delivery of its services through the National **Performance Report.** This report is produced on a monthly basis by the HSE and submitted to the Department of Health. The Performance Report sets out the HSE's performance against its **National Service Plan** commitments.

The HSE also prepares an **Annual Report** which having been submitted to the Minister for Health is laid before the Houses of the Oireachtas.

2.2 Accountability Arrangements at each level

National Directors accountability to the Director General

As set out above, delivery of the National Service Plan will be measured, monitored and performance managed in 2016 through a formal **Performance Agreement** between the Director General and each National Director.

National Directors are accountable for the delivery of their Divisional component of the National Service Plan. This is reflected in the Performance Agreement. The Performance Agreement also focuses on a number of key priorities contained in the Service Plan or Operational Plan. These priorities are captured in a **Balanced Score Card** which will ensure accountability for the four dimensions of **Access** to services, the **Quality and safety** of those Services, doing this within the **Financial resources** available and by effectively harnessing the efforts of its overall **Workforce**.

The Performance Agreement also sets out the core performance expectations, accountability arrangements and escalation, support and intervention measures that will be put in place.

The **Balanced Score Card** is the basis for the Performance Agreements and Performance Management Reports to the Director General. *An extract of 2016 Acute Hospital Division Balanced Scorecard is set out in Appendix 2.*

A sample Heatmap is provided in Appendix 3.

Hospital Group CEOs/ CHO Chief Officers accountability to National Directors

The **Operational Plans** for each Hospital Group and CHO will continue to be the basis against which the performance of these service delivery organisations will be measured and reported.

Mirroring the accountability arrangements in place between the Director General and each National Director, delivery of the Hospital Group and CHO Plans will be measured, monitored and performance managed in 2016 through a formal **Performance Agreement** between the relevant National Directors and each Hospital Group CEO and CHO Chief Officer. This Performance Agreement will focus on a number of key priorities set out in the Hospital Group/ CHO Plans. The Agreement will also set out the core performance expectations and accountability arrangements between the National Directors and the Hospital Group CEOs/ CHO Chief Officers.

Performance Agreements for each Hospital Group CEO and CHO Chief Officer will set out the integration arrangements between hospital and community services.

Service Managers accountability to Hospital Group CEOs/ CHO Chief Officers

Hospital Group and CHO Plans will continue to be the basis against which the performance of each individual service is measured and reported on by the relevant Hospital Group CEO or CHO Chief Officer.

Service Arrangements and Grant Aid Agreements will continue to be the contractual mechanism governing the relationship between the HSE and each Section 38 and Section 39 Agency. Work will be undertaken during 2015 to streamline the Service Arrangement and Grant Agreement process with a particular focus on reducing the requirement for multiple Agreements for single national agencies.

Section 3. Accountability processes

The HSE's Accountability Processes for 2016 are described below.

HSE corporate accountability to the Minister

National Performance Oversight Group

The National Performance Oversight Group as a sub Group of the Directorate will continue to be the principal performance accountability mechanism in the HSE.

As part of the strengthened accountability arrangements for 2016 the following arrangements apply

- National Directors will continue to be directly accountable to the Director General for their performance and that of their Divisions.
- The **National Performance Oversight Group** will continue to have formal delegated authority from the Director General to serve as a key accountability mechanism for the health service and to support him and the Directorate in fulfilling their accountability responsibilities.
- It is the responsibility of the **National Performance Oversight Group** as a part of the overall accountability process to hold each National Director as the head of their Division to account for performance against the National Service Plan, under the four Balanced Score Card quadrants of **Quality and Safety, Finance, Access** and **Workforce.**
- The standing membership of the Group will continue to be the;
  - Deputy Director General (Chair)
  - Chief Financial Officer
  - National Director Quality Assurance and Verification
  - National Director Human Resources.
- The **National Performance Oversight Group** will meet with each National Director for services (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service) on a monthly basis to review the performance of their Division against the National Service Plan.
- The **Directorate-Leadership Team** will be the primary round table meeting to discuss the National Performance Report.
- The National Directors for Clinical Strategy and Programmes and Quality Improvement may be requested to attend the meetings of the NPOG where required.
- Other National Directors, personnel may attend as required to deal with specific performance related issues.

The main outputs from this Group are:

- Scrutiny of the Monthly **Performance Report** for submission to the Director General
- A formal **Escalation Report** in relation to serious performance issues to the Director General by the Deputy Director General which is published as part of the monthly Performance Report.

The Deputy Director General will, on the basis of the Performance Report, report on overall health service performance to the Directorate. The Directorate will then formally consider the Performance Report before its approval and submission to the Minister.

A **post National Performance Oversight Group escalation meeting** with the Director General may be requested by the Deputy DG as Chair of the Group. Depending on the performance issue being escalated, the Chair may be accompanied at this meeting by the Chief Financial Officer, the National Director for Quality Assurance and Verification and other National Directors as required.

National Directors accountability to the Director General

The Director General will formally review the delivery of the **National Director Performance Agreement** at monthly **Performance Review Meetings** with individual National Directors. The Director General may also convene an **Exceptional Performance Review** meeting to address any major issues of underperformance and in particular any issues escalated by the Chair of the NPOG.

A **Performance Agreement Report** to support the Performance Review will continue to be produced monthly. The elements of the report will include;

- Divisional component of the **National Performance Report** based on the **Balanced Score Card (BSC).** A sample *Heat Map* report is set out below and larger copy in Appendix 2)
- A formal **Escalation Report,** in relation to serious performance issues including any formal **actions** taken on foot of underperformance.

If any exceptional issues are to be addressed the Director General may request the attendance of the Deputy Director General, Chief Financial Officer, National Director HR, National Director for Quality Assurance and Verification or other National Directors.

Hospital Group CEOs and CHO Chief Officers accountability to National Directors

The National Directors for Acute Hospitals and Community Services will continue to hold formal monthly Performance Management meetings with Hospital Group CEOs/ CHO Chief Officers. These will take the form of:

Acute Hospitals

The National Director for Acute Hospital Services will formally review the delivery of the **Hospital Group CEO Performance Agreement** at monthly **Performance Review Meetings** with each individual Hospital Group CEO and members of their core teams. These will continue to be the principal accountability meetings at which progress against the **Hospital Group CEO Performance Agreement** and the **Operational Plan** with each Group CEO are reviewed.

During 2015 the National Director Acute Hospitals set out in writing the formal **Performance Management Arrangements** for his Division and agreed these with the Director General, together with his Performance Agreement. These arrangements will remain in place for 2016 and be updated as relevant.

Community Services

The **Community Services Executive Management Committee** will formally review the delivery of the **CHO Chief Officer Performance Agreement** at monthly **Performance Review Meetings** with each CHO Chief Officer and members of their core teams. These will continue to be the principal accountability meetings at which progress against the **CHO Chief Officer Performance Agreement** and the **Operational Plans** are reviewed.

The output of these meetings will form part of the Divisional Component of the National Performance Report.

National Directors and their Divisions will continue to have ongoing interactions with the CHO Chief Officers and their teams in the normal course of the CHOs' business.

During 2015 each of the National Directors for Community Services set out in writing the formal **Performance Management Arrangements** in place for their Division and in relation to their interactions with the CHOs. These were coordinated by the Chair of the Community Services Executive Committee and agreed with the Director General, together with their Performance Agreements. These arrangements will remain in place for 2016 and be updated as relevant.

National Ambulance Service

The National Director with responsibility for the National Ambulance Service will formally review the delivery of Ambulance Services at monthly **Performance Review Meetings** with the Director of the National Ambulance Service and members of his core team. This will continue to be the principal accountability meeting at which progress against the **National Ambulance Service Operational Plan** will be reviewed.

During 2015 the National Director with responsibility for the National Ambulance Service set out in writing the formal **Performance Management Arrangements** for the National Ambulance Service and agreed these with the Director General, together with his Performance Agreement. These arrangements will remain in place for 2016 and be updated as relevant.

Service Managers accountability to Hospital Group CEOs / CHO Chief Officers

Each Hospital Group CEO and CHO Chief Officer will continue to hold a formal monthly performance management process with their next line of managers. It is expected that any deviations from planned performance will be addressed at this level in advance of the Hospital Group or CHO Performance Management meetings with the National Directors.

Section 38 and 39 Agencies accountability to Hospital Group CEOs / CHO Chief Officers

The HSE provides funding of more than €3 Billion annually to the non statutory sector to provide a range of health and personal social services. The **Service Arrangement** or **Grant Aid Agreement** will continue to be the principal accountability agreement between the Hospital Group CEOs and CHO Chief Officers and Section 38 and 39 funded Agencies. There will be a named manager responsible for managing the contractual relationship with each individual agency. The level of seniority will reflect the level of funding provided. This person will be responsible for overseeing the negotiation of the Service Arrangements or Grant Aid Agreements including specific service specification, financial and quality schedules etc. They are also responsible for monitoring the performance and financial management of the specified agreement.

Section 4. Escalation and Intervention Framework 2016

4.1 Purpose

This section sets out the arrangements in place for 2016 between the National Performance Oversight Group (NPOG) and National Directors for identifying and responding to areas of underperformance in relation to service delivery, quality and safety of care, financial management and HR. Its objective is to support the Director General and the Directorate by ensuring that potentially serious issues and areas of underperformance are identified as early as possible and addressed effectively.

It reflects how information will be exchanged and used in a timely manner, the triggers and prompts for escalation and intervention, and where responsibility sits for each level of escalation.

This Framework is intended to be a dynamic process that will be reviewed on an ongoing basis in order to reflect any changes required as the system matures and develops.

4.2 Performance

One of the important elements of the HSE's strengthened accountability arrangements is a requirement that Managers at each level ensure that any issues of underperformance are **identified and addressed at the level where they occur**.

Performance will be measured against the four quadrants of the Balanced Score Card of **Quality and Safety**, **Access**, **Finance** and **Workforce**.

4.3 Underperformance

In the context of the Escalation and Intervention Framework underperformance includes performance that:

- Places patients or service users **at risk**
- **Fails** to meet the **required standards** for that service
- **Departs** from what is considered **normal practice**

Where the measures and targets set out in these areas are not being achieved, this will be considered to be *'underperformance'*.

Escalation can be described as the increased and intensified application of focus and scrutiny on a particular area of underperformance in order to improve performance.

The Escalation Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels.

It is recognised that underperformance may be minor to severe and may be temporary or persistent. Any formal designation of service underperformance will recognise these conditions. Each Divisional National Director will be required therefore as part of

the enhanced Accountability Framework 2016 to agree an overall set of thresholds and 'tolerance levels' against which underperformance issues will need to be escalated to a number of different levels which are described below.

An issue that requires escalation can start in any part of the organisation and this process ensures that Service Managers, Hospital Group CEOs, Chief Officers of Community Healthcare Organisations and National Directors provide assurance or escalate issues in accordance with the processes set out in this document.

Where escalation occurs, the accountability arrangements in place will require the relevant senior manager to ensure that appropriate interventions are commissioned and implemented.

4.4 Escalation Process

Each National Director is responsible for maintaining appropriate governance arrangements for their Division to ensure that it is operating effectively and delivering quality and safe care to patients.

The objective of the National Performance Oversight Group is to co-ordinate their work programme on behalf of the Directorate to seek assurance on the safe, effective and efficient delivery of services. Issues arising will normally be dealt with by National Directors through their normal reporting channels of Hospital Groups and the Executive Management Committee.

The following sections describe the formal performance escalation process as part of the Accountability Framework 2016 and outline the process in terms of:

- Responsibilities at each level of performance and escalation
- The thresholds and tolerances for underperformance services for red escalation (to NPOG) for a number of priority measures
- The type of supports, interventions and sanctions to be taken at each escalation level

4.5 Escalation Levels

The National Performance Oversight Group has developed a **4 point Escalation Framework** from Level 1 (Yellow) to Level 4 (Black) which will be used to escalate issues and incidents as required.

- **Level 1 (Yellow)** is at Hospital Group CEO or Chief Officer CHO level
- **Level 2 (Amber)** is at National Director level
- **Level 3 (Red)** is at National Performance Oversight Group level
- **Level 4 (Black)** is at Director General level.

Table 1 sets out the four escalation levels that will apply, including the characteristics of Divisions or services at each level of escalation, the nature of likely supports, interventions and sanctions available to Divisions to help them to improve performance.

Table 1 aims to provide more clarity for National Directors and the health services about what it means to be at each level of escalation, and to ensure greater consistency in the approach of the NPOG to supporting and intervening Divisions. Section 4.6 provides more detail on each level of escalation and intervention, including performance triggers.

It is important to note that escalation and de-escalation through the levels outlined below may not be sequential and, in the case of financial underperformance, will be differentiated according to performance rating.

- The initial intervention and the level of escalation will be based on the seriousness of the performance issue, the likelihood of rapid deterioration and the magnitude of the issue
- There may be circumstances where the issue is so serious that it merits Red or Black escalation in the first instance or where the level of intervention moves directly from Level 2 to Level 4
- The rate of de-escalation will be determined by an assessment of the complexity of the underlying issues and of the likelihood that the recovery plan will be sustained over time
- The period for KPIs to show improvement after implementation of Corrective or Remedial Plan may require more than one month's data before escalation to a higher level applies
- If an area of underperformance in red escalation demonstrates sustained improvement over a period of three consecutive months, a status of red-amber will apply to reflect these improvements.

4.6 How does escalation occur

The HSE's Accountability Framework 2016 enables the National Performance Oversight Group to seek assurance, on behalf of the Director General, that National Directors are delivering against priorities and driving up standards. As part of this, there is a range of performance indicators against which Divisional performance is monitored. If there is an indication that health services are underperforming, the National Performance Oversight Group will explore this with the relevant National Director and, where issues are identified, the National Director will be required to take remedial action.

The National Director will be expected to attend the monthly performance review meetings having scrutinised the data for their Division, identified any areas of underperformance requiring Red Escalation to the National Performance Oversight Group and assure the NPOG that remedial actions have been put into place to address these areas of concern.

Where data is available on a more frequent basis, for example weekly urgent colonoscopy data, the National Director will be required to escalate areas of concern to the NPOG **at the point of knowledge**. National Directors should not wait for the monthly performance review meetings to escalate such concerns.

From time to time issues will arise which the National Performance Oversight Group need to be informed of in a timely manner and therefore a mechanism for briefing the National Performance Oversight Group outside of the monthly meetings needs to be in place.

Material issues of concern in relation to performance that arise outside of the monthly National Performance Oversight Group meetings should be **escalated to the Chair and Deputy Director General** who will decide whether a Red Escalation needs to be

triggered. If necessary, the Chair may decide an extraordinary National Performance Oversight Group meeting is required to discuss the issue. Triggers for identifying reportable issues via this route include but are not limited to:

- Urgent 28 day colonoscopy breaches
- Patients on trolleys in the ED for greater than 24 hours
- Notifications from regulators

The National Performance Oversight Group has the discretion to recommend additional remedial actions if and when required. This is in accordance with the Accountability Framework 2016.

Level 1 Yellow Escalation – Concern across several areas

Hospital Group CEO or Chief Officer CHO Level

Performance Trigger: Continued failure to achieve or maintain one or more **key deliverables**.

Description: Level 1 Yellow Escalation indicates a concern or concerns that require investigation by the CEO of the Hospital Group or the Chief Officer of the relevant Community Healthcare Organisation. It is likely that this level of escalation will be instigated following persistent performance issues of a material nature that may span one or more areas. It may also be where the CEO Hospital Group or Chief Officer CHO lacks confidence in recovery plan(s) of the service(s) in question.

Escalation Action The CEO Hospital Group or Chief Officer CHO will be actively involved in determining the necessary supports and interventions in order to deliver the required outcomes / improvements.

Support: Support focused on improvement on specific issues and recovery plans

Interventions: Intervention is likely to be focused on supporting improvement in particular areas, but broader intervention can be deployed. Interventions are likely to include the development and implementation of remedial action plans.

Sanctions: No sanctions are likely at this level of escalation

De-escalation Sustained improvement of KPIs causes removal of escalation actions.

Accountability: Accountability at this level of escalation is through the relevant Hospital Group CEO or the Chief Officer of the Community Healthcare Organisation. The involvement of the National Performance Oversight Group is **not required**

Thresholds and tolerances will be reviewed in light of the NSP2016 and agreed with National Directors

Level 2 Amber Escalation– Concern requiring step up investigation

National Director Level

Performance Trigger: Continued failure to achieve or maintain one or more key deliverables and or lack of confidence in recovery plans following yellow escalation where intended benefits have not materialised.

Description: Level 2 Amber Escalation indicates a concern or concerns that require investigation by the National Director. The involvement of the National Performance Oversight Group is **not required.**

Escalation Action The National Director will be actively involved in determining the necessary supports and interventions in order to deliver the required outcomes / improvements.

Supports: Supports focused on improvement on specific issues and recovery plans.

Interventions: The National Director will require the Hospital Group CEO or Chief Officer CHO to undertake an in-depth assessment and formally meet with the National Director to present options to redress the problem and a detailed recovery plan and timetable for resolution. A schedule of meetings will be set to monitor progress of the recovery plan.

Sanctions: No sanctions likely at this level of escalation.

De-escalation Sustained improvement of KPIs causes removal of escalation actions.

Accountability: Accountability at this level of escalation is through the relevant National Director. If the National Performance Oversight Group is confident that underperformance on a given indicator has been appropriately understood and is being addressed at National Director, Hospital Group and CHO level, **no discussion is needed**. This will increase the time available for areas where the NPOG needs more assurance.

Thresholds and tolerances will be reviewed in light of the NSP2016 and agreed with National Directors

Level 3 Red Escalation – Material Issue or Serious Concern

National Performance Oversight Group Level

Performance trigger: Continued failure and or a failure to maintain an agreed improvement trajectory following Amber Escalation and intervention or an issue of serious concern in its own right.

Concerns may be triggered by a single event or a combination of factors which may relate to areas across the Balanced Scorecard such as:

- Issues relating to the Quality and Safety of Care
- Underperformance on issues relating to access to services which ultimately impact on the quality of care
- Underperformance in relation to financial management
- Issues of concern in respect of HR and Workforce Planning

Description: A serious concern to service delivery, quality and safety of care and or organisational effectiveness arises when the severity, frequency or persistence of problems appear to exceed that which can be dealt with through routine arrangements.

Escalation: Divisions or services in Red Escalation will be subject to a set of specific interventions designed to rapidly improve performance or the quality of care. The NPOG will intensify its engagement with the National Director. While the interventions and support brought to bear during this process will reflect the circumstances and needs of the Division, there are a small number of interventions which will apply to every service or Division placed in Red Escalation including the development of a clear formal improvement plan to address the issues raised, with clear timelines for improvement.

Supports: Supports at this level of escalation may include:

- Partnering with a high performer as a 'buddy' arrangement as a source of support and advice
- Requesting additional reporting and information
- Formal Improvement Plan for submission to and approval by the NPOG

Interventions: Interventions may include:

- The appointment of an Improvement Lead or Director working on behalf of the HSE and working with services escalated to red, accountable to the Hospital Group CEO/ Chief Officer for a defined period.
- Full Governance Review and independent diagnostic report
- Convening special meetings whereby the NPOG meets the Hospital Group or CHO Senior Management Team. This would be a very formal meeting to go through the full performance.

Sanctions: Sanctions may include

- Issuing of a formal performance notice to the relevant National Director specifying the performance improvement expectation, timeframe, accountability arrangements and consequences where there is insufficient improvement.

Financial sanctions will be differentiated according to the performance rating and may include the following:

- Group CEO or Chief Officer authority to recruit is restricted to certain grades
- Non-core replacement posts required advanced National Director approval based on submission of business case and approval of same

Red Escalation will be a time-limited period, the expectation being that National Directors – with the support of the NPOG – will make the necessary improvements within a specified time or until such a time when the escalation level reduces downwards.

De-escalation: Maintenance of agreed improvement trajectories causes return to escalation level 2 Amber Escalation.

Accountability: Accountability at this level of escalation is through the National Performance Oversight Group

Thresholds and tolerances will be reviewed in light of the NSP2016 and agreed with National Directors

How to assure this level of escalation

- Ensure causes fully explain underperformance and question whether these might have been foreseen
- Gain appropriate reassurance that corrective actions will address the issues highlighted and will prevent reoccurrence in the medium and longer term
- Question the levels of control in the system if performance is showing significant fluctuations
- Ensure the timeline for projected improvement is realistic and achievable
- Clear understanding of the information required and the learning from that information

The priority measures and trigger points for Red Escalation to the National Performance Oversight Group have been identified in relation to each Division in Appendix 1.

Level 4 Black Escalation – 'Performance Watch'

Director General Level

Performance Trigger: The Black Escalation level process will apply to National Directors who, within their Division, have serious failures in their quality of care and/ or financial performance, along with concerns that the existing leadership cannot make the necessary improvements without intensive oversight and support. .

Escalation: Black Escalation can be triggered by the Director General following a recommendation by the National Performance Oversight Group or where serious issues of concern are escalated in their own right.

Supports: Supports at this level of escalation are similar to those at Red Escalation level however the intensity of these supports are enhanced. They may include:

- Increasing the frequency of engagement between the National Director, the NPOG and the Director General
- Weekly reporting on recovery plans and progress to improve performance
- Partnering with a high performer as a 'buddy' arrangement as a source of support and advice

Interventions: The Director General will determine the appropriate course of action to be taken to redress the problem on a case by case basis. The course of action will be tailored to the specific circumstances of the non-performing area and may involve one or more of the following actions:

- Formal Improvement Plan for submission to and approval by the DG
- **Full Governance Review**. This is when a senior manager with considerable experience within the system spends three to four days on site interviewing board and staff members as well as patients and stakeholders. An independent diagnostic report is compiled as a result of this Governance Review
- **Convening of special performance meetings**. The NPOG and DG meets the whole Hospital Group or CHO Senior Management Team. This would be a very formal meeting to go through the full performance. .
- The appointment of an **Improvement Lead or Director** working on behalf of the HSE and accountable to the Hospital Group CEO or CHO Chief Officer.

Sanctions: Sanctions that may be imposed by the Director General may include:

- Invoking the disciplinary process up to and including the removal from post of the National Director, Hospital Group CEO or Chief Officer.

- Financial sanctions will be differentiated according to performance rating:
    - Removal of authority/ autonomy in relation to staffing – in line with the National Framework issued jointly by the CFO and National director Human resources
    - Increased monitoring of implementation of cost reduction plans as directed by the Director General
    - Restriction imposed on sites, groups or personnel in participation in 'additional activities' to facilitate focus on reducing deficits
    - Year end deficits to be considered in the context of first charge principle set out in 2013 legislation to disestablished HSE Vote

De-escalation: Maintenance of agreed improvement trajectories causes return to escalation level 3 Red Escalation.

Accountability: Accountability at this level is through the Director General

Table 1: Summary Performance Escalation Levels for 2016 detailing supports, interventions, sanctions and accountability

Level	Name	Characteristics of Divisions/ services in this category	Support	Intervention	Sanction	Accountability
1	Yellow Escalation	Continued failure to maintain or achieve one or more key deliverables. Concern or concerns that require investigation by the Hospital Group CEO or CHO Chief Officer.	Support focused on improvement on specific issues and recovery plans	Intervention likely to be focused on supporting improvement in particular areas, but broader intervention can be deployed	No sanctions likely at this level of escalation	Through HG CEO/ Chief Officer CHO
2	Amber Escalation	Continued failure to achieve or maintain one or more key deliverables and or lack of confidence in recovery plans following yellow escalation where intended benefits have not materialised.	Support focused on improvement on specific issues and recovery plans	Intervention likely to be focused on supporting improvement in particular areas for example: • An assessment of the factors contributing to underperformance • Development of a detailed recovery plan with a timetable for resolution • Increased frequency of engagement and enhanced monitoring	No sanctions likely at this level of escalation	Through Divisional National Director
3	Red Escalation	Continued failure and or a failure to maintain an agreed trajectory following Amber escalation or an issue of serious concern in its own right. A serious concern to service delivery, quality and safety of care and or organisational effectiveness arises when the severity, frequency or persistence or problems appear to exceed that which can be dealt with through routine arrangements.	• Increased frequency of engagement with relevant National Director • Partnering with a high performer as a 'buddy' arrangement to provide advice and support • Requesting additional reporting and information • Formal Improvement Plan for submission to NPOG	• The appointment of an Improvement Lead who will have presence on the ground and sit on the HG or CHO senior management team. • Full Governance Review and independent diagnostic report is compiled • Special meetings, whereby the NPOG meets the HG or CHO Senior Management Team. This would be a very formal meeting to go through the full performance.	• Issuing of a formal performance notice to the National Director specifying the performance improvement expectation, timeframe, accountability arrangements and consequences where there is insufficient improvement • Financial sanctions will be differentiated according to the performance rating and is likely to include restrictions on recruitment and non-core replacement of posts without advanced approval	Through National Performance Oversight Group

Level	Name	Characteristics of Divisions/ services in this category	Support	Intervention	Sanction	Accountability
4	Black Escalation	Serious failures in the quality of care and or financial performance, along with concerns that existing leadership cannot make the necessary improvements without intensive oversight and support.	• Increased frequency of engagement between the DG, NPOG and National Director • Weekly reporting on recovery plans and progress to improve performance • Partnering with a high performer as a 'buddy' arrangement to provide advice and support	• Formal Improvement Plan for submission to and approval by DG and which will be discussed with DPER at monthly meetings • Full Governance Review and independent diagnostic report is compiled • Special meetings, whereby the NPOG and DG meets the HG or CHO Senior Management Team. This would be a very formal meeting to go through the full performance. • The appointment of an Improvement Lead who will have presence on the ground and sit on the HG or CHO senior management team.	• Invoking the disciplinary process up to and including the removal from post of the National Director, Hospital Group CEO or Chief Officer In respect of poor financial performance, sanctions will be differentiated according to the performance rating and will be led by the CFO: • Removal of authority/ autonomy in relation to staffing, in line with the National Framework issued jointly by the CFO and National Director HR • Restriction imposed on sites, groups or personnel in participation in additional activities to facilitate focus on reducing deficits • Year end deficits to be considered in the context of first charge principle	Through Director General

Appendices

KPIs Targets and Thresholds for Red and Black Escalation
Sample Balanced Score Cards
Sample Performance Report (Heatmap)

Appendix 1- Key Performance Indicator (KPIs), Targets and Thresholds for Red and Black Escalation

Targets and Thresholds for Escalation for Selected Priority KPIs								
BSC Quadrant	Division	Key Performance Indicators	Target	Level 4 Black Escalation (DG)	Level 3 Red Escalation (NPOG)	Level 2 Amber Escalation (Nat Dir)	Level 1 Yellow Escalation (HG CEO or Chief Officer CHO)	Business As Usual (No escalation)
Quality	All Divisions	Serious Reportable Event [2]- 'No Event Declaration'		Cannot be provided to the NPOG	Cannot be provided to the National Director QAV	Cannot be provided to the National Director	Cannot be provided to the HG CEO/ CHO CO	
Quality	All Divisions	% SREs notified within 24 hours to Senior Accountable Officer and entered on the NIMS	99%	<80%	<85%	<90%	<95%	<97%
Quality	All Divisions	% investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	90%	<70%	<80%	<85%	<85%	<89%
Quality	All Divisions	% of complaints investigated within 30 working days of being acknowledged by complaints officer	75%		Any complaint not investigated within 60 days			
Quality	Mental Health	Admission of children to CAMHs Acute Inpatient Units as a % of total admissions of children to mental health acute inpatient units	95%		<95%			

[2] SREs of themselves do not get escalated through the NPOG. This happens through the safety incident management process and system

Targets and Thresholds for Escalation for Selected Priority KPIs								
BSC Quadrant	**Division**	**Key Performance Indicators**	**Target**	**Level 4 Black Escalation (DG)**	**Level 3 Red Escalation (NPOG)**	**Level 2 Amber Escalation (Nat Dir)**	**Level 1 Yellow Escalation (HG CEO or Chief Officer CHO)**	**Business As Usual (No escalation)**
Access	Acute Hospitals	% of people waiting > 4 weeks for an urgent colonoscopy	0%		1 breach (Zero tolerance)			
Access	Acute Hospitals	% of people waiting > 13 weeks for a routine colonoscopy/ OGD	<30%		>30%			
Access	Acute Hospitals	Symptomatic Breast – Urgent seen within 2 weeks	95%	Red escalation for 3 consecutive months	Hospital or HG <80% for 2 consecutive months or missing data for 2 consecutive months			
Access	Acute Hospitals	Lung Service - patients to be seen within 10 working days Prostate Cancer - patients to be seen within 20 working days	95% 90%	Red escalation for 3 consecutive months	Hospital or HG <80% for 3 consecutive months or missing data for 2 consecutive months			
Access	Acute Hospitals	Radiotherapy - The number of patients who completed radical treatment for primary cancer, and for those the number whose interval from ready to treat to date of first fraction was ≤15 working days	90%		If the hospital or HG falls below <75% for 3 consecutive months or has missing data for 2 consecutive months			
		No of people subject to delayed discharges	< 500 overall 0 >90 days		Discharge delayed by >90 days			
Access	Acute Hospitals	No patient should wait on a trolley in ED for > 24 hours	0		1 breach (Zero tolerance)			
Access	Acute Hospitals	% of ambulances that have a time interval of 60 minutes from arrival at ED to when the ambulance crew clears the readiness of the ambulance to accept another call	100%		Any ambulance not released within 3 hrs or 1 hospital holding more than 1 ambulance for > 2 hours at any one time	> 3 hours		

Targets and Thresholds for Escalation for Selected Priority KPIs								
BSC Quadrant	**Division**	**Key Performance Indicators**	**Target**	**Level 4 Black Escalation (DG)**	**Level 3 Red Escalation (NPOG)**	**Level 2 Amber Escalation (Nat Dir)**	**Level 1 Yellow Escalation (HG CEO or Chief Officer CHO)**	**Business As Usual (No escalation)**
Access	Acute Hospitals	% adults waiting > 15months for an elective procedure % children waiting > 20 weeks for an elective procedure % people waiting > 52 weeks for first access to OPD	<5% <40% <15%		> 5%			
Access	Social Care	NHSS – Wait Times for Fair Deal approval	4 weeks		Any client waiting > 20 weeks			
Access	Social Care	Disability Act Compliance: % of assessments completed within the timelines as provided for in the regulations	100%		<50%			
Access	Primary Care	% of completed Medical / GP visit card applications processed within the 15 days	95%		Any client waiting > 3 months			
Access	Primary Care	Reduce the proportion of patients on the orthodontic treatment waiting list longer than 4 years (grade IV and V)	<5%		>10%			
Access	Palliative Care	Inpatient Units Waiting Times Access to specialist inpatient bed within 7 days	98%		Any patient waiting > 14 days			
Access	Mental Health	CAMHS: Total number on waiting list for a first appointment waiting> 12 months	0%		Any patient waiting > 12 months			
Finance	All Divisions	Projected net expenditure to year end	Break Even	Projection for overall Division is deficit above .75% or Projection for overall HSE is deficit above .33%	Projection for overall Division is deficit less than .33%			

Targets and Thresholds for Escalation for Selected Priority KPIs								
BSC Quadrant	**Division**	**Key Performance Indicators**	**Target**	**Level 4 Black Escalation (DG)**	**Level 3 Red Escalation (NPOG)**	**Level 2 Amber Escalation (Nat Dir)**	**Level 1 Yellow Escalation (HG CEO or Chief Officer CHO)**	**Business As Usual (No escalation)**
HR	All Divisions	EWTD shifts <24 hours (Acute and Mental Health) EWTD<48 hour working week (Acute and Mental Health)	100% 95%					

Appendix 2

Balanced Scorecard Acute Services *sample*

Quality and Safety

Service User Experience

- Complaints
- Compliments

Safe Care

- Serious Reportable Events
- Safety Incident Reporting
- % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals
- % of maternity units / hospitals with implementation of IMEWS
- % of hospitals with implementation of IMEWS for pregnant patients
- % maternity units which have completed and discussed Maternity Patient Safety Statements at Hospital Management Team each month
- **Healthcare Associated Infections (HCAI)**
- **Colonoscopy / Gastrointestinal Service**

Effective Care

- **Stroke**
- **Acute Coronary Syndrome**
- **Re-admission**
- **Surgery**
- **Emergency Care and Patient Experience Time**
- **Average Length of Stay**
- **Symptomatic Breast Cancer Services**
- **Lung Cancers**
- **Prostate Cancers**

Access

- **Discharge Activity**
- **Outpatients**
- **Inpatient, Day Case and Outpatient Waiting Times**
- **Colonoscopy / Gastrointestinal Service**
- **Emergency Care and Patient Experience Time**
- **Delayed Discharges**
- **Acute Medical Patient Processing**
- **Symptomatic Breast Cancer Services**
- **Lung Cancers**
- **Prostate Cancers**
- **Radiotherapy**

Finance

Budget Management including savings

Net Expenditure variance from plan (budget)

- Pay - Direct / Agency / Overtime
- Non-pay
- Income
- Acute Hospital private charges – Debtor Days – Consultant Sign-off
- Acute Hospitals private income receipts variance from Actual v Plan

Service Arrangements/ Annual Compliance Statement

- % of number and monetary value of Service Arrangements signed
- % of Annual Compliance Statements signed

Capital

- Capital expenditure versus expenditure profile

Key Result Areas – Governance and Compliance (Development focus in 2015)

Internal Audit

- No of recommendations implemented, against total number of recommendations within 6 /12 months of report being received

Human Resources

Absence

- % of absence rates by staff category

Staffing Levels and Costs

- Variance from HSE employment threshold (within approved funding levels)

Compliance with European Working Time Directive (EWTD)

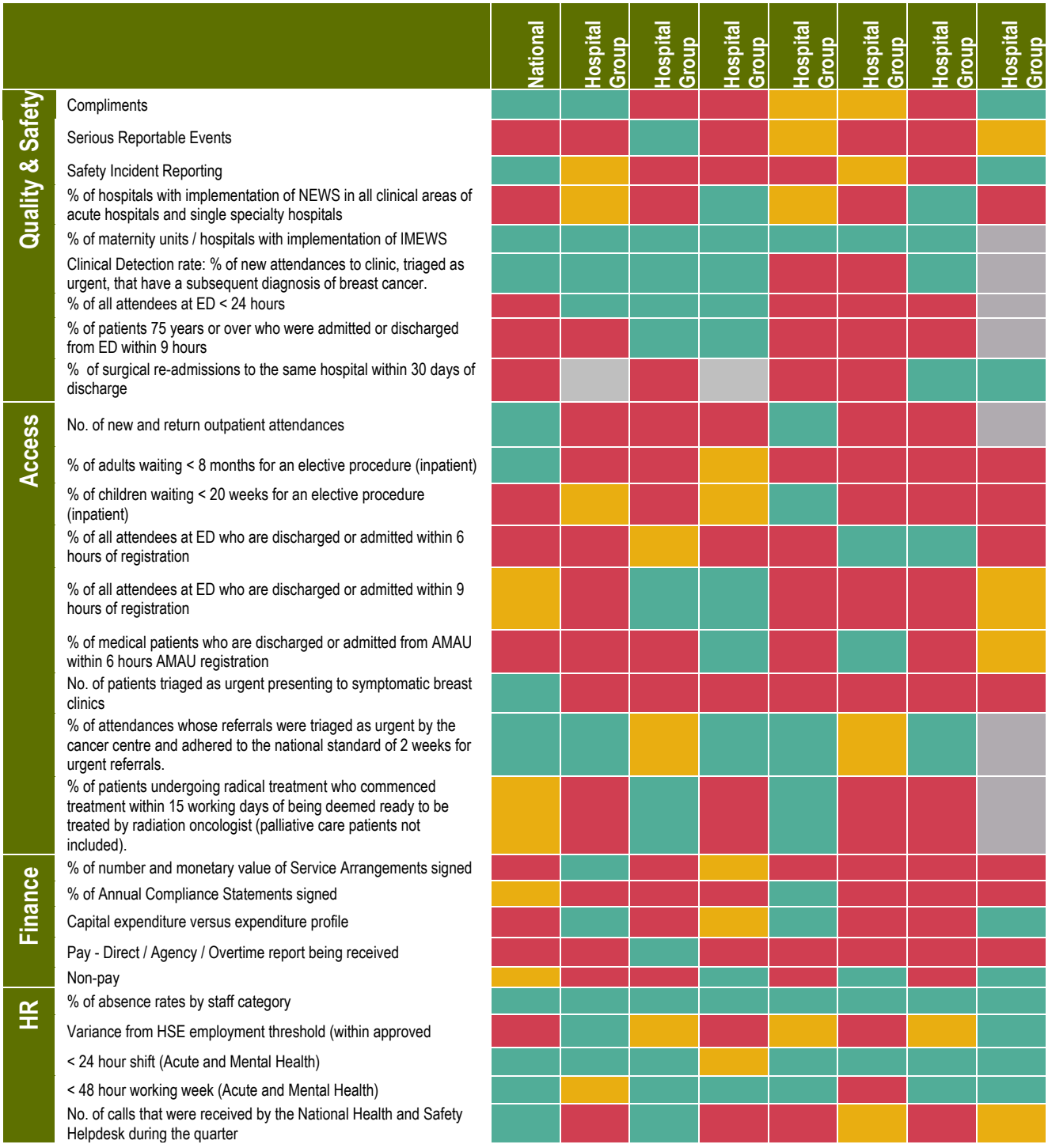
- < 24 hour shift (Acute and Mental Health)
- < 48 hour working week (Acute and Mental Health)

Health and Safety

- No. of calls that were received by the National Health and Safety Helpdesk during the quarter

Appendix 3

Acute Services Heatmap *sample*



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