Acute Hospital Services Divisional Plan

Building a Better Health Service

Seirbhís Sláinte Níos Fearr á Forbairt

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

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

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

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

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

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Acute Hospitals Introduction

Acute services include emergency care, urgent care, short term stabilisation, scheduled care, trauma, acute surgery, critical care and pre-hospital care for adults and children. Hospitals continually work to improve access to scheduled and unscheduled care, ensuring quality and patient safety within the allocated budget.

There are forty nine acute hospitals that are incorporated into seven Hospital Groups as follows:

- Children's Hospital Group
- Dublin Midlands Hospital Group
- Ireland East Hospital Group
- RCSI Hospital Group
- Saolta Hospital Group
- South South West Hospital Group
- University Limerick Hospital Group

The Hospital Groups provide the structure to deliver an integrated hospital network of acute care in each geographic area. This structure is progressing in a phased manner, providing for devolved decision-making, and fostering flexibility, innovation and local responsiveness. The Hospital Groups individual operational plans will be cognisant of the *Sláintecare* report and provide additional detail to that included in this divisional plan.

The hospitals have a key role in improving the health of the population by providing a range of services from brief intervention training and self-management support, to optimising care pathways for patients admitted with exacerbations of chronic diseases and complex conditions.

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

Hospitals will continue to reduce length of stay whilst responding to increased demand for acute services as the population increases and the demographic changes as the number of patients over 64 years increases. In cases where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved and the available funding level and planning assumptions provided by the Department of Health (DoH), the HSE is required to manage within the available resources

while seeking to prioritise services to those in greatest need. Within acute services, this primarily applies to elective services. To address this funding gap, the HSE, in partnership with the DoH and our staff, suppliers and providers will, during 2018, seek to implement realistic and achievable measures to improve efficiency and effectiveness, a subset of which will reduce this funding gap to the greatest extent feasible

Learning from the information gathered in the National Patient Experience survey 2017 will be used to improve quality of patient care in 2018.

In the case of some services, given that the HSE is the statutory public provider and the realities around the relatively fixed nature of certain costs, there is a requirement to respond to need even if this exceeds what can be supported by any level of realistic efficiencies coupled with the available funding. Within acute services, this primarily applies to emergency and maternity services and will lead to an estimated overall funding gap in 2018 of €244.6m / 4.4%. In arriving at the overall funding gap of €244.6m / 4.4%, assumptions have already been made in relation to cost avoidance.

The National Women and Infants' Health Programme (NWIHP), National Cancer Control Programme (NCCP), National Screening Service and the National Ambulance Service work closely with the Acute Hospitals Division and lead the strategic development of Cancer treatment, Cancer screening and Ambulance transport services respectively.

Acute hospitals will work closely with the Health and Wellbeing Division to continue to improve surveillance and management of Healthcare Associated infections (HCAIs) including Carbapenem-producing Enterobacteriaceae (CPE). In the context of the *National Public Health Emergency Team (NPHET)* monitoring systems for CPE infection rates, implementation of screening guidelines for CPE and the national policy on restricted anti-microbial agents, will be established.

Section 1: Key Reform Themes

Patients expect to be cared for in the most appropriate environment and in an efficient manner, therefore acute services are increasingly provided in ambulatory settings as clinically appropriate. The overall population is rising and although more patients are being cared for as outpatients and day cases, the acuity, complexity and age profile of those that are admitted is rising steadily. Acute hospitals are challenged in addressing **increased demand** in terms of the overall number of patients being treated by hospitals and the complexity of their conditions. In addressing this challenge, acute hospitals continue to support initiatives which improve GP access to diagnostics and specialist opinion, to ensure that acute referrals are clinically appropriate, to reduce length of stay and improve pathways of care for the frail elderly and those with complex conditions.

There are **critical care capacity** deficits in hospitals across the country. Following the organisation of hospitals into Hospital Groups, it is clear that critical care capacity building is required in the 'hub' hospitals to meet the on-going and increasing critical care requirements of complex, multi-specialty, severely critically ill patients. It is known that access delays for critically ill patients arising from capacity deficits is associated with increased mortality, increased costs and poorer outcomes. During 2018 the acute hospitals will commence monitoring of access times to ICU from decision to admit in order to inform improvement plans in this regard.

Management of **bed capacity** is challenged by the large number of delayed discharges in acute hospitals and particularly for patients who have particular requirements for rehabilitation, complex, disability or residential care needs including younger adults in need of long term care. Pressure on bed capacity is also impacted on by the lack of single occupancy rooms for infection control measures. Bed utilisation rates are greater than 90%, particularly in larger hospitals therefore discharge by 11am is promoted to improve admission waiting times for patients from Emergency Departments (EDs). Additional bed capacity will be provided in 2018 to address some of the demand for inpatient beds. Using performance improvement tools (e.g. NQAIS systems), the acute hospitals will continue to monitor performance, identifying areas that will maximise ambulatory care services, improving day of surgery rates, and minimising length of stay.

Improving access times to inpatient, day case elective procedures and outpatient consultations is a constant challenge which the service is continuing to address by implementing waiting list action plans and by working with the National Treatment Purchase Fund (NTPF) to drive the roll-out of the *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.* The acute hospitals will optimise capacity to undertake additional NTPF elective surgery cases. Specific focus will be placed on reducing numbers waiting greater than 9 months by the end of June 2018 compared to those waiting greater than 9 months at the end of June 2017. A targeted approach to reducing clinically urgent long

waiters by NTPF and HSE will include a review of the longest waiters on a case by case basis with particular emphasis on Orthopaedics and Ophthalmology.

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

Providing **specialist services** within acute hospitals remains a priority as we respond to increasing complexity of presentations and advances in medical technology and interventions. The Hospital Groups are continuing the development of clinical networks of specialist services. These will consolidate secondary and tertiary care in appropriate locations, in line with *"The Framework for Smaller Hospitals"*, improving clinical outcomes and streamlining elective and emergency pathways across hospitals.

Specific focus on implementing a sustainable plan for paediatric orthopaedics including scoliosis in 2018 is a priority.

Other specialist national services will be supported in 2018 including:

- Further development of the national adult narcolepsy service in St James's Hospital including transition of adolescents from the Children's University Hospital
- Invest in spina bifida services in particular improved access to urology services in Children's University Hospital, Temple St.
- The publication of the policy on a national trauma system for Ireland is expected in early 2018 and a national clinical lead will be appointed to commence implementation of this policy.
- Additional staff will be resourced in MMUH and SJUH to support development of gastroenterology physiology.
- Investment in all Island deep brain stimulation in MMUH
- Neonatal transport Programme will be supported with additional Consultants to ensure appropriate clinical governance for a 24/7 service.
- Commence development of Transgender services in Ireland East Hospital Group and the Children's Hospital Group
- Additional transcatheter aortic valve implantation (TAVI) in order to address the increase in demand and clinical appropriateness for this advanced procedure
- Commence development of the National Genetics and Genomics Service
- Further development of the National Transplant Service

The *National Cancer Strategy 2017-2026* was published in 2017 and support for the implementation of its recommendations will address some of the current deficits in cancer services nationally. Details of the NCCP's priorities can be seen in Section 4: Cancer Services.

Meeting increased demand for urgent **colonoscopy waiting times, urgent GI endoscopy waiting times** and targeting significant reductions in overall waiting lists and efficiencies is a key focus for acute services. The Endoscopy Programme undertook a review of services nationally in 2017 in order to identify capacity and service requirements. The Programme will commence implementation of Phase 1 of the plan to address capacity during 2018 and commence to invest in services to address deficits.

Ensuring that services for children are managed in an integrated way, including improving paediatric access, are key challenges for acute services. The **new Children's Hospital**, when completed, will transform acute paediatric and emergency care for children. A key milestone in the Children's Hospital Project and Programme (CHP&P) is the planned opening of the new Paediatric Outpatient and Urgent Care Centre at Connolly Hospital in early 2019. The programme will support the development of an integrated clinical network for paediatrics across the health system as the system works towards developing outreach and regional services across the country in advance of moving services into the new Children's Hospital by 2021. This is supported by the national model of care for paediatrics and neonatology, as set out by the Integrated Care Programme for Children, of a single integrated national service for paediatrics. It is also envisaged that, in 2018, legislation to establish a new single entity to run the new hospital and outpatient care centres will be progressed, which will be a milestone in the structure and approach for healthcare delivery.

Priorities 2018

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

Section 2: Quality and Safety

Introduction

The Acute Hospitals Division places significant emphasis on the quality of services delivered and on the safety of those who use them. A three-year National Safety Programme to develop and oversee the implementation of national safety priorities and initiatives across all parts of the health system is continuing and we will work with HSE Quality Improvement Division (QID), Quality Assurance and Verification (QAV) and the National Patient Safety Office to deliver on national patient safety priorities.

The National Patient Safety Programme

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

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

The programme aims to:

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

In association with the National Patient Safety Programme the Acute Hospitals Division will continue to:

Enhance and build capacity of Quality Patient Safety (QPS) structure and function across Hospital Groups

- Develop an agreed proposal with hospital groups for QPS staffing capacity and capability models which will support the delivery of an effective QPS function
- Continue to progress guidance and information resources to enable groups to enhance and develop their QPS Committee Structure

Incident and Risk Management

- Continue to embed robust risk and incident management process
- Work with Quality Assurance and Verification to provide on-going training and support through Hospital Groups for front line staff in relation to integrated Risk Management policy procedures and guidelines.
- Support and guide the implementation of the HSE Incident Management Policy Framework (2017) across all Acute Hospitals in 2018
- Continue to work with Hospital Groups to ensure reporting of all incidents on the National Incident Management System in a timely manner – including the notification of all serious incidents serious reportable events in line with policy.
- Support Hospital Groups in driving a culture of open disclosure including promotion of training and information for open disclosure

Performance Monitoring and Assurance

- Develop a surveillance tool to collate all available Quality and Patient safety related indicators for surveillance of acute services. Continue to embed the process for monitoring of the implementation of recommendations from national reports
- Monitor and support ongoing publication of Hospital Patient Safety Indicator Reports

National Standards for Safer Better Health Care (NSSBHC)

- Lead the review of the NSSBHC self-assessment process to maximise quality improvement, value, and outcomes with HGs.
- Develop and maximise the use of the QA&I Tool to support the hospital groups self-assess against the national standards

Patient, Public and Staff Participation and feedback

- Undertake the National Patient Experience survey programme in Acute Hospitals to include Maternity Services
- Advance the development of the staff patient safety culture survey for Acute Hospitals
- Involve patients and family members in the design, delivery and evaluation of services through the National Patient Forum, Patients for Patient Safety Ireland, and focus groups with the patient representative panel.

Patient Safety and Quality Improvement

Through quality and risk surveillance activity (risk information/incidents/reviews/best evidence) and engagement with HGs, identify areas for improvement and prioritise patient safety programmes for Acute Hospitals.

- Support the Implementation of Quality Improvement Framework and the National Patient Safety Programmes and SQI Programmes etc.
- Support the implementation of Deteriorating Patient Recognition & Response Improvement Programme, including Sepsis and Early Warning Systems.
- Continue to work with Hospital Groups in the implementation of Quality and Patient Safety walk-rounds and Schwartz rounds
- Participate in and support the National Nutrition Policy development group
- Participate in and support the work of the National Public Health Emergency Team

  (NPHET) for Carbapenem producing Enterobacteriaceae (CPE)
- Continue to monitor incidence of *Staphylococcus aureus, C. difficile and CPE* infections in acute hospitals in accordance with performance assurance protocols.
- Establish monitoring systems for implementation of screening policy for CPE and use of restricted antimicrobials.

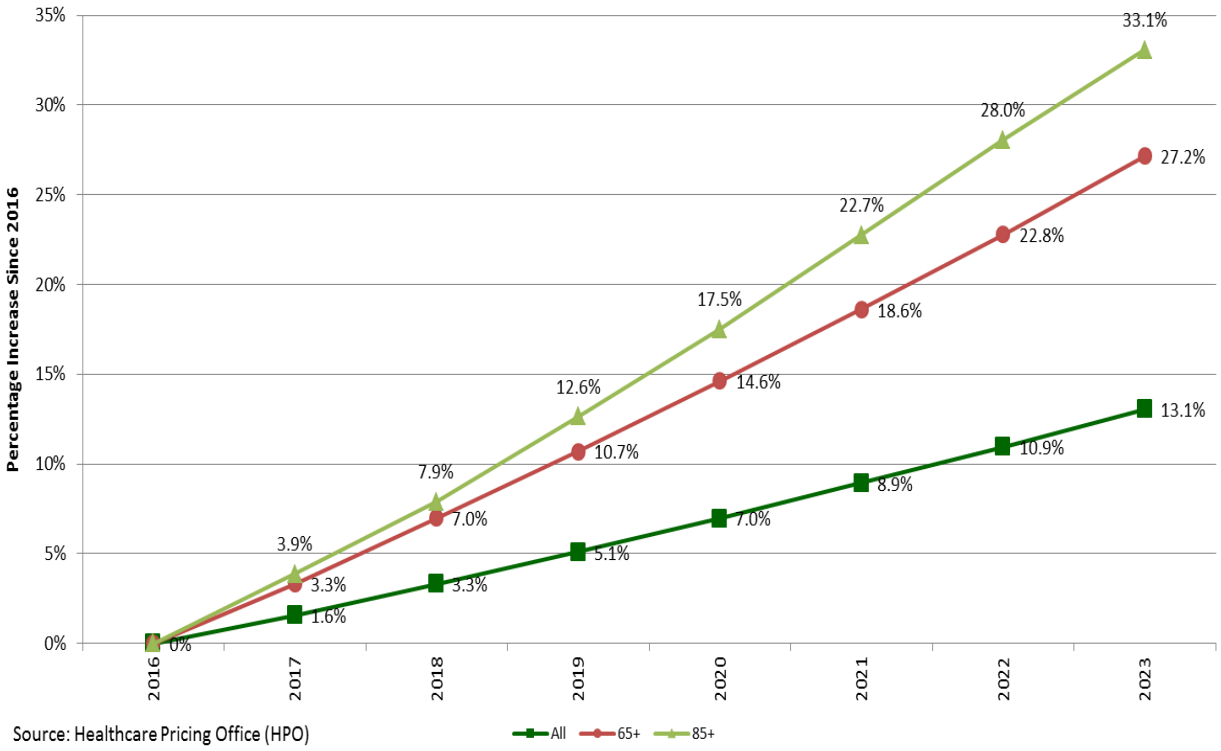
Section 3: Acute Hospitals Division

3.1 Our Population

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

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

Projected total inpatient and day case percentage cost changes 2016 to 2023



Source: Healthcare Pricing Office (HPO)

3.2 Building a Better Health Service

Healthy Ireland: Chronic disease prevention and management

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

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

National Clinical and Integrated Care Programmes

In 2018, the Acute Hospitals Division will continue to support the National Clinical and Integrated Care Programmes in their focus on developing new integrated care models and pathways to ensure safe, timely, efficient healthcare which is provided as close to home as possible. The Acute Hospitals Division will support the **Integrated Care Programme for Children** in its aim to improve the way in which healthcare services are designed and delivered to children and their families, the completion of the design of the screening programme for infants at risk of developmental dysplasia of the hip, and the continued progress the Waterford Paediatric Initiative and the development of an integrated care pathway for children with

neuromuscular disorders. We will work with the **Integrated Care Programme for Older Persons** to incrementally develop integrated pathways for older people especially those with more complex care needs and frailty. The **Integrated Care Programme for Patient Flow** is developing a standardised approach to managing patient flow in a number of areas including urgent and emergency care, scheduled care, outpatients and community healthcare. The programme will develop a plan to support the reorganisation of urgent and emergency care in line with best outcomes and the best experience for patients in association with acute hospitals.

Clinical and operational leads will continue to support improvements in Stroke care, Acute Coronary Syndrome, medical and surgical services with acute hospitals and support development and implementation of NCEC guidelines in association with DOH as appropriate.

3.3 Improving Value

Recognising the necessity to secure improved value, the HSE is taking forward a systematic review of its existing activities to drive value with a view to taking forward, from the beginning of 2018, a comprehensive **Value Improvement Programme**. The Acute Hospitals Division will work with national teams on the various work streams:

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

Key objectives and outputs

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

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

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

A range of initiatives will to be prioritised to improve the **quality of care** for patients and deliver better **value for money**, including ensuring maximum benefit for patients from the health service's expenditure on medicines and allowing new effective medicines to be adopted in the future. The **Acute Hospital Drugs**

Management Programme has a number of initiatives underway and in development, aimed at achieving efficiency through procurement practices, closer scrutiny of outcomes and maximising the use of drugs with proven cost effectiveness such as biosimilars. In particular, in order to ensure affordability of medicines into the future, value from patent-expired medicines must be maximised.

Phase 2 of the Patient Income Process Improvement Project will see the roll-out of standardisation of patient income processes in hospitals.

3.4 Service Delivery

Implementing priorities 2018 in line with Corporate Plan goals

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

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

Priority	Accountable	Date
Develop and implement clinical guidelines for under-nutrition and an acute hospital food and nutrition policy.	AHD and HGs	Q1-Q4
Continue implementing *Healthy Ireland* plans in the Hospital Groups.	HGs	Q1-Q4
Continue to Improve staff uptake of the flu vaccine.	AHD and HGs	Q1-Q4
Prioritise the implementation of Making Every Contact Count in all care settings.	AHD and HGs	Q1-Q4
Support the progression of the implementation of the chronic disease demonstrator projects in the Hospital Groups	AHD and HGs	Q1-Q4

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

Increase critical care capacity

Enhance critical care capacity with the opening of additional capacity at Cork University Hospital 2 ICU beds, 4 HDU Beds Mater Misericordiae University Hospital, Dublin.1 ICU Beds, 6 HDU Beds	SSWHG IEHG	Q1-Q4
Commence monitoring of time from decision to admit to admission to Intensive Care Unit	Critical Care Clinical Programme & HGs	Q1-Q4

Improve the provision of unscheduled care

Improve pathways for care of older people living with frailty in acute hospitals in association with the Integrated Care Programme for Older Persons (ICPOP).	ICPOP and HGs	Q1-Q4
Continue to ensure that no patient remains over 24 hours in ED.	HGs	Q1-Q4
Continue to implement measures to address seasonal increase and reduce delayed discharges in association with community healthcare.	AHD, SC & HGs	Q1-Q4
Support the continued roll-out of the Integrated Care Programme for Patient Flow.	AHD and HGs	Q1-Q4
Generate improved capacity by improving internal efficiencies and more appropriate bed usage by reducing length of stay, early discharge and improving access to diagnostics	HGs	Q1-Q4

Improve the provision of scheduled care

Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate.	HGs	Q1-Q4
Monitor length of stay and opportunities for improvement using NQAIS	HGs	Q1-Q4
Provide additional Musculoskeletal services with the addition of Physiotherapy staff	SSWHG	Q1-Q4
Reduce waiting times for all patients and particularly those waiting over 15 months on outpatient and inpatient / day case waiting lists by implementing waiting list action plans.	AHD and HGs	Q1-Q4
Develop a plan to address waiting lists challenges in Orthopaedics and Ophthalmology	AHD and HGs	Q1-Q4
Improve efficiencies relating to inpatient and day case activity by streamlining processes and maximising capacity in acute hospitals.	AHD and HGs	Q1-Q4
Work with the NTPF to implement the *National Inpatient, Day Case and Planned Procedure (IDPP) Waiting List Management Protocol.*	AHD and HGs	Q1-Q4
Work with the NTPF to develop and implement a waiting list action plan for 2018.	AHD and HGs	Q1-Q4
Implement the findings and recommendations of the NTPF special audit to	HGs	Q1-Q4

drive process and performance improvement in scheduled care.		
Collaborate with the clinical programmes to complete a suite of pathways of care at condition-level, through the Outpatient Services Performance Improvement Programme (OSPIP).	OSPIP and HGs	Q1-Q4
Further develop GP referral guidelines and standardised pathways, supported by efficient electronic referral systems.	OSPIP and HGs	Q1-Q4
Roll out the national validation project for inpatient, day case and outpatient waiting lists.	HGs	Q1-Q4
Work with National Radiology Programme to establish national vetting criteria for radiology diagnostic tests.	AHD, HG's CSPD	Q1-Q4
Continue to work with the NTPF to develop a national dataset and waiting list for CTs, MRIs and Ultrasounds	AHD , HG's NTPF	Q1-Q4

Increase acute hospital capacity

Open additional beds and new units to increase capacity and improve access over the winter period:		
Our Lady of Lourdes Hospital, Drogheda , • New Emergency Department • New ward block	RCSI	Q1-Q4
University Hospital Galway • 30 additional Beds	Saolta	Q1-Q4
University Hospital Limerick • 17 Short Stay beds	ULHG	Q1-Q4
St. Vincent's University Hospital, Dublin • 22 additional beds	IEHG	Q1-Q4
University Hospital Waterford • 19 additional beds	SSWHG	Q1-Q4
Cork University Hospital • Convert 30 beds from transitional care to acute care	SSWHG	Q1-Q4
St. Luke's Hospital, Kilkenny • Additional 14 Beds	IEHG	Q1-Q4
Commence project to provide modular unit at South Tipperary General Hospital	SSWHG	Q4

• 40 additional beds.		
Expand medical assessment hours at Roscommon University Hospital.	Saolta	Q1-Q4

Continue to oversee the new Children's Hospital development including the Paediatric Outpatient and Urgent Care Centre

Support the on-going implementation of the new Children's Hospital Integration Programme	CHG	Q1-Q4
Support the continued development of the all-island paediatric cardiology service.	CHG	Q1-Q4
Continue to improve access to paediatric orthopaedics expanding ambulatory and inpatient services for trauma and elective demand	CHG	Q1-Q4
Continue to develop the new model of care for Scoliosis, supported by the recommendations of the Scoliosis Co-Design Group which is underpinned by the development of a standardised pathway of care for children and adolescents with scoliosis which will be evidence-based and patient-centred.	CHG	Q1-Q4
Continue the development of the orthopaedic service for young adults with scoliosis in the Mater Misericordiae University Hospital, and Cappagh Orthopaedic Hospital for patients transferring from paediatric services.	IEHG	Q1-Q4
Continue the development of urology services for children with spina bifida with the appointment of additional consultant and health and social care professionals.	CHG	Q1-Q4
Provide additional consultants for paediatric ENT services	CHG	Q1-Q4
Continue to work with paediatric services and the CHG to progress development of appropriate KPIs for paediatric care	AHD, CHG CP	Q1-Q4

Develop and improve national specialties

Commence development of the National Genetics and Genomic Network with the progression of the recruitment of a Clinical Director.	AHD	Q1-Q4
Implement a range of service and capacity improvement actions in accordance with Phase 1 of the implementation plan developed by the National Endoscopy Programme.	Endoscopy Programme & HG's	Q1-Q4
Further develop the national narcolepsy service at St. James's Hospital, Dublin in order to transition adolescents from TSCUH and further develop	DMHG	Q1-Q4

neurology sleep disorder services with recruitment of the multi-disciplinary team		
Progress the recruitment of consultant and relevant staff in order to open additional assessment beds to support the national transplant service in the Mater Misericordiae University Hospital, Dublin.	IEHG	Q1-Q4
Progress recruitment of a national clinical lead and establishment of the National Office for Trauma Services to begin implementation planning of the Trauma Report	AHD	Q1-Q4
Additional staff will be provided to support development of gastroenterology physiology, including the transfer of adolescents to appropriate adult care	DMHG & SSWHG	Q1-Q4
Commence development of an All- Island deep brain stimulation service	IEHG	Q1-Q4
Support the Neonatal Transport Programme with the appointment of additional Neonatologists	NNTP, RCSI, IEHG	Q1-Q4
Commence development of transgender services for children and adults	IEHG	Q1-Q4
Additional Transcatheter Aortic Valve Implantation (TAVI) will be provided to address demand in the following sites CUH, GUH, MMUH,SJUH and OLCHC	HG's	Q1-Q4
Continue to support the implementation of National Strategies for Cancer Services, Women and Infant Health and National Ambulance Services	HGs, NCCP, WIHP & NAS	Q1-Q4

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

Ensure quality and patient safety

Facilitate initiatives which promote a culture of patient partnership including next phase of the National Patient Experience Survey.	AHD and HGs	Q1-Q4
Monitor and control HCAIs in line with guidance documents	AHD and HGs	Q1-Q4
Continue to develop robust governance structures at hospital, group and national level to support management of HCAI / AMR.	AHD and HGs	Q1-Q4
Collate information on incidence of CPE and associated infection control measures including use of screening guidelines and appropriate accommodation of patients	AHD and HGs	Q1-Q4
Continue to improve compliance with the use of sepsis screening tools and National Clinical Guidelines	AHD	Q1-Q4

	and HG's	
Review assessment process for National Standards for Safer Better Healthcare and develop guidance to support monitoring and compliance against same	AHD and HGs	Q1-Q4

Enhance medicines management

Further enhance medicines management, improve equitable access to medicines for patients and continue to optimise pharmaceutical value through the Acute Hospitals Drugs Management Programme with a focus on the use of biosimilars.	AHD and HGs	Q1-Q4
Commence implementation of the Report on the Review of Hospital Pharmacy, 2011 (McLoughlin Report) with a focus on the development of pharmacist roles to improve and enhance medication safety, and implement HIQA medication safety reports.	AHD and HGs	Q1-Q4
Advance the reimbursement of (Enzyme Replacement Therapy (ERT) through PCRS to ensure equitable access for all patients.	AHD and HGs	Q1-Q4
Commence audit of Neurology Drug use and Guidelines with a particular focus on Tysabri and Lemtrada for Multiple Sclerosis treatment	AHD and HGs	Q1-Q4

Implement Children First

Commence implementation of the *Children First Act 2015* including mandatory training for staff as appropriate	AHD and HGs	Q1-Q4

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

Support and progress the policies and initiatives of the Office of the Chief Nursing Officer, DoH and European Directives on working hours

Extend and roll out nationally the Phase 1 Framework for Staffing and Skill Mix for Nursing in General and Specialist Medical and Surgical Care in acute hospitals within the allocated resources.	AHD and HGs	Q1-Q4
Implement a pilot for the Phase 2 Framework for Staffing and Skill Mix for Nursing in emergency care settings.	AHD and HGs	Q1-Q4
Enhance the training and development of Advanced Nurse Practitioners in association with DOH and NMPDU	AHD and HGs	Q1-Q4

Continue to improve compliance with the European Working Time Directorate with particular focus on the 24 and 48 hour targets	AHD and HGs	Q1-Q4

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

On-going monitoring and performance management of financial allocations in line with the Performance and Accountability Framework

Monitor and control hospital budgets and expenditure in line with allocations.	AHD and HGs	Q1-Q4
Identify and progress realistic and achievable opportunities to improve economy efficiency and effectiveness	AHD and HGs	Q1-Q4
Secure reductions in cost and or improvements in efficiency of services currently provided	AHD and HGs	Q1-Q4
Continue the next phase of ABF including the incentivised scheme for elective laparoscopic cholecystectomy.	AHD and HGs	Q1-Q4
Ensure compliance with the memorandum of understanding between the HSE and VHI in conjunction with National Finance.	AHD and HGs	Q1-Q4
Progress Phase 2 of the Hospital Income Review which will focus on training, standardisation of processes and measurement of improvements in billing and collection of income by hospitals.	AHD and HGs	Q1-Q4

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Section 4: Cancer Services

The population aged over 65 years is estimated to more than double in the 25 years between 2011 and 2036. This ageing of the population will drive a large increase in the number of new cancer cases, with the number of new patients receiving chemotherapy expected to increase by between 42% and 48% in the period from 2010 to 2025. The National Cancer Control Programme will continue to work with the National Screening Service to increase early detection of cancer in order to reduce the impact of the condition on patients and their outcomes.

Services provided

Services for the treatment of cancer include surgery, radiotherapy and systemic anti-cancer therapy (SACT), which includes medical oncology and haemato-oncology. The majority of, but not all, cancer surgery now takes place in the designated cancer centres. Eight adult hospitals and one paediatric hospital are designated as cancer centres (with a satellite unit in Letterkenny University Hospital for breast cancer services). A further 17 public hospitals provide SACT (chemotherapy, immunotherapy, etc.) and an additional two centres provide radiotherapy services under service level agreements.

In 2018 the national programme for radiation oncology (NPRO) phase 2 capital developments (St. Luke's Hospital, Rathgar, Cork University Hospital and Galway University Hospitals) will proceed and assist with meeting the current level of demand, along with continuing and developing the cross border radiotherapy initiative.

As part of the *National Cancer Strategy 2017-2026*, initiatives will be set up in 2018 across the continuum of care, from prevention to diagnosis and treatment, to appropriate follow-up and support, in both the hospital and community setting across the four strategy goals:

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

Issues and opportunities

Realising the huge importance of **cancer prevention and early detection** is key to reducing the cancer burden on people and on the health service, It is also necessary to develop acute services to meet the estimated **increase in cancer incidence.** Preventative efforts will be particularly directed at more deprived populations. The National Cancer Control Programme (NCCP) will continue to develop integrated care

pathways in collaboration with GPs and hospital-based specialists. To meet the expected growth in the number of people living with and beyond cancer, a new model of care for **survivorship** will be developed.

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

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

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

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

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

Priorities 2018

- Develop a comprehensive implementation plan for the *National Cancer Strategy 2017-2026* and continue the implementation of the strategy.
- Improve the quality of cancer services through evidence-based enhancement of patient care
- Develop a cancer prevention and early detection function in the NCCP.
- Develop cancer survivorship and psycho-oncology services.
- Support the expansion of the NPRO including NPRO phase 2 developments and the cross border radiotherapy initiative.
- Support the enhancement of funding programmes for the best available cancer drug treatments, and support hospitals in meeting the continuing burden of drug costs and in implementing quality initiatives in cancer care.
- Commence the implementation of the Medical Oncology Clinical Information System (MOCIS)
- Support the development of workforce planning, in line with the *National Cancer Strategy 2017-2026*.

4.1 Our Population

Life Expectancy and Health Status

The ageing population is a significant driver of increased cancer incidence and prevalence in Ireland. Older patients (generally those over 75 years) are less likely to have tumour directed treatment, more likely to have non-cancer comorbidities, tend to present at a later stage and are often more commonly diagnosed after an emergency presentation.

Health Inequalities

Reducing health inequalities is a priority of our new strategy, as lifestyle risk factors generally follow social, deprivation, gender and age patterns. In addition, health inequalities are associated with poor symptom awareness, delayed presentation and low uptake of services, including screening. Initiatives to reduce cancer incidence and increase the proportion of cancers diagnosed early must specifically address such inequalities.

4.2 Building a Better Health Service

Healthy Ireland

The proportion of cancer incidence attributable to modifiable lifestyle and environmental factors is estimated to be in the 30% to 40% range. Cancer prevention measures in areas such as smoking, improved diet, more exercise and reduced alcohol intake are being integrated with overall health and wellbeing initiatives under the Healthy Ireland programme.

Health Service Improvement

NCCP are continuing work with the assistance of the Programme for Health Service Improvement on the Rapid Access Clinic (RAC) KPI Improvement project and the implementation of the 26 service recommendations across the 24 Rapic Access clinics (Breast, Prostate, Lung). NCCP are also working with the office of the Chief Information Officer and the Programme for Health Service Improvement on the roll out of the MOCIS system across 26 hospital sites.

The Rapid Access Clinic (RAC) Review is the first comprehensive exercise undertaken across all centres since the service provision commenced. It focussed on understanding the clinics' performance and the challenges in responding to demand. It also provided an important insight into the viability of this service delivery model, should it be rolled out to other disease streams.

A set of recommendations for hospitals and Hospital Groups to support sustainable improvement in clinics' performance was developed. These key recommendations are closely aligned with the Outpatient Services Performance Improvement Programme (OSPIP) Strategy for the Design of Integrated Outpatient Services 2016-2020. The proposed initiatives will result in some fundamental changes to the clinics' processes. These changes will require full commitment and support from the hospitals and Hospital Groups and include increasing administrative support at the clinics and supporting for radiology/pathology staffing to address increased demands and improving care pathways for return patients.
The NCCP will work with HSE Estates services to identify improvements in infrastructure and maintain and replace diagnostic and surgical equipment required to support cancer services.

National Clinical and Integrated Care Programmes

It is important that any recommendations arising from the RACs review are considered in the context of the work undertaken by the National Clinical and Integrated Care Programmes. Therefore the NCCP will continue to develop linkages and to collaborate with the following national clincial care programmes, acute medicine, acute/elective surgical programme, care of the older person, pathology, radiology, medicine management (PCRS, NMIC, NCPE), anaesthesia care, dermatology on pathways of care for cancer patients.

4.3 Service Delivery

Implementing priorities 2018 in line with Corporate Plan goals

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

Develop cancer survivorship and psycho-oncology services

Priority	Accountable	Date
Ensure appropriate clinical and non-clinical staff are in place with the appointment of NCCP Survivorship lead, 2 Clinical Lead post's, 1 NCCP Nursing lead, 1 Psycho oncology lead	NCCP	Q4
Complete a national cancer survivorship needs assessment.	NCCP	Q2-Q4
Link with other stakeholder agencies to implement survivorship model and psycho-oncology service across the cancer centres.	NCCP/ PC/ HGs	Q3-Q4
Develop a national implementation plan for cancer survivorship	NCCP/ PC/HGs	Q4

Develop a cancer prevention and early detection function in the NCCP

Ensure appropriate clinical and non-clinical staff are in place with appointment of NCCP Cancer prevention officer and Early detection lead in conjunction with NSS as appropriate	NCCP	Q4
Commence assessment of population awareness of cancer risk and opportunities for early detection in collaboration with Healthy Ireland teams and voluntary agencies	NCCP, H&W, AHD & PC	Q1-Q4
Launch Cancer Prevention and Early Detection Network to develop and implement a national plan which includes research a stream in conjunction with *Healthy Ireland*, Voluntary Agencies and academic partners	NCCP, H&W, HGs, & PC	Q4
Commence development of measures to enhance early detection of cancers including a first national awareness campaign around early detection of lung cancer	NCCP, H&W, AHD & PC	Q3-Q4
Support Healthy Ireland policy programmes	NCCP, H&W, AHD & PC	Q1-Q4

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

Implement the *National Cancer Strategy 2017-2026*

Work with the DoH and other stakeholders on the implementation of the *National Cancer Strategy 2017-2026.*	NCCP, DOH AHD & PC	Q1-Q4
Support integrated care initiatives between GPs and hospital-based specialists	NCCP, AHD, & PC	Q1-Q4
Continue the implementation of the centralisation of cancer surgery in line with the *National Cancer Strategy 2017-2026* with the appointment of 5 additional consultant posts.	NCCP & AHD	Q1-Q4

Lead on service developments including cancer prevention, early diagnosis, treatment and survivorship within a performance monitoring framework.	NCCP, H&W AHD, & PC	Q1-Q4
Implement a molecular testing framework for tests that are predictive for drug treatment.	NCCP	Q1-Q4
Continue to ensure that cross border collaboration at the North West cancer radiation centre at Altnagelvin is progressing to full capacity, allowing patients in the North West to receive radiotherapy closer to home.	NCCP/ Saolta/ SLRON	Q1-Q4
Develop build standards for SACT day wards and Pharmacy Department Aseptic Compounding Units (ACUs) to improve safety.	NCCP AHD & Estates	Q3-Q4
Develop a business case for replacement and new ACUs to ensure SACT service resilience.	NCCP, AHD Estates	Q3-Q4
Introduce standard SACT documentation across hospitals providing SACT services.	NCCP, & HGS	Q3-Q4
Continue to develop national chemotherapy regimens and begin the development of national supportive care regimens for patients receiving SACT.	NCCP	Q3-Q4
Develop a Model of Care for patients receiving oral anticancer medicines to ensure that all patients receive such medicines in a safe and effective manner.	NCCP & AHD	Q3-Q4

Expand the NPRO

Support the expansion of the NPRO including NPRO phase 2 developments and the cross border radiotherapy initiative and the appointment of the medical, nursing and Health and Social Care professionals to support multi-disciplinary teams for Radiation Oncology in CUH, GUH and SLRON	NCCP, Saolta, SSWHG, SLRON & Estates	Q1-Q4

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

Improve the quality of cancer services

Work with Hospital Groups to implement the recommendations of the performance improvement plan for breast, prostate and lung cancer rapid access clinics and other rapid access cancer services with the appointment of additional posts in each cancer centre and the support of critiical developments for radiology/pathology services as appropriate.	NCCP, AHD & HGs	Q1-Q4
Commence the roll-out of the medical oncology clinical information system	NCCP/	

(including multi-disciplinary meeting module) on a phased basis across the 26 SACT hospital sites.	CIO/HGs	Q1-Q4
Improve care in relation to patient / family psychological impact after a diagnosis of cancer, supported by new lead posts	NCCP/ AHD/PC	Q4
Further develop cancer clinical guidelines, GP referral guidelines, follow-up protocols and national chemotherapy regimens.	NCCP/ NCEC/ CSPD	Q1-Q4
Look after the needs of people who are living with and beyond cancer utilising the recommendations from the national cancer survivorship needs assessment	NCCP & PC	Q1-Q4

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

Support the development of workforce planning, in line with the *National Cancer Strategy 2017-2026*

Commence workforce planning requirements as set out in the *National Cancer Strategy 2017-2026*.	NCCP NPRO, CSPD	Q2-Q4
Support development of national leads and sub-specialisation (Gerontology, Psycho-oncology, research, molecular, prevention & early dectection – NCCP)	NCCP	Q4

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

Support the enhancement of funding programmes for the best available cancer drug treatments, and support hospitals in meeting the continuing burden of drug costs and implementing quality initiatives in cancer care

Undertake and review quarterly activity data to ensure compliance with protocols	NCCP H&W	Q1-Q4
Review trends for cancer drug spending in hospitals.	NCCP PCRS	Q1-Q4
Monitor and evaluate the provision of private radiotherapy providers in University Hospital Limerick and University Hospital Waterford.	NCCP AHD	Q1-Q4
Implement a funding model which promotes review of Cancer medication use in hospitals in areas where there are biosimilars available	NCCP PCRS	Q1-Q4

Section 5: Women and Infants' Health

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

Services provided

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

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

Issues and opportunities

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

The NWIHP will continue to implement recommendations of reports on adverse incidents in maternity services over the past years. The programme will implement a new framework for the management of maternity related incidents, which will include the recruitment of quality and safety resources for each of the six maternity networks. The critical focus will be on adverse incidents.

NCEC national clinical guidelines relating to maternity care and risk stratification for the model of care have been commissioned and are in development. In line with the NMS, these will support the model of care

when complete. Pending the completion of the guidelines, core principles to underpin the model of care will be developed and implemented.

Priorities 2018

- Quality and safety: Establish a Serious Incident Management Forum in each Hospital Group.
- Model of care: Establish the community midwifery model.
- Anomaly scanning: Ensure anomaly scanning is available to all women attending ante-natal services.
- Health and wellbeing: Develop a bespoke Make Every Contact Count programme.
- Obstetric anaesthetics: Pilot the anaesthetics model of care.
- Maternal and New-born Clinical Management System (MN CMS): Roll out MN CMS phase II.
- Online resource: Develop an online resource for maternity services.
- Benign gynaecology services: Develop a national plan for benign gynaecology.

5.1 Our Population

The following sections highlight trends related to maternity and neonatal services in Ireland.

Age and Health Status

Although the number of births in Ireland has decreased by 15.4 per cent between 2008 and 2016, Ireland has one of the highest birth rates in the European Union with 14.6 per 1,000 population (NPRS, 2017).

The average age of a mother giving birth in Ireland has increased from 30.5 years in 2006 to 32.1 years in 2015 (NPRS, 2017). In 2016, women aged between 25 and 34 years accounted for 53.7 per cent of maternity inpatient discharges, while women aged 35–44 years accounted for 33.1 per cent (HIPE, 2017). During these years there has been an increase in the number of women who have had at least one previous pregnancy (IMIS, 2017).

The number of spontaneous births has decreased in Ireland since 2006 from 58.8 per cent to 53.5 per cent in 2015. In 2015, 31.4 per cent of births were delivered by Caesarean section; increasing by 6.1 per cent since 2006.

The WHO defines low birth weight as weighing less than 2,500 grams (NPRS, 2015). In 2015, the average birth weight for live births was 3446.9 grams for total live births. Low birth weight babies are more likely to have poor perinatal outcomes with consequences for later life experience. A total of 5.7 per cent were classified as low births (NPRS, 2017).

Health Inequalities

Ireland has low maternal mortality rate at 10.4 per 100,000 when compared to other OECD members (CMDE, 2014). It is acknowledged that there is a higher rate of maternal mortality among women from lower socio-economic backgrounds (Walker, 2010).

The highest stillbirth rate was 4.9 per 1,000 births also reported for mothers under 25 years. The lowest perinatal mortality rate was recorded among the ‘lower professional’ and ‘intermediate non-manual workers’ socio-economic groups at 5.4 per 1,000 births and 5.9 per 1,000 births, respectively (NPRS, 2017).

A perinatal mortality rate of 6.5 per 1000 births was reported by the NPRS in 2015 (NPRS, 2017). The highest perinatal mortality rate of live births and stillbirths was reported among mothers in the socio-economic group 'home duties' at 9.2 per 1,000, 8.1 per 1,000 among mothers 'unemployed'.

Chronic conditions and lifestyle behaviours are strongly influenced by socioeconomic determinants. These conditions and behaviours increase risk during pregnancy and birth.

Demographic Cost Pressure

There are an increasing number of complex presentations relating to; age; obesity; diabetes; and other co-morbidities. Women giving birth for the first time over the age of 40 years are more likely to experience complications during pregnancy and childbirth. In 2016, 45.9 per cent of maternity inpatient discharges were classified as non-delivery discharges, where hospital stays related to women's obstetrical experience but they did not deliver during that episode of care. The increase in the number of women delivering by Caesarean section may be attributed to an increase in demand for hospital resources. The total overnight inpatient length of stay has shown to increase with age, from an average of 2.8 days for females aged less than 25 years to an average of 4.5 days for those aged 45 years and over. However, the average length of stay in maternity services was 2.7 days which is consistent with previous years.

5.2 Building a Better Health Service

The launch of the National Maternity Strategy and the development of the National Women and Infants' Health Programme are strategic responses to the absence of a coordinated approach to women's health, and maternity services in particular. The programmatic approach will ensure all the services being delivered are coordinated nationally, and achieve the four strategic priorities set out in the National Maternity Strategy.

Healthy Ireland

One of the four strategic priorities is a health and wellbeing approach to maternity services. This is an all-encompassing objective from pre-conception health, to the health and wellbeing of mother and baby after delivery.

NWIHP will work in collaboration with the Health and Wellbeing Directorate to ensure that the maternity related developments are consistent with the overall national approach.

Core elements of NWIHP implementation plan that relate to Healthy Ireland include:

- Breastfeeding: NWIHP is now responsible for the baby friendly initiative, which aims to implement the WHO 10 Steps to Successful Breastfeeding. NWIHP will work in conjunction with National Breastfeeding Coordinator in implementing this programme.
- Make Every Contact Count: NWIHP, in conjunction with the Health and Wellbeing Directorate will develop a bespoke Make Every Contact Count for maternity services. This will address core areas of concern, such as:
    - Smoking cessation;
    - Alcohol consumption;
    - Substance misuse;
    - Healthy diet and life style.

- It will also address issues of social disadvantage and domestic violence.

National Clinical and Integrated Care Programmes

NWIHP is working in collaboration with a number of Clinical Care Programmes.

Obstetrics and Gynaecology: NWIHP and OBGYN Clinical Care Programme are working on a number of collaborations, around the development, maintenance and implementation of national guidelines. The key priority for 2018 for the OBGYN CCP is the development of clinical guidelines for child birth, which will underpin the NWIHP model of care.

Anaesthetics: NWIHP are working with the CCP in anaesthetics in developing a separate on call team for maternity emergencies for general hospitals. NWIHP will fund two anaesthetic posts in 2018 to test the model developed by the CCP.

Critical Care: NWIHP are working with the CCP in critical care to identify capacity requirements and develop pathways for critically deteriorating women within maternity units of general hospitals.

Neonatology: NWIHP is working in collaboration with the CPP in neonatology to support the implementation of the neonatal model of care.

5.3 Service Delivery

Implementing priorities 2018 in line with Corporate Plan goals

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

Develop a bespoke Make Every Contact Count programme

Priority	Accountable	Date
Provide social work and dietetics at maternity network level to create appropriate clinical pathways for women.	NWIHP	Q4 2018
Commence the process of developing pathways for women, who have an identified need from the Make Every Contact Count programme.	Maternity Networks	Q4 2018

Develop an online resource for maternity services

Develop an online resource to act as a one-stop shop for all maternity related information.	NWIHP	Q4 2018

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

Ensure anomaly scanning is available to all women attending antenatal services

Provide resources on a phased basis to improve access to anomaly scanning in units that do not currently offer any woman access to anomaly scanning (five units), and to the seven units where less than 100% of women are provided this service.	NWIHP	Q2 2018

Each maternity network will provide access for clinically appropriate women, where an anomaly scanning service is not available locally.	NWIHP HG's	Q3 2019

Establish the community midwifery model

Develop model for community midwifery to support implementation of the three care pathways within the model of care.	NWIHP	Q3 2018
Provide resources to maternity networks to implement the model at model for community midwifery and provide informed choice to women.	NWIHP	Q3 2018

Develop a national plan for benign gynaecology

Improve outpatient, inpatient, day case and emergency out of hours access to benign gynaecology services by developing a multi-year plan to address capacity.	NWIHP	Q3 2018

Roll out the anaesthetics model of care

Work with the clinical care programme in anaesthetics to commence the roll-out of an anaesthetics model of care for maternity services.	NWIHP/ CCP Anaesthetics	Q4 2018
Develop and implement principles to underpin the model of care pending completion of the National Clinical Effectiveness Committee guidelines.	NWIHP	Q4 2018

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

Support the establishment of maternity networks in each hospital group to provide governance and leadership for maternity services	NWIHP/ Group CEOs	Q2 2018
Oversee the establishment of maternity specific Serious Incident Management Teams in each maternity network with additional teams to ensure every serious incident is appropriately reviewed. Dedicated Quality and Patient Safety resource will be allocated to each network	Group CEOs	Q2 2018

Section 6: Finance

Financial Allocations for 2018

Gross Allocation Under ABF	Income	Net Allocation Under ABF
€5,657,645,000	€897,546,000	€4,760,099,000

Context

The National Service Plan of the HSE for 2018 sets out the service delivery targets, performance indicators and available funding to the health system for the year. This plan has been approved by the Minister for Health and is published on the website of the HSE. There is an overriding focus on patient safety as referred to in the National Service Plan.

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

In that context, the HSE estimates that there will be a financial challenge within the operational service areas of approximately €346m / 2.4% excluding what the HSE refers to as pensions and demand-led areas. This is after significant measures have been taken to avoid unfunded costs growth.

The National Service Plan identifies that in looking forward to 2018, including the key risk areas, the financial challenge within acute hospitals, after application of the DoH-provided planning assumptions is estimated to be €245 / 5.2%. Further context is provided within the Acute Hospital Services section of the plan. Through the Value Improvement Programme, we will target improvement opportunities to address the acute hospital financial challenge while maintaining levels of activity.

Income Budget

The income budget for Groups remains substantially unchanged from 2017 with the exception that the Accelerated Income Target of €44m has been removed. It is acknowledged that there will be specific issues relating to income billing and collection in 2018 and that there is a potential shortfall in this area of €60m nationally based upon the 2017 pattern of charging. While we can estimate the shortfall, the

requirement for the Hospital Groups for 2018 is to ensure that all charges required under the Health Acts are raised and collected to the greatest extent possible.

Value Improvement Programme

The HSE has set out a value improvement programme in Chapter 7 of the National Service Plan 2018. All Groups will be required to play an active part in the delivery of this programme across the three "priority themes" identified.

Priority Theme 1 in the National Service Plan the Hospital Groups are required to make savings/contain growth equivalent to 1% of your determined net budget for 2018. The Hospital Groups are required to set out proposals to save the 1% which nationally amounts to €46m across all Hospital Groups. The €46m target is not a budget reduction and has not impacted upon the budget allocation reference above.

Priority Theme 2 identifies a required cost containment of €119m:

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

There is no reduction in the Hospital Groups budget for any portion of this amount at this stage. The Operational plan for each Hospital Group will need to recognise the requirement to actively partake in the "systematic assessment" of all overhead expenditure. Upon completion of this assessment, targets will be determined for the entire HSE. Savings / cost containments will only be counted under this heading when the reduction targets in priority Theme 1 are achieved.

Priority Theme 3 the National Service Plan indicates a figure of €150m under this heading:

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

There is no impact on the hospital group budget for Theme 3 and no requirement for actions on the part of the hospital groups at this time.

Section 7: Workforce

The Health Services People Strategy 2015-2018

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

- **Staff Health and Wellbeing** - implement and operationalise the Staff Health and Wellbeing Strategy 2017.
- **Staff Engagement –** encourage participation in the 3rd staff survey and further develop and implement staff engagement and staff health and wellbeing programmes in response to findings.
- **Pay and Staffing Strategy** – monitor and support the implementation of the Pay and Staffing Strategy 2018.
- **Workforce Planning** - operationalise the *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning, 2017*.
    - **New Children's Hospital -** progress the development of Workforce Plans for the new Children's Hospital and Paediatric Outpatient and Urgent Care Centre.
    - **Quality & Patient Safety Function** – in consultation with the National Quality Improvement Division develop the Operating Model to support the development and enhancement of the Quality & Patient Safety function at both Acute Hospital and Hospital Group level.
    - **Human Resources Function -** in consultation with National Human Resources, develop the Operating Model to support the development and enhancement of the Human Resources function at both Acute Hospital and Hospital Group level.
- **Public Service Stability Agreement 2018 – 2020** - supports reform and change in Acute Hospitals, which will be further supported by the delivery of the Health Services Change Model 2nd Edition alongside the establishment of a range of accessible supports to further enhance organisational and change management capacity.
- **European Working Time Directive** – Acute Hospitals remain committed to maintaining and progressing compliance with the requirements of the European Working Time Directive.

During 2018 we plan to progress to the next phase of implementation of the strategy, continuing to focus on the priority outcome areas of Leadership & Culture, Staff Engagement, Learning & Development, Workforce Planning, Evidence and Knowledge, Performance, Partnering alongside the provision of Human Resource Professional Services, building on progress achieved to date.

Staff Health & Wellbeing

The implementation of the 'Staff Health and Wellbeing Strategy 2017' alongside the 'Healthy Ireland in the Health Services' Policy are key priorities, supporting initiatives to encourage staff to look after their own health and wellbeing ensuring we have a resilient and healthy workforce within Acute Hospital services.

The Health Services aims to:

- Protect health and wellbeing for staff by reducing work–related risk factors.
- Promote health and wellbeing for staff by developing the positive aspects of work and the strengths of employees.
- Address and support those with health problems regardless of cause.

Under National Human Resources, a Workplace Health and Wellbeing Unit was an initiative set up in 2016 under the *Health Services People Strategy 2015-2018*. This unit is committed to standardising approach to supporting our staff in managing their health and wellbeing and the challenges of working in the health service nationally.

Staff Engagement

Another key priority is to encourage participation of all Acute Hospital staff in the survey on engagement to ensure that their views are sought out and are listened to; creating circumstances where everyone's opinion counts and can make a difference, guiding us on what we can do to make our services better, both for our service users and for staff. Coupled with this is the need to take further actions based on the survey findings.

The Workforce Position

Government policy on public service numbers and costs is focused on ensuring that the health workforce operates within the pay budgets available. Each Hospital Group CEO has the delegated authority to manage their pay and staffing requirements.

Pay and Staffing Strategy 2018 and Funded Workforce Plans

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

- Operate strictly within allocated pay frameworks, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed.

- Comply strictly with public sector pay policy and the Code of Practice: Appointment to Positions in the Civil Service & Public Service.
- Identify further opportunities for pay savings to allow for reinvestment purposes in the health sector workforce and to address any unfunded pay cost pressures.

Pay and staff monitoring, management and control, at all levels, will be further enhanced in 2018 in line with the Performance and Accountability Framework. Early intervention and effective plans to address any deviation from the approved funded workforce plans will be central to ensuring full pay budget adherence at the end of 2018. An integrated approach, with management across Acute Hospitals being supported by HR and Finance, will focus on reducing and / or controlling pay costs, including agency and overtime, and implementing cost containment plans, in addition to maximising the performance and productivity of the health workforce.

Workforce Planning

The Department of Health published a *National Strategic Framework for Health Workforce Planning – Working Together for Health* in 2017, providing an integrated, dynamic and multi-disciplinary approach to workforce planning at all levels of the health service. We will support work to commence the operationalisation of the framework across Acute Hospitals in 2018. The implementation will also be guided by the relevant themes and work streams of the *Health Services People Strategy 2015-2018*, in conjunction with the Programme for Health Service Improvement. Particular attention will be directed to the further development of measures to support the sourcing, recruitment, and retention of staff categories where critical skills shortages have been identified.

Public Service Stability Agreement 2018 - 2020

The Public Service Stability Agreement, which represents an extension of the Lansdowne Road Agreement, was negotiated between government and unions in 2017 and will continue until December 2020. The Agreement builds on the provisions of previous agreements and enables reform and change in the health services.

European Working Time Directive

Acute Hospitals are committed to maintaining and progressing compliance with the requirements of the European Working Time Directive. Through the forum of the National EWTD Verification and Implementation Group, the Division continues to work collaboratively with Irish Medical Organisation, the Department of Health and other key stakeholders to work collectively towards the achievement of full compliance with the EWTD. The Division is also partnering with the Department of Health, the Irish Medical Organisation alongside National HR to facilitate a further Learning Day in 2018 to outline progress achieved to date alongside sharing the learning from different experiences in relation to implementation of measures across Acute Hospitals in support of compliance.

Conclusion

Side-by-side with the *Health Services People Strategy 2015-2018* detailed work plans have been developed across the priority outcome areas. In 2018, these work plans will be further developed and rolled out, with a particular focus on the key priorities identified for Acute Hospitals, in addition to the work plans already commenced during 2017.

Appendices

Appendix 1: Financial Tables

Group	Gross Allocation Under ABF	Income	**Net Allocation Under ABF
	€'000's	€'000's	€'000's
Ireland East	€1,114,943	€185,710	€929,233
Dublin Midlands	€1,065,212	€178,627	€886,585
RCSI	€863,297	€135,789	€727,508
Childrens Hospitals	€326,798	€34,481	€292,317
South South West	€981,373	€179,179	€802,194
UL Hospitals	€376,302	€69,574	€306,728
Saolta Healthcare	€863,189	€104,341	€758,848
National / Regional	€66,530	€9,000	€57,530
TOTAL ACUTE HOSPITALS DIVISION	€5,657,645	€896,703	€4,760,943

**Please note that the figures reported in the AHD Operational Plan are directly in line with the budget allocation, the Hospital Group Operational Plan figures may vary from these figures as a result of post budget reconciliation

Appendix 2: HR Information

HR Information, December 2017							
Staff Category: Dec 2017	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support	Patient & Client Care	**Total**
Acute Services	**7,918**	**21,707**	**7,166**	**8,819**	**5,942**	**6,549**	**58,102**
Children's	440	1,218	510	598	201	138	**3,104**
Dublin Midlands	1,280	3,790	1,618	1,576	891	1,147	**10,301**
Ireland East	1,647	4,358	1,351	1,717	1,399	910	**11,382**
RCSI	1,285	3,335	1,062	1,366	1,012	716	**8,777**
Saolta Healthcare	1,317	3,390	1,024	1,294	895	754	**8,674**
South/ South West	1,444	4,047	1,211	1,495	1,199	582	**9,979**
University of Limerick	504	1,559	388	646	331	547	**3,974**
other Acute Services		8	2	58			**68**
Ambulance	1	2		71	14	1,755	**1,843**

Appendix 3: Scorecard and Performance Indicator Suite

Acute Hospitals Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
Quality and Safety	**Complaints investigated within 30 days**	% of complaints investigated within 30 working days of being acknowledged by complaints officer
	Serious Incidents	% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident
	HCAI Rates	Rate of new cases of hospital acquired Staph. Aureus bloodstream infection (<1 per 10,000 bed days used)
		Rate of new cases of hospital acquired C. difficile infection (<2 per 10,000 bed days used)
		No. of new cases of CPE
	Urgent Colonoscopy within four weeks	No. of people waiting > four weeks for access to an urgent colonoscopy
	Surgery	% of emergency hip fracture surgery carried out within 48 hours
Access and Integration	**Delayed Discharges**	No. of beds subject to delayed discharges
	Emergency Department Patient Experience Time	% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration
		% of all attendees at ED who are discharged or admitted within six hours of registration
	Waiting times for procedures	% of adults waiting <15 months for an elective procedure (inpatient)

Acute Hospitals Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
		% of adults waiting <15 months for an elective procedure (day case)
		% of children waiting <15 months for an elective procedure (inpatient)
		% of children waiting <15 months for an elective procedure (day case)
		% of people waiting <52 weeks for first access to OPD services
	Cancer	Breast cancer: % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of two weeks for urgent referrals
		Lung Cancer: % of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres
		Prostate cancer: % of patients attending prostate rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres
		% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)
Finance, Governance and Compliance	**Financial Management**	Net expenditure variance from plan (total expenditure)
		Gross expenditure variance from plan (pay + non-pay)
		% of the monetary value of service arrangements signed
	Governance and Compliance	Procurement - expenditure (non-pay) under management
		% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received
Workforce	**EWTD**	<48 hour working week

Acute Hospitals Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
	Attendance Management	% absence rates by staff category
	Funded Workforce Plan	Pay expenditure variance from plan

Acute Hospitals Division 2018 Targets										
KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	CHG	DMHG	IEHG	RCSI	Saolta	SSWHG	ULHG	National Expected Activity/ Target 2018**
Discharge Activity Inpatient Cases	640,627	634,815	25,169	96,063	128,763	102,655	113,064	116,311	51,761	633,786
Inpatient Weighted Units	639,487		29,742	113,316	133,328	99,231	99,558	117,406	42,857	635,439
Daycase Cases (includes dialysis)	1,062,363	1,049,851	28,037	224,486	190,679	151,496	189,571	212,372	60,239	1,056,880
Day Case Weighted Units (includes dialysis)	1,028,669		36,788	179,423	207,394	139,417	181,041	213,009	68,935	1,026,007
Total inpatient & day cases	**1,702,990**	**1,684,666**	**53,206**	**320,549**	**319,442**	**254,151**	**302,635**	**328,683**	**112,000**	**1,690,666**
Emergency Inpatient Discharges	429,872	430,995	19,120	60,758	85,625	69,794	79,792	78,111	37,659	430,859
Elective Inpatient Discharges	94,587	92,172	6,049	13,452	18,328	10,479	15,878	19,753	7,488	91,427
Maternity Inpatient Discharges	116,168	111,648		21,853	24,810	22,382	17,394	18,447	6,614	111,500
Inpatient Discharges ≥ 75 years	New NSP 2018	New NSP 2018		17,404	25,949	18,026	23,736	23,471	10,580	119,166
Day case discharges ≥ 75 years	New NSP 2018	New NSP 2018		35,890	36,309	26,974	36,801	37,389	10,175	183,538
Emergency Care - New ED attendances	1,168,318	1,177,362	109,776	183,497	261,520	172,731	191,394	197,229	62,830	1,178,977
- Return ED attendances	94,225	97,238	7,689	14,570	23,108	14,483	10,938	22,951	3,632	97,371
Injury Unit attendances	81,919	91,463			7,976	16,141	6,502	29,880	31,088	91,588
Other emergency presentations	48,895	48,642	269	3,280	11,862	6,337	14,927	12,033		48,709
Births Total number of births	63,247	61,720		9,511	13,959	13,137	8,999	11,665	4,449	61,720

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	CHG	DMHG	IEHG	RCSI	Saolta	SSWHG	ULHG	National Expected Activity/ Target 2018**
Outpatients Number of new and return outpatient attendances	3,340,981	3,324,615	142,877	645,177	732,421	505,482	509,603	582,671	219,737	3,337,967

** Activity targets in the Operational Plan differ slightly (0.03%-0.8%) from those published in NSP 2018 following analysis by Health Pricing Office based on a later version of the national HIPE file

Acute Hospital Division 2018			
KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Beds Available			
In-patient **	10,681	10,771	10,857
Day Beds / Places **	2,150	2,239	2,239
Outpatient Attendances - New : Return Ratio (excluding obstetrics, warfarin and haematology clinics)	1:2	1:2.5	1:2
Activity Based Funding (MFTP) model			
HIPE Completeness - Prior month: % of cases entered into HIPE	100%	93%	100%
Dialysis			
Number of haemodialysis patients treated in Acute Hospitals **	170002	168,337	168,337
Number of haemodialysis patients treatments treated in Contracted Centres **	81,900 – 83,304	82,000	92,500
Number of Home Therapies dialysis Patients Treatments **	90,400 – 98,215	85,000	93,750
Outpatients (OPD)			
New OPD attendance DNA rates **	12%	13.5%	12%
Inpatient & Day Case Waiting Times			
% of adults waiting <15 months for an elective procedure (inpatient)	90%	82.70%	90%
% of adults waiting <15 months for an elective procedure (day case)	95%	89.30%	95%
% of children waiting <15 months for an elective procedure (inpatient)	95%	82.50%	90%
% of children waiting <15 months for an elective procedure (day case)	97%	85.30%	90%
% of people waiting < 52 weeks for first access to OPD services	85%	74.30%	80%
% of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	90%	76.30%	90.00%
Elective Scheduled care waiting list cancellation rate **	1.7%	1.70%	1%
Colonoscopy / Gastrointestinal Service			

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Number of people waiting greater than 4 weeks for an urgent colonoscopy	0	0	0
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	70%	51.90%	70%
Number of paediatric patients waiting greater than 2 weeks for access to an urgent colonoscopy **	New KPI 2018	New KPI 2018	0
Number of adult patients waiting greater than 4 weeks for access to an urgent colonoscopy **	New KPI 2018	New KPI 2018	0
Number of paediatric patients waiting greater than 2 weeks for access to an urgent oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	0
Number of adult patients waiting greater than 4 weeks for access to an urgent oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	0
% of paediatric patients waiting > 6 weeks following a referral for a routine colonoscopy or oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	70%
% of adult patients waiting < 13 weeks following a referral for a routine colonoscopy or oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	70%
Emergency Care and Patient Experience Time			
% of all attendees at ED who are discharged or admitted within six hours of registration	75%	66.80%	75%
% of all attendees at ED who are discharged or admitted within nine hours of registration	100%	81.30%	100%
% of ED patients who leave before completion of treatment	<5%	5%	<5%
% of all attendees at ED who are in ED <24 hours	100%	96.90%	100%
% of patients attending ED aged 75 years and over **	13%	11.70%	13%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration	95%	44.30%	95%
% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration	100%	63%	100%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration	100%	92.50%	100%
Ambulance Turnaround Times			

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
% 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)	95%	92.60%	95%
Length of Stay			
ALOS for all inpatient discharges excluding LOS over 30 days	4.3	4.7	4.3
ALOS for all inpatients **	5	5.3	5
Medical			
Medical patient average length of stay	6.3	6.8	≤6.3
% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration	75%	63.80%	75%
% of all medical admissions via AMAU	45%	33.70%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge	11.10%	11.00%	≤11.1%
Surgery			
Surgical patient average length of stay	5	5.3	≤5.0
% of elective surgical inpatients who had principal procedure conducted on day of admission	82%	74.70%	82%
% day case rate for Elective Laparoscopic Cholecystectomy	>60%	45.70%	>60%
Percentage bed day utilisation by acute surgical admissions who do not have an operation **	35.80%	38.00%	35.80%
% of emergency hip fracture surgery carried out within 48 hours	95%	84.90%	95%
% of surgical re-admissions to the same hospital within 30 days of discharge	<3%	2%	≤3%
Delayed Discharges			
Number of bed days lost through delayed discharges	≤182,500	≤193,661	≤182,500
Number of beds subject to delayed discharges	<500 (475)	563	500
Mortality			
Standardised Mortality Ratio (SMR) for inpatient deaths by hospital and defined clinical condition	New KPI 2018	New KPI 2018	N/A

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Patient Experience			
% of Hospitals Groups conducting annual patient experience surveys amongst representative samples of their patient population	100%	To be reported in Jan 2018	100%
National Early Warning Score (NEWS)			
% of Hospitals with implementation of NEWS in all clinical areas of acute Hospitals and single specialty hospitals	100%	98%	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning System)	New NSP KPI 2018	New NSP KPI 2018	100%
Stroke			
% acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	New NSP KPI 2018	New NSP KPI 2018	90%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	9%	12%	12%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	90%	65%	90%
Acute Coronary Syndrome			
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	90%	TBC	90%
% reperfused STEMI patients (or LBBB) who get timely PPCI	80%	TBC	80%
COPD			
median LOS for patients admitted with COPD **	New KPI 2018	New KPI 2018	5 days
% re-admission to same acute hospitals of patients with COPD within 90 days **	24%	25%	24%
Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	33 sites	29 sites	33 sites
Asthma			
% nurses in secondary care who are trained by national asthma programme **	70%	1.30%	70%

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Diabetes			
Number of lower limb amputation performed on Diabetic patients **	<488	513	<488
Average length of stay for Diabetic patients with foot ulcers **	≤17.5 days	15.8	≤17.5 days
% increase in hospital discharges following emergency admission for uncontrolled diabetes **	≤10% increase	4%	≤10% increase
ICU Access			
The % of patients admitted within one hour of a decision to admit **	New KPI 2018	New KPI 2018	50%
The % of patients admitted within four hours of a decision to admit **	New KPI 2018	New KPI 2018	80%
Hip Fracture			
% of patients with hip fracture who have surgery within 48 hours from first presentation **	New KPI 2018	New KPI 2018	85%
Rate of Hospital Acquired Venous thromboembolism (VTE, blood clots)**	New KPI 2018	New KPI 2018	TBC
Quality			
Rate of slip, trip or fall incidents as reported to NIMS that were classified as major or extreme	Reporting to commence in 2017	0.01	NA
Rate of medication incidents as reported to NIMS that were classified as major or extreme	Reporting to commence in 2017	0.01	NA
% of acute hospitals with an implementation plan for the guideline for clinical handover	100%	TBC	100%
% of Hospitals who have completed second assessment against the NSSBH	100%	27%	100%
% of Acute Hospitals which have completed and published monthly hospital patient safety indicator report	New NSP KPI 2018	New NSP KPI 2018	100%
Ratio of compliments to complaints **	2:1	Data not available	2:1
CPE			
Rate of new cases of Hospital acquired Staph. Aureus bloodstream infection	<1/10,000 BDU	0.7	<1/10,000 BDU
Rate of new cases of Hospital acquired C. difficile infection	<2/ 10,000 BDU	2.4	<2/ 10,000 BDU

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Number of new cases of CPE	New KPI 2018	New KPI 2018	Reporting to commence in 2018
% of acute hospitals implementing the requirements for screening of patients with CPE guidelines	New KPI 2018	New KPI 2018	100%
% of acute hospitals implementing the national policy on restricted anti-microbial agents	New KPI 2018	New KPI 2018	100%
National Women and Infants Health Programme			
Irish Maternity Early Warning Score (IMEWS)			
% of maternity units/ hospitals with implementation of IMEWS	100%	100%	100%
% of hospitals with implementation of IMEWS	100%	94.30%	100%
Clinical Guidelines			
% of maternity units / hospitals with an implementation plan for the guideline for clinical handover in maternity services	100%	Data not available	100%
% Maternity Units which have completed and published Maternity Patient Safety Statements and discussed at Hospital Management team/ Hospital Group/ NWIHP meetings each month	100%	100%	100%
National Cancer Control Programme			
Symptomatic Breast Cancer Services			
Number of patients triaged as urgent presenting to symptomatic breast clinics	18000	19,000	19600
Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals	17100	14,060	18620
% 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%	74%	95%
Number of Non-urgent attendances presenting to Symptomatic Breast clinics	24000	22,500	22500
Number 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 (Number offered an appointment that falls within 12 weeks)	22800	16,200	21375

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)	95%	72%	95%
Clinical detection rate: Number of new attendances to clinic, triaged as urgent, which have a subsequent primary diagnosis of breast cancer	>1,100	1,960	1,176
% of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer	>6%	10%	>6%
Lung Cancer			
Number of patients attending the rapid access lung clinic in designated cancer centres	3300	3,600	3700
Number of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	3135	2,880	3515
% of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	95%	80%	95%
Clinical detection rate: Number of new attendances to clinic, that have a subsequent primary diagnosis of lung cancer	>825	1,160	925
% of new attendances to clinic, that have a subsequent primary diagnosis of lung cancer	>25%	32%	>25%
Prostate			
Number of patients attending the prostate rapid access clinic in the cancer centres	2600	3,000	3100
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	2340	1800	2790
% 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	90%	60%	90%
Clinical detection rate: Number of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer	>780	1100	930
% of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer	>30%	37%	>30%

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Radiotherapy			
Number of patients who completed radical radiotherapy treatment (palliative care patients not included)	4900	5200	5200
Number 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)	4410	3900	4680
% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	90%	75%	90%

** denotes Operational Plan KPI only, all others are also in National Service Plan 2018

Appendix 4: Capital Infrastructure

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

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
Acute Hospital Services									
RCSI Hospital Group									
Our Lady of Lourdes Hospital, Drogheda, Co. Louth	Phase 3: Fit-out and equipping of theatres	Q4 2018	Q4 2018	0	0	8.16	10.94	0	0
	Phase 4: Fit-out and equipping of ED expansion at ground floor of ward block - including reconfiguration of existing ED and equipping of surgical ward	Q2 2018	Q2 2018	28	25	3.97	9.09	110	4.0
	Upgrade of hospital-wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q4 2017	Q1 2018	0	0	0.55	1.30	0	0
Connolly Hospital, Dublin	Phased upgrade of the existing radiology department - phase 1 in 2015 (Interventional Suite) includes equipment	Q1 2018	Q2 2018	0	0	1.00	8.32	0	0
	Upgrade of hospital-wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q1 2017	Q1 2018	0	0	0.22	1.02	0	0
Beaumont Hospital, Dublin	Provision of accommodation for the cochlear implant programme - refurbishment of existing St. Martin's ward after decant to renal dialysis unit	Q4 2018	Q4 2018	0	0	0.90	1.61	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
Dublin Midlands Hospital Group									
Simms Building, Tallaght, Dublin	Purchase and fit out of the building to provide accommodation for chronic care / day services from Tallaght Hospital	Q4 2017	Q1 2018	0	0	0.10	3.43	0	0
Midland Regional Hospital, Portlaoise, Co. Laois	New hospital street extension linking ED and AMAU	Q3 2018	Q3 2018	0	0	0.80	1.00	0	0
Ireland East Hospital Group									
St. Vincent's University Hospital, Dublin	The provision of a PET-CT facility. (PET-CT being donated by UCD)	Q4 2017	Q1 2018	0	0	0.00	0.89	0	0
Saolta University Health Care Group									
Sligo University Hospital	Upgrade of boiler plant and boiler room	Q3 2018	Q3 2018	0	0	1.20	2.30	0	0
University Hospital Galway	Medium temp hot water system upgrade/replacement Phase 1	Q1 2018	Q1 2018	0	0	0.20	0.50	0	0
	Provision of a new IT room for the hospital	Q2 2018	Q2 2018	0	0	0.35	0.50	0	0
Letterkenny University Hospital, Co. Donegal	Refurbish / upgrade CSSD	Q4 2017	Q1 2018	0	0	0.05	0.70	0	0
Mayo University Hospital	Replacement of lifts in main concourse.	Q4 2017	Q1 2018	0	0	0.08	0.70	0	0
UL Hospitals Group									
St. John's Hospital, Co. Limerick	Upgrade of hospital wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q4 2017	Q1 2018	0	0	0.08	0.88	0	0
University Hospital Limerick	Reconfiguration of recently vacated ED to create an medical short stay unit	Q4 2018	Q1 2019	17	0	0.60	1.00	30	1.4

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
Ennis Hospital, Co. Clare	Phase 1a of the redevelopment of Ennis General Hospital - consists of the fit out of vacated areas in the existing building to accommodate physiotherapy and pharmacy (complete) and the reconfiguration of layouts and the provision of a viewing room.	Q4 2017	Q1 2018	0	0	0.05	1.32	0	0
Nenagh Hospital, Co. Tipperary	Part 2 - Refurbishment of vacated space, support accommodation for 16 single rooms and 4 double rooms (part funded by the Friends of Nenagh Hospital)	Q3 2018	Q4 2018	0	0	0.90	4.79	0	0
South / South West Hospital Group									
Cork University Hospital	Blood Science Project - extension and refurbishment of existing pathology laboratory to facilitate management services tender	Q4 2018	Q1 2019	0	0	1.10	2.20	0	0
	Radiation oncology	Q4 2018	Q4 2019	0	0	20.00	56.00	0	0
	Provision of a helipad	Q3 2018	Q3 2018	0	0	1.00	1.70	0	0
South Tipperary General Hospital	Upgrade of hospital wide fire detection and alarm system and emergency lighting to facilitate current and future developments	Q1 2018	Q1 2018	0	0	0.22	1.02	0	0
Children's Hospital Group									
Our Lady's Children's Hospital (Crumlin), Dublin	Upgrade of services to the existing PICU	Q1 2018	Q1 2018	0	0	0.25	0.50	0	0