Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

UL Hospitals Group Operational Plan

2017

Building a Better Health Service

CARE COMPASSION TRUST LEARNING

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Operational Plan 2017 Acute Hospital Division

Introduction

	2017 Available Budget €m	2016 Budget €m
UL Hospitals Group	€277.730m	€279.540m

The demand for acute hospital services continues to increase in line with a growing and ageing population. The Hospital Groups continue to implement the Securing the Future of Smaller Hospitals: A Framework for Development. This will ensure that all hospitals irrespective of size work together in an integrated way to meet the needs of patients and staff, with an increased focus on small hospitals managing routine or planned care locally and more complex care managed in the larger hospitals.

Acute hospital services will continue to respond to demographic and demand driven cost pressures in 2017. An estimated increase of 1.7% in costs associated with increasing population and age profile is predicted for acute hospitals in 2017 compared with 2016. In addition, an increase in ED presentations of 5% is evident at the end of 2016, compared to the same period in 2015. The division will monitor this activity closely and manage the potential impact on elective services.

Acute hospital services aims to provide safe, quality, effective patient centred care to all service users.

Acute Hospital Division Priorities 2017

- Embed robust structures within Hospital Groups to provide direct support to the smaller hospitals in the group in line with the development of the Hospital Group strategic plan
- Enhance and build capacity of quality and patient safety across hospitals
- Continue to develop a system to report hospital safety statements in conjunction with Hospital Group CEOs and Clinical Directors.

UL Hospital Group

Introduction

University of Limerick (UL) Hospital Group is comprised of a group of six hospitals functioning collectively as a single hospital system in the Mid-West of Ireland. The six sites include:

University Hospital Limerick (UHL)

St. Johns Hospital Limerick (SJHL)

University Maternity Hospital (UMHL)

Nenagh Hospital (NH)

Croom Hospital (CH)

Ennis Hospital (EH)

University Hospital Limerick is the Model 4 hospital for the region providing major surgery, cancer treatment and care, emergency department services, as well as a range of other medical, diagnostic and therapy services. It is where all critical care services are located in addition to a 24/7/365 Emergency Department and it is a designated cancer centre. UHL is one of the busiest Emergency Departments in Ireland with over 64,000 (new and return) patients annually.

Emergency and complex surgeries are only undertaken at UHL. The hospital is the hub for Ennis hospital, Nenagh hospital and St. John's hospital which manage the majority of their local population through their medical assessment units and inpatient beds.

Patients who require access to critical and complex care are seen at University Hospital Limerick and either stabilised and transferred to a local Model 2 hospital, namely Ennis or Nenagh or admitted to UHL if required. Croom Hospital is part of the UL Hospitals group. It is the dedicated orthopaedic hospital for adults and children in the Mid-West region. Croom hospital also accepts the transfer of Orthopaedic patients from UL hospital for post-acute. In addition to Orthopaedic services, Rheumatology and Pain Management services are also provided.

University Maternity Hospital, Limerick is the second largest maternity hospital outside Dublin with approximately 4,500 births (2016) and the sole provider of obstetrical, midwifery and neonatal intensive care to the Mid-West region. It serves Limerick, Clare and Tipperary N.R. The maternity hospital also accommodates patients from outside the Mid-west region. These include women from North Cork, Tipperary, North Kerry and areas of Offaly. They also provide tertiary referral for smaller Neonatal Units from outside the region.

UL Hospitals CEO Priorities 2017

No.	Priority Actions	Persons Responsible	Target / Date
1.	Engage & Develop UL Hospitals next 3 year Strategy 2017 – 2020.	CEO & Executive	Q1
2.	Set up Academic Hub with University of Limerick focusing on all Health Sciences.	CEO & Executive	Q2-Q3
3.	Review Medicine Divisions and agree a new system of medical rotas and equal access.	CEO & CCD	Q2
4.	Grow and flourish UL Hospitals Group that attracts and retains professionals with a focus on improving NCHD educational supports.	CEO & DHR	Q3
5.	Open New Emergency Department that is aligned to new pathways that improves patient access across the services.	CEO & COO	Q3
6.	Review Department of Radiology which enhances workflow across the Group and supports Diagnostic services.	CEO & COO	Q3
7.	Review UL Hospitals approach to eHealth and enhance our ICT team function underpinned by a clear Strategy for eHealth.	CEO & Director of Informatics, Planning & Performance	Q3
8.	Progress Peri Operative Strategy to include: • Increasing surgical procedures at Nenagh & Ennis Hospital • Develop a National Centre for Robotic Surgery • Open & develop the Vascular Hybrid Theatre	CEO & CCD	Q3 & Q4
9.	Progress Capital Planning Applications for: • UL Hospitals New Maternity Hospital • 96 bed block at University Hospital Limerick	CEO	Q4
10.	Embed QRPS function across the Group with clear oversight and accountability on all aspects of QRPS.	CEO/Director IPP	Q4
11.	Agree a clear approach to Research at UL Hospitals Group with the University of Limerick and seek Research Board funding and acknowledgement.	CEO & CCD	Q3-Q4

No.	Priority Actions	Persons Responsible	Target / Date
12.	Implement Accountability Framework across the Executive & Directorates in line with National Performance requirements.	CEO	Q1
13.	Deliver on Pay & Numbers Strategy and manage costs in line with the budget.	CEO & Executive	Q1-Q4
14.	Progress the Values In Action Project across all MDT to improve culture.	CEO & Executive	Q1-Q2
15.	Progress the National Maternity Strategy.	CEO & DOM	Q1-Q4
16.	Support and Lead out on the GE 'LEAF Project' at UL Hospitals to improve efficiency.	CEO,COO, CCD	Q1-Q4

Governance UL Hospitals

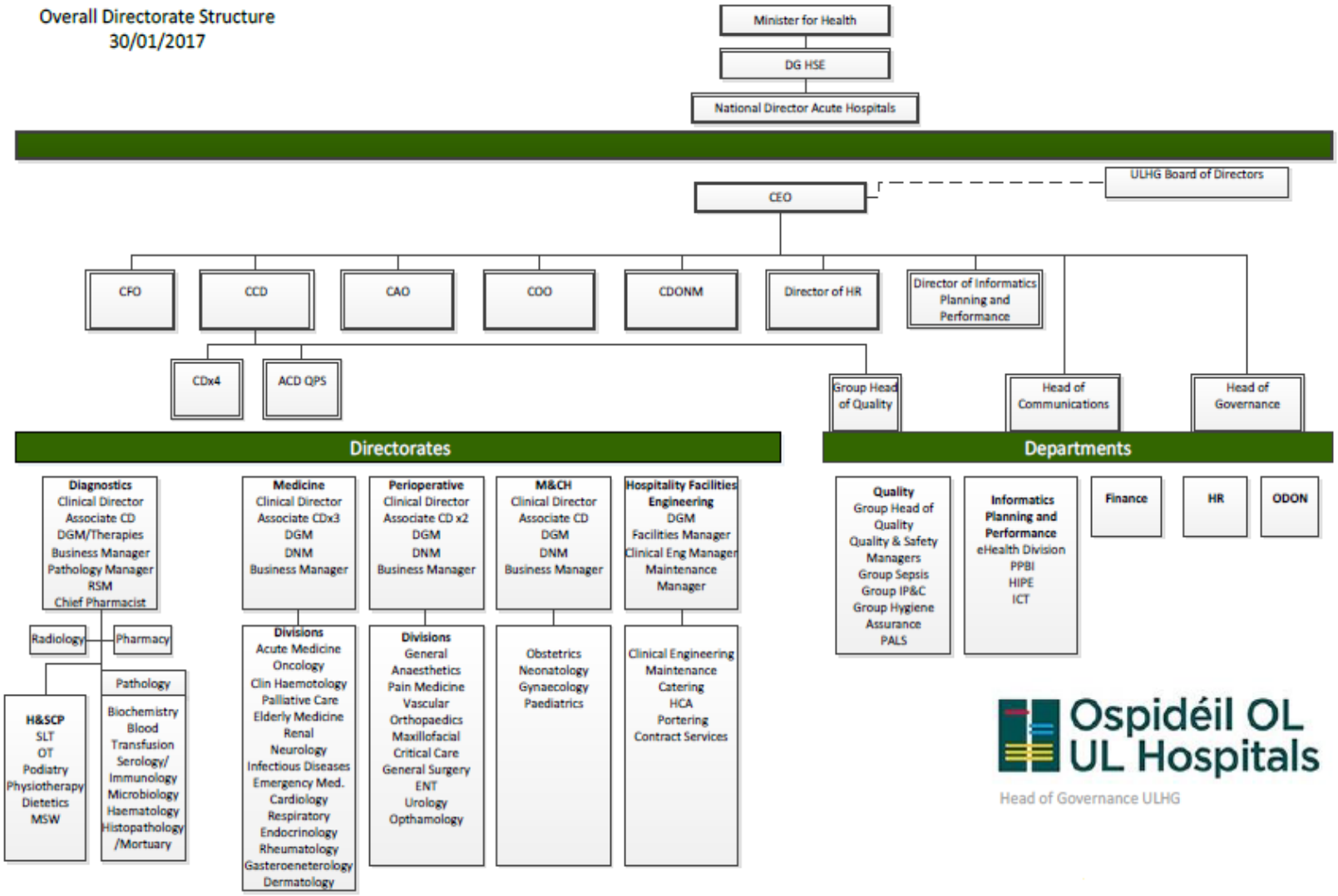
The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2017 and allocated Group budgets. The UL Hospitals Group Operational Plan 2017 is aligned with this Acute Hospitals Division overarching Operational Plan.

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

UL Hospitals is governed by an interim Board and an Executive Management Team led by a CEO who reports to the Board. Our services are delivered across the six sites under the leadership of five directorates namely, Medicine Directorate, Perioperative Directorate, Diagnostic Directorate, Maternal and Child Health Directorate and Facilities Directorate. Each Directorate is led by a team of staff bringing Clinical, Managerial and Financial expertise together to provide quality driven safe services, focused on the experience and outcomes for the patient.

Back row left to right: Mr Jim Canny, Mr Graham Knowles, Mr Michael Mulcahy SC and, seated left to right, Dr Mary Gray, Prof Niall O'Higgins (Chairman) and Mr Alec Gabbett.

Organisational Chart



Impact of Demographics on Hospitals

According to 2016 CSO Preliminary figures, the population of the Mid-West Region is 385,172. This is 1.5% higher than the 2011 reported figures. The biggest increase in population appeared to occur in Limerick City (2.1%). The population in Limerick County grew by 1.6%, North Tipperary by 1.5% and Clare saw an increase of 1.2%.

The Hospital Group serves a socially diverse population including Limerick City which is the most deprived local authority nationally with 36.8% of its inhabitants either very disadvantaged or disadvantaged (*Health Profile 2015 Limerick City*). In sharp contrast to this, Limerick County is ranked as the eight most affluent local authority area nationally with 54% of its population either being marginally above affluence or affluent (*Health Profile 2015 Limerick County*).

The national age profile particulary impacts on emergency services. Life expectancy at birth in Ireland has increased and is above the EU average of 80.9 years (*Source: Eurostat*). People are living longer through medical advances, technology along with an increased knowledge and focus on health and general well-being. According to the European Commission, ageing is one of the greatest social and economic challenges for all countries and by 2025 more than 20% of Europeans will be 65 or over with a particular rapid increase in the numbers of those aged 80 and above. Based on 2011 CSO figures, the population of over 65s was set to increase by 3.1% or 19,400 persons between 2015 and 2016 with an additional 2,900 persons over 85 years of age in 2016.

Population	Persons 2011	Persons 2016 *	Actual change 2011-2016	% change 2011-2016
Limerick City	57,106	58,319	1,213	2.1%
Limerick County	134,703	136,856	2,153	1.6%
North Tipperary	70,322	71,370	1,048	1.5%
Clare	117,196	118,627	1,431	1.2%
Mid-West	379,327	385,172	5,845	1.5%
Ireland	4,588,252	4,757,976	169,724	3.7%

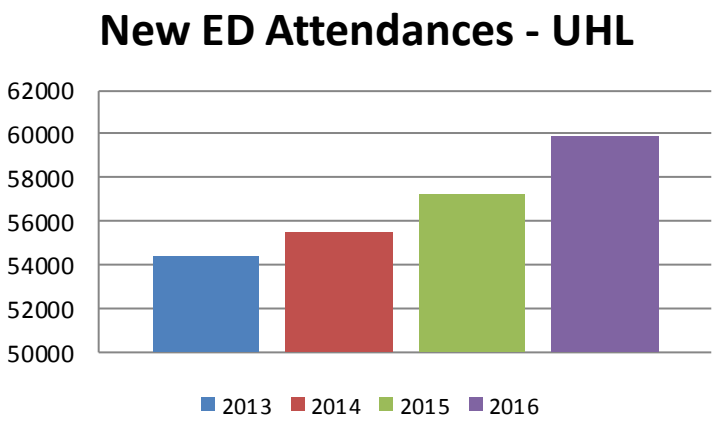
** 2016 CSO figures are Preliminary*

The challenge remains to adapt health care services, settings and models of care to adequately meet the needs of an ageing population whilst providing a safe, dignified and patient centred service at all times within allocated budgets. In addition, chronic diseases (Cardiovascular disease, Cancer, Stroke, Respiratory Disease and Diabetes) are on the rise with population projections indicating that by 2021 a further 94,580 people will have at least one chronic condition (*Tilda, 2010*) representing a 20% increase. However, due to heightened awareness, a strong leaning towards more active and healthy lifestyles along with continuing focused clinical and academic research, surviorship of chronic diseases in Ireland is also increasing which is a postive and welcome transition.

2016 Activity

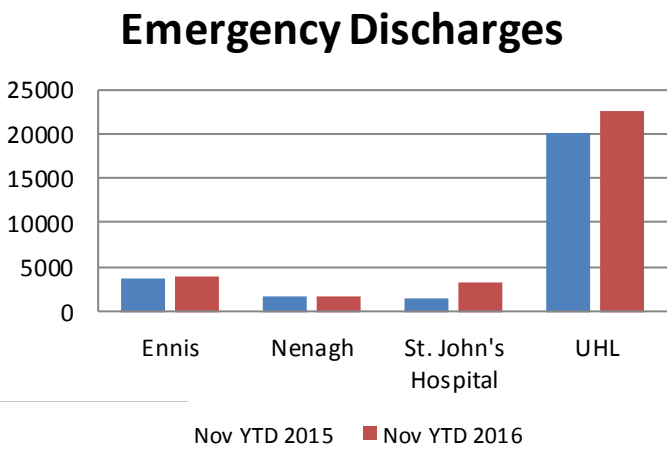
Unscheduled Care

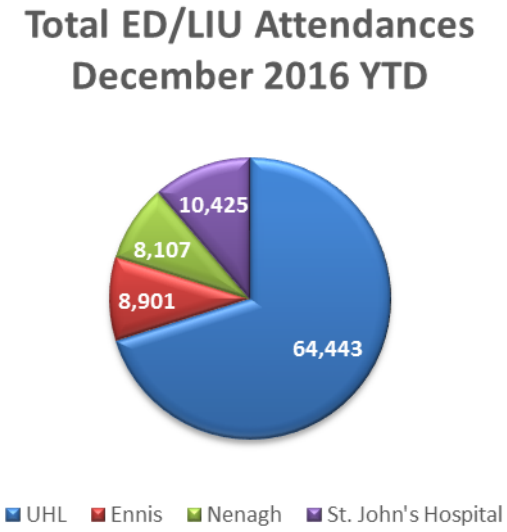
In 2016 (December 2016 YTD) there was a 4.6% increase in the number of new patients presenting to the Emergency Department in University Hospital Limerick (59,950 YTD December 2016 up from 57,297 YTD December 2015). The Local Injury Units (LIU) within UL Hospitals Group also saw an overall increase in patients of 2.5% when compared to the same period last year (YTD Dec 2016 v YTD Dec 2015).



The result of this pressure on emergency services was a 16.9% year on year rise in the number of emergency discharges (YTD Nov 2015 v 2016) across the Group.

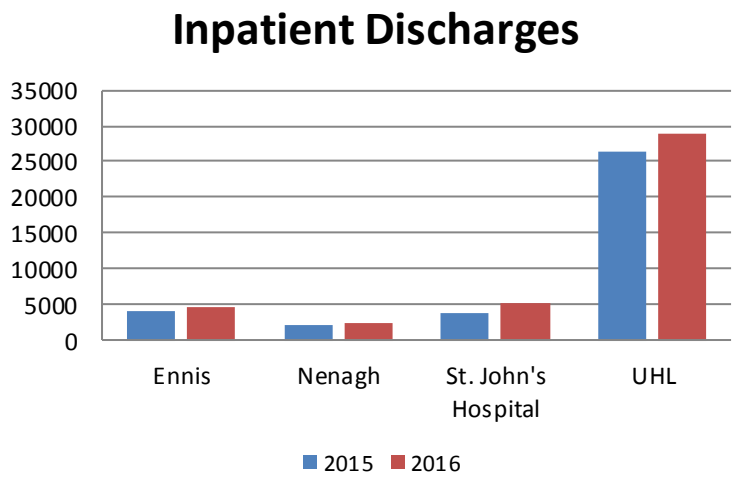
(*Nov 2016 most recent available data)*





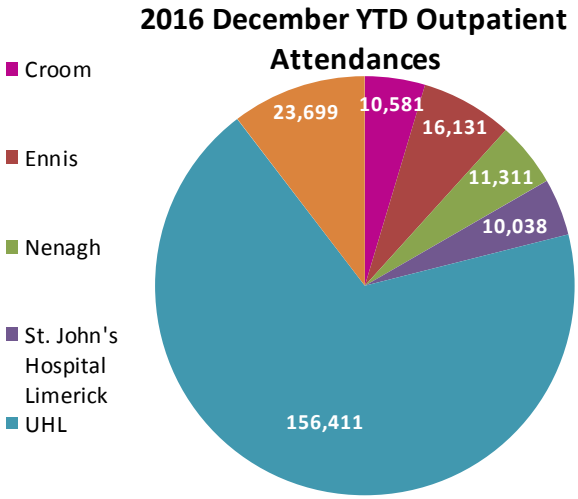
LIU's now account for just over 30% of all emergency presentations for the Group.

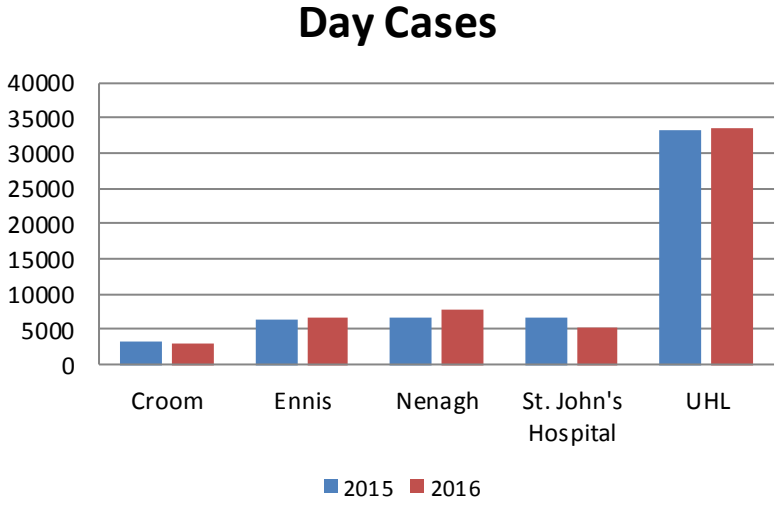
Scheduled Care



Inpatient Discharges across the Group YTD December 2016 when compared to the same period in 2015 are showing an increase of 8.8%.

Outpatient attendances have grown by 1.5% across the Group year on year. UL Hospital Group has treated over 228,000 patients in all our outpatient centres this year to date (December 2016).





The 2016 Day Case Activity Based Funding (ABF) target was met.

Operational Framework – Financial Plan

Introduction

The University of Limerick Hospital Groups net budget allocation for 2017 amounts to €277.730m.

Directorate/ St. John's Hospital	Net Budget 2016	Indicative Net Budget 2017
NCG-Diagnostics	47,333,990	46,958,551
NCG-Peri-Operative Care	63,737,029	63,231,486
NCG-Medicine	75,470,496	74,871,886
NCG-Maternal & Child Health	26,369,084	26,159,932
NCG-Facilities & Hospitality	29,934,456	29,697,025
NCG-Acute Shared Services	18,695,927	18,547,637
St John's Hospital	17,998,937	18,264,136
Net Budget	**279,539,920**	**277,730,652**

Indicative Budgets for 2017, as based on a pro rata allocation over closing budgets 2016

Existing level of service

The cost of maintaining existing services increase each year for all hospital groups due to a variety of factors including:

- Incremental costs of developments commenced during 2016
- Impact of national pay agreements
- Increases in drugs and other clinical non pay costs
- Inflation related price increases
- Additional costs associated with demographic pressures

Financial Approach

Delivering the maximum amount of services, as safely as effectively as possible, within the limits of the funding available to the Group will remain a significant area of focus in 2017. There will be pressures within acute hospitals in the year ahead, in relation to responding to emergency presentations, costs of maintain appropriate staffing levels, the additional demands of treating an ageing population and the growing costs of drugs and medical technologies.

The key components of ULHG approach to addressing its financial challenge, will involve pursing increased efficiency, value for money and budgetary control and it will include:

- Governance : continued focus of budgetary control through the Performance and Accountability Framework, which spans across the four domains of ***Access*** to services, ***Quality and Safety*** of those services, doing this within the ***Financial*** resources available and effectively harnessing the efforts of our ***Workforce***
- Pay – adherence to the Pay and Numbers Strategy for 2017. The Pay and Numbers Strategy 2017, is a continuation of the initial strategy approved in July 2016, which is compliance within allocated pay and expenditure budgets. Overall pay expenditure, which is made up of direct employment costs, overtime and agency will continue to be monitored, managed and controlled.
- Non Pay implement targeted cost improvement programmes for specific high growth areas
- Income, sustain and improve wherever possible the level on income generated in 2016. An accelerated income target has been assigned to ULHG for 2017, which will be a financial challenge.
- Activity, use the ***Activity Based Funding (ABF)*** model progressively as part of the management process within the Group.

Operational Framework – Workforce Plan

The Acute Hospital Division recognises and acknowledges its people as its most valuable assets and key to service delivery in 2017. The People Strategy 2015 – 2018 "Leaders in People Services" underpins the wider health reform. It focuses on people services for the whole of the health services with the ultimate goal of delivering safer better healthcare. This is being achieved through leadership driving cultural change, enabled by staff engagement, workforce planning and adopting a partnering approach. The strategy is underpinned by a commitment to value and support the workforce. In particular, the role of HR Partner has been established as the link between National HR, the HR Leads in the Hospital Groups and the Acute Hospitals Division.

The following are the HR priorities as identified in the National Service Plan for 2017:

1. **Pay-Bill Management & Control -** Compliance with the framework and the requirement for Hospital Groups to operate within the funded pay envelope continues to be a key priority for the Acute Hospital Division for 2017 alongside the management of risk and service implications. The monitoring of the funded workforce plans is a recurring agenda item of the monthly performance meetings held under the Performance and Accountability Framework. The Division is also partnering with National HR through the National Coordination Group.

2. **Workforce Planning -** The development of funded workforce plans at both Hospital and Hospital Group level requires alignment to the on-going review of skill mix requirements alongside effective staff deployment to manage workforce changes that are necessary in support of service delivery. The Division and Hospital Groups are partnering with HR Workforce Planning, Analytics, & Informatics in relation to the development of workforce planning and resourcing knowledge, skills and capability of local HR Managers and Service Managers.

3. **Staff Engagement -** All Acute Hospital employees are encouraged to complete in Staff Surveys to ensure that their views are considered to create circumstances where everyone's opinion can make a difference in providing guidance on what can be done to make the services better, both from the service user and staff perspective. There is also a need to take actions based on survey findings.

4. **Workplace Health & Wellbeing -** The implementation of the 'Healthy Ireland in the Health Services' Policy is a priority to encourage staff to consider their own health and wellbeing to ensure a resilient and healthy workforce.

5. **EWTD (European Work Time Directive) -** Through the forum of the National EWTD Verification and Implementation Group, the Division continues to work collaboratively with Irish Medical Organisation (IMO), the Department of Health (DOH) and other key stakeholders to work towards the achievement of full compliance with the EWTD. The Division also collaborates with the DOH, the IMO and the National HR to facilitate a Learning Day to obtain progress to date from different experiences in relation to the implementation of measures in support of compliance.

In 2017 detailed work plans across the following themes; Leadership and Culture; Staff Engagement; Learning and Development; Workforce Planning; Evidence and Knowledge; Performance; Partnering, and; Human Resource Professional Services are being further developed with a particular focus on leadership development and e-HRM, in addition to the work plans commenced in 2016.

Cancer Services

The National Cancer Control Programme will lead the implementation of the new cancer strategy in the HSE. This will involve providing leadership across the continuum of care, from diagnosis, treatment, to appropriate follow-up and support, in both the hospital and community setting.

The main area of focus will continue to be the diagnosis and treatment of cancer. Further progress will be made in the consolidation of surgical oncology services into the cancer centres to ensure that optimal treatment is provided and outcomes are improved. Service improvements will be underpinned by evidence, best practice and continued development of further National Clinical Guidelines. Services will be monitored against agreed performance parameters.

Quality and Patient Safety

The Acute Hospital Division will prioritise the establishment of a robust governance and accountability structure for Quality and Patient Safety programmes within the Division during 2017.

The division will work with the Hospital Groups including UL Hospitals to develop a model for patient safety and quality.

The aim is to further enhance and build capacity of QPS departments across National Division, Hospital Groups and at hospital level and to focus on the following key areas of development:

1. **The Division will continue to implement the Framework for Quality Improvement and National Patient Safety Programmes in partnership with NCSP, QAV and QID in the following areas:**
   - HCAI
   - Decontamination
   - Medication Safety
   - Pressure Ulcers to Zero
   - Sepsis and Early Warning Scores/ Systems
   - Falls Prevention
   - Clinical Handover
   - Quality and Safety Governance e.g. Board on Board initiative.

2. **Improve Risk and Patient Safety incident management**
   - Improve overall response to safety incidents by developing and streamlining processes and systems for managing, investigating, reviewing and learning from incidents
   - Continue to put in place measures to improve reporting
   - Implement revised Integrated Risk Management policy

3. **Develop capacity to listen and learn from patients, public and staff**
   - Support and provide HSE project management for 2017 Patient Experience Programme- joint initiative with HIQA and DOH
   - Develop project plan and lead the patient safety culture survey project
   - Continue implementation and embed a culture of Open Disclosure across all services

4. **Quality and Safety Performance Monitoring and Reporting**
   - Strengthen QPS monitoring and surveillance to ensure Patient Safety areas for improvement are identified and learning is shared
   - Continue to publish monthly Maternity Safety Statements. Commence monthly Hospital Safety Statement monthly Reporting

- UL Hospitals will support the Acute Hospital Division as they develop clinical and healthcare audit programmes.

Performance and Accountability Framework

The Performance and Accountability Framework (PAF) sets out the process by which the National Divisions and Hospital Groups are accountable for improving their performance under four domains; **Access** to services, the **Quality and Safety** of those Services, doing this within the **Financial Resources** available and by effectively harnessing the efforts of the **Workforce**.

Accountabilty Structure

There are five main layers of acccountabilty in the HSE

1	Service Managers and the CEOs of Section 38
2	Hospital Group CEOs to the relevant National Directors
3	National Directors to the Director General
4	The Director General to the Directorate
5	The Directorate to the Minister

The Accountable Officers have delegated responsibilty and accountabillity for *all aspects* of service delivery across the four domains outlined above. The Framework outlines what is expected of them and what happens if targets are not achieved. In this context, the individual hospital managers also have a responsibility for proactively identify issues of underperformance, to act upon them promptly and, to the greatest extent possible, to avoid the necessity for escalation. This performance review process is monitored and scrutinised by National Performance Oversight Group (NPOG) on behalf of the Director General and the Directorate in fulfilling their accountability responsibilities.

Service Arrangements will continue to be the contractual mechanism governing the relationship between the HSE and Section 38 Agencies[1] to ensure delivery against targets.

Performance management process

Each level of management has a core responsibility to manage the delivery of services for which they have responsibility. This process involves;

- Keeping performance under constant review
- Having a monthly performance management process in place that will include formal performance meetings with their next line of managers
- Agreeing and monitoring actions at performance meetings to address underperformance
- Taking timely corrective actions to address any underperformance emerging
- Implementing a full Performance Improvement or Recovery Plan where significant and sustained underperformance has been identified and remedial actions have been unsuccessful.

A formal escalation process can be applied at both the organsiation and the individual level where there is continued underperformance following monitoring and support. This can result in senior managers responsible for particular services attendance at relevant Oireachtas Committees to account for service delivery, quality and financial performance issues.

The full text of Performance and Accountabililty Framework is available at www.hse.ie

[1] The HSE Acute Hospitals Division provides funding to 16 Voluntary Hospitals, known as Section 38 Agencies for the delivery of a range of healthcare services.

Implementing Priorities 2017

Priority Area	Priority Actions	Lead	CP Goal	Date
Governance and Compliance	Embed robust structures within the hospital groups to facilitate effective managerial and clinical governance which will provide direct support to the smaller hospitals in the groups.	UL Hospitals	2	Q1-Q4
Control and Prevention of HCAIs	Ensure governance structures are in place in Hospital Groups to drive improvement and monitor compliance with targets of HCAIs / AMR with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms.	UL Hospitals	2	Q1-Q4
Support of Surgical Clinical Programmes	Refurbishment of Old ICU to accommodate POA/DOSA/SAU in line with Surgical Clinical Programme, Corporate strategic goal no 2 and the Peri-Operative Strategic Plan and The CSI programme	Peri-Operative Directorate, UL Hospitals	2	Q1
Increase capacity/improve services in acute hospitals	**Newly Commissioned Units:**			
	Open new Emergency Department at University Limerick Hospital	Medicine Directorate, UL Hospitals	2	Q2
	Introduction of a Bed Bureau System to manager and triage all medical emergencies	Medicine Directorate, UL Hospitals	2	Q1
	Unscheduled Care:			
	Implement the ED Task Force report recommendations	UL Hospitals	2	Q1
	Target a 5% improvement in PET (moving towards a 100% target).			Q1-Q4
	Implement the Patient Flow Project in pilot sites and implement the winter initiative 2016/2017 aimed at alleviating pressures on the hospital system over the winter period.			Q1-Q4
	Endeavour to eliminate ED waiting times of> 24hours for patients > 75 years. Co-operate with the roll-out of the Integrated Care Programme for Older People as appropriate, in acute hospital demonstrator sites			Q1-Q4

Priority Area	Priority Actions	Lead	CP Goal	Date
	Scheduled Care:	UL Hospitals	2	Q1-Q4
	Work with the National Treatment Purchase Fund (NTPF), in relation to the funding of €15m allocated nationally to the NTPF, to implement waiting list initiatives, to reduce waiting times and provide treatment to those patients waiting longest			
	Waiting list management: actively manage waiting lists for inpatient and day case procedures by strengthening operational and clinical governance structures including chronological scheduling to ensure no patient is waiting longer than 18 months and achieve targets for patients waiting < 15 months.			Q1-Q4
	Implement the Strategy for Design of Integrated Outpatient Services 2016-2020 on a phased basis under the direction of the outpatient services performance improvement programme.			Q1-Q4
	Endoscopy Clinical Programme to develop guidelines and provide support to improve access to GI endoscopy			Q1-Q4
	Provide dialysis in UHL, contracted units and in the home at 2016 funded levels			Q1-Q4
Implementation of Maternity Strategy	Provide high level co-ordination of maternity, gynaecology and neonatal services and continue the implementation of the Maternity Strategy including the development of clinical maternity networks across the Hospital Groups	UL Hospitals	2	Q1-Q4
	Publish maternity safety statements for all maternity units/ hospitals.			Q1-Q4
	Roll-out the Maternal and Newborn Clinical Management System (MN-CMS) in phase 1 hospitals (Rotunda Hospital and National Maternity Hospital) and commence phase 2 preparation and roll-out.			Q1-Q4
	Progress plans for the relocation University of Limerick Maternity Hospital.			Q1-Q4
	Assist with the national implementation of a range of improvement actions based on the National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death.			Q1-Q4

Priority Area	Priority Actions	Lead	CP Goal	Date
	Participate in the development of the Irish Maternity Indicator System (IMIS) Audit to facilitate assessment of quality of care in maternity services.	UL Hospitals	2	Q1-Q4
	Continue to support the Guideline Development Group for NCEC Intra-partum Care Guidelines.			Q1-Q4
Quality and Patient Safety	Build Quality and Patient Safety capacity and capability at hospital group and divisional level to support Quality Improvement initiatives Monitor and support implementation of National Standards for Safer Better Healthcare	UL Hospitals	2	Q1-Q4
	Assist in the development and implementation of a quality and safety framework and programmes across the hospital groups.			Q1-Q4
	Continue to embed a culture of open disclosure.			Q1-Q4
	Work with the Acute Hospital Division to develop Group wide Clinical / Healthcare Audit Programme			Q1-Q4
	Work with the Acute Hospitals Division to endeavour to produce monthly Hospital Safety Statement monthly Reporting			Q1-Q4
	Co-operate with Quality Improvement Division in the Preventing VTE (blood clots) in Hospital Patients Improvement Collaborative"			Q1-Q4
Cancer Services and the National Cancer Control Programme	NCCP will work with Hospital Groups to implement the recommendations of the KPI quality improvement plan for the Rapid Access Clinics Breast, Prostate and Lung Cancers.	UL Hospitals	2	Q1-Q4
	Roll out the Medical Oncology Clinical Information System on a phased basis (MOCIS) across the 26 systemic anticancer therapy hospital sites.			Q1-Q4
National Services	Prepare for the implementation of the policy in Trauma Systems for Ireland.	UL Hospitals	2	Q1-Q4
Human Resources	**People Strategy 2015-2018**			
	Continue to work on implementing the People Strategy 2015–2018 within acute hospitals.	UL Hospitals	4	Q1-Q4

Priority Area	Priority Actions	Lead	CP Goal	Date
	Employee Engagement:			
	Use learning from the employee survey to shape organisational values and ensure that the opinions of staff are sought and heard.	UL Hospitals	4	Q1-Q4
	Workplace Health & Wellbeing:			
	Implement the 'Healthy Ireland in the Health Services' Policy supporting initiatives to encourage staff to look after their own health and wellbeing ensuring we have a resilient and healthy workforce	UL Hospitals	4	Q1-Q4
	Promote influenza vaccine uptake rates amongst staff in frontline settings			Q1-Q4
	European Working Time Directive (EWTD):			
	Implement and monitor compliance with the EWTD	UL Hospitals	4	Q1-Q4
National Policy Compliance	**Children First**			
	• Support the Children First National Office in their Implementation, training and roll-out of 'Children First' across the Hospital Groups. • Engage with the Children First National Office as reports are developed and tracked and monitored in relation to Child protection policies across the Hospital Groups.	UL Hospitals	3	Q1-Q4
	Patient Feedback			
	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	UL Hospitals	3	Q1-Q4
	Internal Audit			
	Ensure that processes in place at Group level to govern the oversight of Internal Audit recommendations.	UL Hospitals	3	Q1-Q4

Priority Area	Priority Actions	Lead	CP Goal	Date
Finance/ HR	**Employment Controls**			
	Ensure compliance with the Pay-bill Management and Control Framework within acute hospitals services.	UL Hospitals	3	Q1-Q4
	Activity based funding	UL Hospitals	5	Q1-Q4
	Support the next phase of ABF programme as per ABF Implementation Plan 2015 – 2017.		5	Q1-Q4
	Ensure hospital activity and patient data is reported within 30 days.		5	Q1-Q4
Patient Charges	Ensure compliance with the terms of the "MOU between the HSE, named hospitals and VHI Insurance DAC" (March 2016)	UL Hospitals	5	Q1-Q4
	Hospital groups and hospitals to ensure billing is appropriate and current and that bed maps are accurate.		3	Q1-Q4
Medicines Management	Work on implementing the provisions of the Irish Pharmaceutical Healthcare Association Framework Agreement on the Pricing and Supply of New Medicines.	UL Hospitals	3	Q1-Q4
Information Management	Support the development of NQAIS Clinical to combine information from NQAIS Surgery and NQAIS Medicine.	UL Hospitals	5	Q1-Q4
	Support the continued development of the Irish National Orthopaedic Register.			Q1-Q4
	Support the development of TARN to evaluate the care of trauma patients.			Q1-Q4
Health and Wellbeing	**Healthy Ireland**			
	Implement *Healthy Ireland in the Health Services National Implementation Plan 2015–2017* across all hospital groups with local implementation of Hospital Group plans on a phased basis.	UL Hospitals	1	Q1-Q4
	Tobacco Free Ireland			
	Complete planned *Brief Intervention Training sessions for Smoking Cessation* in line with existing programme and rollout of *Making every contact count* and *Generic Brief intervention Training* schemes by H&Wb Division.	UL Hospitals	1	Q1-Q4

Priority Area	Priority Actions	Lead	CP Goal	Date
Self-Management of Chronic Diseases	Support the Implementation of the Self-Management Support (SMS) framework in all hospital groups on a phased basis	ULHG	1	Q1-Q4

Appendices

Appendix 1: Human Resources

University Limerick Hospital Group WTE December 2016

Hospital Group	Medical/ Dental	Nursing	Health & Social Care	Management/ Admin	General Support Staff	Patient & Client Care	Total
UL Hospitals Group	**474**	**1,498**	**366**	**602**	**264**	**450**	**3,596**

Hospital	WTE December 2016
University Hospital Limerick	2,383
University Maternity Hospital	323
Croom Hospital	151
Ennis Hospital	220
Nenagh Hospital	218
St. John's Hospital	301
Total	**3,596**

Appendix 2: Performance Indicator Suite - DOP

System-Wide				
Indicator	Reporting Frequency	NSP 2016 Expected Activity / Target	Projected Outturn 2016	Expected Activity / Target 2017
Budget Management including savings Net Expenditure variance from plan (within budget) Pay – Direct / Agency / Overtime	M	0.33%	To be reported in Annual Financial Statements 2016	≤ 0.1%
Non-pay	M	0.33%		≤ 0.1%
Income	M	0.33%		≤ 0.1%
Capital Capital expenditure versus expenditure profile	Q	100%	100%	100%
Audit % of internal audit recommendations implemented by due date	Q	75%	75%	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received	Q	95%	95%	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%
Workforce % absence rates by staff category	M	≤ 3.5%	4.3%	≤ 3.5%
% adherence to funded staffing thresholds	M	> 99.5%	> 99.5%	> 99.5%
EWTD < 24 hour shift (Acute and Mental Health)	M	100%	97%	100%
< 48 hour working week (Acute and Mental Health)	M	95%	82%	95%
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	15% increase	15%	10% 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	99%	40%	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	0%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	90%	50%	90%
Extreme and major safety incidents as a % of all incidents reported as occurring	Q	New PI 2017	New PI 2017	Actual results to be reported in 2017

System-Wide				
Indicator	Reporting Frequency	NSP 2016 Expected Activity / Target	Projected Outturn 2016	Expected Activity / Target 2017
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	55%	40%
HR ® Number of nurses and midwives with authority to prescribe medicines	Annual	New PI 2017	New PI 2017	Up to 940
Number of nurses and midwives with authority to prescribe Ionising Radiation (X-Ray)	Annual	New PI 2017	New PI 2017	Up to 310

® The expected Activity/target 2017 for this KPI is a national target i.e. inclusive of all divisions

Acute Hospitals											
Service Area	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017							
Activity				University of Limerick Hospitals	UHL	UMHL	CH	SJL	EH	NH	National Target
Beds Available Inpatient beds **	Existing	Monthly	10,643								10,681
Day Beds / Places **	Existing	Monthly	2,150								2,150
Discharges Activity∞ Inpatient Cases	Existing	Monthly	635,414	49,549	28,549	7,579	1,766	5,099	4,265	2,291	640,627
Inpatient Weighted Units	Existing	Monthly	632,282	42,958	26,793.6	4,972.2	3,207.9	3,929.4	2,173.2	1,881.7	639,487
Day Case Cases∞ (includes Dialysis)	Existing	Monthly	1,044,192	57,730	34,787	159	3,164	5,362	6,606	7,652	1,062,363
Day Case Weighted Units (includes Dialysis)	Existing	Monthly	1,030,918	67,007	37,390.2	213.3	5,374.2	6,878.1	7,377.1	9,773.8	1,028,669
Total inpatient and day case Cases∞	Existing	Monthly	1,679,606	107,279	63,336	7,738	4,930	10,461	10,871	9,943	1,702,990
Emergency Inpatient Discharges	Existing	Monthly	424,659	34,712	24,338	808	408	3,287	4,039	1,832	429,872
Elective Inpatient Discharges	Existing	Monthly	94,587	7,904	4,042	10	1,358	1,812	223	459	94,587

Acute Hospitals											
Service Area	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2016**	**Expected Activity/ Targets 2017**							
Activity				University of Limerick Hospitals	UHL	UMHL	CH	SJL	EH	NH	National Target
Maternity Inpatient Discharges	Existing	Monthly	116,168	6,933	169	6,761			3		116,168
Emergency Care - New ED attendances	Existing	Monthly	1,141,437	60,523	60,523						1,168,318
-Return ED attendances	Existing	Monthly	94,483	4,159	4,159						94,225
- Injury Unit attendances Ω	New PI 2017	Monthly	81,141	27,418				10,274	9,255	7,889	81,919
- Other emergency presentations	New PI 2017	Monthly	49,029								48,895
Births: Total no. of births	Existing	Monthly	63,420	4,441		4,441					63,247
OPD: Total no. of new and return outpatient attendances	Existing	Monthly	3,342,981	236,614	159,643	25,507	11,287	10,644	17,399	12,134	3,340,981
Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	Existing	Monthly	1:2.4	1:2	1:2	1:2	1:2	1:2	1:2	1:2	1:2

Detailed Activity targets by hospital for Inpatients and day cases

Group	Hospital	Elective/ Emergency/ Maternity	Inpatients		Daycases	
			Cases	WU	Cases	WU
6. UL Group	Maternity Limerick	Elective	10	26.0		
6. UL Group	Maternity Limerick	Emergency	808	1,191.3		
6. UL Group	Maternity Limerick	Maternity	6,761	3,754.9	159	213.3
6. UL Group	Limerick	Elective	4,042	5,498.1	34,772	37,359.6
6. UL Group	Limerick	Emergency	24,338	21,239.6		
6. UL Group	Limerick	Maternity	169	55.9	15	30.6
6. UL Group	Croom	Elective	1,358	2,438.8	3,164	5,374.2
6. UL Group	Croom	Emergency	408	769.1		
6. UL Group	St Johns Limerick	Elective	1,812	2,198.7	5,362	6,878.1
6. UL Group	St Johns Limerick	Emergency	3,287	1,730.7		
6. UL Group	Ennis	Elective	223	148.3	6,606	7,377.1
6. UL Group	Ennis	Emergency	4,039	2,024.6		
6. UL Group	Ennis	Maternity	3	0.3		
6. UL Group	Nenagh	Elective	459	178.5	7,652	9,773.8
6. UL Group	Nenagh	Emergency	1,832	1,703.2		

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017
Activity Based Funding (MFTP) model HIPE Completeness – Prior month: % of cases entered into HIPE	Existing	Monthly	96%	100%
Dialysis Δ Number of Haemodialysis patients treated in Acute Hospitals **	New PI 2017	Bi-Annual	New PI 2017	170002
Number of Haemodialysis patients treated in Contracted Centres **	New PI 2017	Bi-Annual	New PI 2017	81,900 – 83,304
Number of Home Therapies dialysis Patients Treatments **	Existing	Bi-Annual	89,815	90,400 – 98,215
Outpatient New OPD attendance DNA rates **	Existing	Monthly	12.7%	12%
% of Clinicians with individual OPD DNA rate of 10% or less **	Existing	Monthly	36.5%	50%
Inpatient, Day Case and Outpatient Waiting Times % of adults waiting < 15 months for an elective procedure (inpatient)	Existing	Monthly	88.1%	90%
% of adults waiting < 15 months for an elective procedure (day case)	Existing	Monthly	92.2%	95%
% of children waiting < 15 months for an elective procedure (inpatient)	Existing	Monthly	93%	95%
% of children waiting < 15 months for an elective procedure (day case)	Existing	Monthly	96.8%	97%
% of people waiting < 52 weeks for first access to OPD services	Existing	Monthly	84.3%	85%
% of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	Existing	Monthly	75.8%	90%
Elective Scheduled care waiting list cancellation rate)**	Existing/ amended	Monthly	TBC	TBC
Colonoscopy / Gastrointestinal Service Number of people waiting greater than 4 weeks for access to an urgent colonoscopy	New PI 2017	Monthly	0	0
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	Existing	Monthly	51.5%	70%
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within 6 hours of registration	Existing	Monthly	68%	75%
% of all attendees at ED who are discharged or admitted within 9 hours of registration (goal is 100% performance with a target of ≥ improvement in 2017 against 2016 outturn)	Existing	Monthly	81.5%	100%
% of ED patients who leave before completion of treatment	Existing	Monthly	5.2%	<5%
% of all attendees at ED who are in ED < 24 hours	Existing	Monthly	96.5%	100%
% of patients attending ED aged 75 years and over **	Existing	Monthly	11.4%	13%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration	Existing	Monthly	44.5%	95%
% of patients 75 years or over who were admitted or	Existing	Monthly	62.2%	100%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017
discharged from ED within nine hours of registration				
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration	New PI 2017	Monthly	New PI 2017	100%
Ambulance Turnaround Times % of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	Existing	Monthly	93.4%	95%
Length of Stay ALOS for all inpatient discharges excluding LOS over 30 days	Existing	Monthly	4.6	4.3
ALOS for all inpatients **	Existing	Monthly	5.4	5
Medical Medical patient average length of stay	Existing	Monthly	6.8	6.3
% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration	Existing	Monthly	63.7%	75%
% of all medical admissions via AMAU	Existing	Monthly	35%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge	New PI 2017	Monthly	New PI 2017	11.1%
Surgery Surgical patient average length of stay	Existing	Monthly	5.3	5.0
% of elective surgical inpatients who had principal procedure conducted on day of admission	Existing	Monthly	72.5%	82%
% day case rate for Elective Laparoscopic Cholecystectomy	Existing	Monthly	43.6%	> 60%
Percentage bed day utilisation by acute surgical admissions who do not have an operation**	Existing	Monthly	37.8%	35.8%
% of emergency hip fracture surgery carried out within 48 hours	Existing	Monthly	86.7%	95%
% of surgical re-admissions to the same hospital within 30 days of discharge	Existing	Monthly	2.1%	< 3%
Delayed Discharges No. of bed days lost through delayed discharges	Existing	Monthly	200,774	< 182,500
No. of beds subject to delayed discharges	Existing	Monthly	630	< 500 (475)
Health Care Associated Infections (HCAI) % compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	Existing	Bi- Annual	89.2%	90%
Rate of new cases of Hospital acquired Staph. Aureus bloodstream infection	New PI 2017	Monthly	New PI 2017	< 1/10,000 Bed days used
Rate of new cases of Hospital acquired C. difficile infection	New PI 2017	Monthly	New PI 2017	< 2/10,000 Bed days used
Mortality Standardised Mortality Ratio (SMR) for inpatient deaths by hospital and defined clinical condition **	Existing/ Modified	Annual	Data Not Yet Available	N/A

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017
Quality Rate of slip, trip or fall incidents for as reported to NIMS that were classified as major or extreme	New PI 2017	Monthly	New PI 2017	Reporting to commence in 2017
Medication Safety Rate of medication error incidents as reported to NIMS that were classified as major or extreme	New PI 2017	Monthly	New PI 2017	Reporting to commence in 2017
Patient Experience % of hospital groups conducting annual patient experience surveys amongst representative samples of their patient population	Existing	Annual	TBC	100%
National Early Warning Score (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	Existing	Quarterly	96%	100%
% of all clinical staff who have been trained in the COMPASS programme	Existing	Quarterly	64.5%	> 95%
% of hospitals with implementation of PEWS (Paediatric Early Warning System) **	Existing	Quarterly	N/A	100%
Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with full implementation of IMEWS	Existing	Quarterly	100%	100%
% of hospitals with implementation of IMEWS for pregnant patients	Existing	Quarterly	84%	100%
Clinical Guidelines % of maternity units / hospitals with an implementation plan for the guideline for clinical handover in maternity services	New PI 2017	Quarterly	New PI 2017	100%
% of acute hospitals with an implementation plan for the guideline for clinical handover	New PI 2017	Quarterly	New PI 2017	100%
National Standards % of hospitals who have completed first assessment against the NSSBH	Existing	Quarterly	90%	100%
% of hospitals who have commenced second assessment against the NSSBH	Existing	Quarterly	50%	95%
% maternity units which have completed and published Maternity Patient Safety Statement and discussed same at Hospital Management Team meetings each month	Existing	Monthly	100%	100%
% of Acute Hospitals which have completed and published Patient Safety Statements and discussed at Hospital Management Team each month **	Existing	Monthly	N/A	100%
Patient Engagement % of hospitals that have processes in place for participative engagement with patients about design, delivery & evaluation of health services **	Existing	Annual	N/A	100%
Ratio of compliments to complaints **	Existing	Quarterly	1:1	2:1
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit **	Existing	Quarterly	56.2%	90%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	Existing	Quarterly	10.5%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	Existing	Quarterly	65.9%	90%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Existing	Quarterly	89.7%	90%
% of reperfused STEMI patients (or LBBB) who get timely PPCI	Existing	Quarterly	70.8%	80%
COPD Mean and median LOS for patients admitted with COPD **	Existing	Quarterly	7.7 5	7.6 5
% re-admission to same acute hospitals of patients with COPD within 90 days **	Existing	Quarterly	27%	24%
No. of acute hospitals with COPD outreach programme **	Existing	Quarterly	15	18
Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	Existing	Quarterly	29	33
Asthma % nurses in secondary care who are trained by national asthma programme **	Existing	Quarterly	1.3%	70%
Number of bed days used by all emergency in-patients with a principal diagnosis of asthma**	Existing/ amended	Quarterly	11,394	3% Reduction
Number of bed days used by emergency inpatients < 6 years old with a principal diagnosis of asthma**	Existing/ amended	Quarterly	1,650	5% Reduction
Diabetes Number of lower limb amputations performed on Diabetic patients **	Existing	Annual	449	<488
Average length of stay for Diabetic patients with foot ulcers **	Existing	Annual	17.4	≤17.5 days
% increase in hospital discharges following emergency admission for uncontrolled diabetes. **	Existing	Annual	Data Not Available Until Q1 2017	≤10% increase
Blood Policy No. of units of platelets issued in the reporting period **	Existing	Monthly	20,704	21,000
% of units of platelets outdated in the reporting period **	Existing	Monthly	5.1%	<5%
% of O Rhesus negative red blood cell units issued **	Existing	Monthly	13.3%	<14%
% of red blood cell units rerouted **	Existing	Monthly	3.4%	<4%
% of red blood cell units outdated out of a total of red blood cell units issued**	Existing	Monthly	0.5%	<1%
HR – Compliance with EWTD European Working Time Directive compliance for NCHDs - < 24 hour shift	Existing	Monthly	97.1%	100%
European Working Time Directive compliance for NCHDs - < 48 hour working week	Existing	Monthly	81%	95%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017
Symptomatic Breast Cancer Services No. of patients triaged as urgent presenting to symptomatic breast clinics	Existing	Monthly	19,502	18,000
No. of non urgent attendances presenting to Symptomatic Breast clinics **	Existing	Monthly	23,266	24,000
Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of two weeks for urgent referrals **	Existing	Monthly	17,348	17,100
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of two weeks for urgent referrals	Existing	Monthly	89%	95%
Number of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals (No. offered an appointment that falls within 12 weeks) **	Existing	Monthly	18,468	22,800
% 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)	Existing	Monthly	79.4%	95%
Clinic Cancer detection rate: no. of new attendances to clinic, triaged as urgent, which have a subsequent primary diagnosis of breast cancer **	Existing	Monthly	1,841	> 1,100
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer	Existing	Monthly	11%	> 6%
Lung Cancers Number of patients attending the rapid access lung clinic in designated cancer centres	Existing	Monthly	3,372	3,300
Number 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 **	Existing	Monthly	2,796	3,135
% 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	Existing	Monthly	81.2%	95%
Clinic Cancer detection rate: Number of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of lung cancer **	Existing	Monthly	1,030	> 825
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of lung cancer	Existing	Monthly	32.4%	> 25%
Prostate Cancer Number of patients attending the rapid access prostate clinic in cancer centres	Existing	Monthly	2,626	2,600
Number 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 **	Existing	Monthly	1,366	2,340
% of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of	Existing	Monthly	52%	90%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2016	Expected Activity/ Targets 2017
receipt of referral in the cancer centres				
Clinic Cancer detection rate: Number of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer **	Existing	Monthly	1,058	> 780
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of prostate cancer	Existing	Monthly	41.5%	> 30%
Radiotherapy No. of patients who completed radical radiotherapy treatment (palliative care patients not included) **	Existing	Monthly	5,088	4,900
No. of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care **	Existing	Monthly	4,394	4,410
% 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)	Existing	Monthly	86.4%	90%

*** KPIs included in Divisional Operational Plan only*

∞Discharge Activity is based on Activity Based Funding (ABF) and weighted unit (WU) activity supplied by HPO. Dialysis treatments in Acute Hospitals are included in same..

These indicators are dependent upon the type and volume of services being provided and the underlying level of demand. We commit to continually improving our performance and many targets are set to stretch achievement therefore there may be a performance trajectory to full compliance. (footnote as per NSP 2017)

Appendix 3: Capital Projects

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2017 Implications	
						2017	Total	WTE	Rev Costs €m
ACUTE SERVICES									
University of Limerick Hospital Group									
Ennis Hospital	Redevelopment of Mid-Western Regional Hospital, Ennis (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 2017	Q1 2018	0	0	0.85	1.65	0	0.00
University Hospital Limerick	Acute MAU and OPD reconfiguration. The AMAU will be accommodated in the (old) Ward 6A and adjacent areas	Q4 2017	Q1 2018	8 assessment spaces	12 assessment spaces	1.06	1.40	0	0.00
	Reconfiguration of former ICU to create a surgical and pre-operative assessment unit	Q3 2017	Q3 2017	14 assessment spaces	0	0.74	0.79	0	0.00
	Clinical education and research centre (co-funded with University of Limerick)	Q4 2016	Q1 2017	0	0	1.30	12.90	4	0
	New Emergency Department	Q1 2017	Q2 2017	0	0	8.75	24.00	93.5	1.40
Nenagh Hospital	Ward block extension and refurbishment programme, incl. 16 single rooms and 4 double rooms (part funded by the Friends of Nenagh Hospital)	Q3 2017	Q3 2017	3	21	1.34	4.90	0	0.00