Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Acute Hospitals Division

Operational Plan 2016

Vision

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

Mission

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

Values

We will try to live our values every day and will continue to develop them

- Care
- Compassion
- Trust
- Learning

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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Executive Summary

Introduction

The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the *Health Act 2004* in line with National Service Plan (NSP) 2016 and allocated Group budgets. In this context each group will produce a detailed operational plan for 2016 which will be aligned with this Acute Hospitals Division overarching Operational Plan. The detail of the services which will be delivered at each of the hospitals within the funding allocation will be included in these Hospital Group Operational Plans for 2016.

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

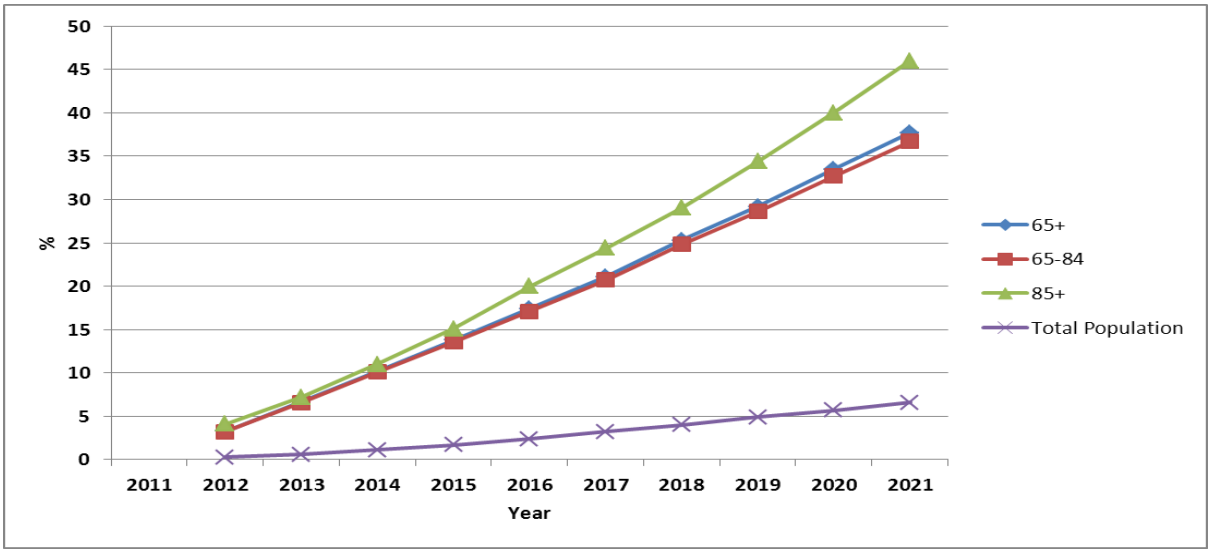
	2016 Available Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m
Acute Hospitals	4,053.5	4,134.8	3,925.0
National Cancer Screening Service	17.8	17.5	17.5
Clinical Strategy and Programmes	10.0	10.7	10.7
National Cancer Control Programme	54.4	54.3	54.3
Other	1.7	3.6	3.6
Total Available Funding*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

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

Impact of Demographics on Hospitals

The demand for acute hospital services continues to increase in line with a growing and ageing population. The overall population growth year on year is in the order of 1%. However, the growth of the over 65 year age group is increasing at a steeper rate, and of the order of 3-4% per year. In 2016 we can expect a projected increase of 32,500 persons in our population, including an increase of 19,400 aged 65 years and over and an increase of 2,900 persons of 85 years and over. Figure 1 below demonstrates the projected cumulative percentage change in 65 years and older population versus total population 2011 – 2021. A steep increase in the older age cohorts is evident.

Figure 1: Projected cumulative percentage change in 65 years and older population versus total population 2011–2021



Source: CSO

The *Health Information Paper 2015/2016 Trends and Priorities to Assist Service Planning 2016* outlines the impact of the changing age profile of our population with respect to Inpatient and Day Case activity, some key points include:

- In 2014, adults 65 years and over made up 12.7% of our population but used 53.3% of total hospital in-patient care and approximately 36% of day case care, and this trend is likely to continue.
- In 2014, adults 85 years and over represented 1.4% of our total population but use 13.5% of the in-patient beds.
- The five leading medical and surgical in-patient specialities in adults over 65 years include general medicine 37.2%, general surgery 11.9%, orthopaedic surgery 8.4% geriatric medicine 8.2% and cardiology 5.6%. General Medicine and Geriatric Medicine combined represent over 45% of all admissions in adults greater than 65 years.
- In adults over 65 it is projected, from 2014 to 2016, that there will be an increase of 3,846 discharges in General Medicine, 1,228 in General Surgery, 875 in Orthopaedics, 853 in Geriatric Medicine and 584 in Cardiology.
- The trend in projected in-patient costs for those over the age of 65 is an increase of 3.4% from 2015 to 2016.

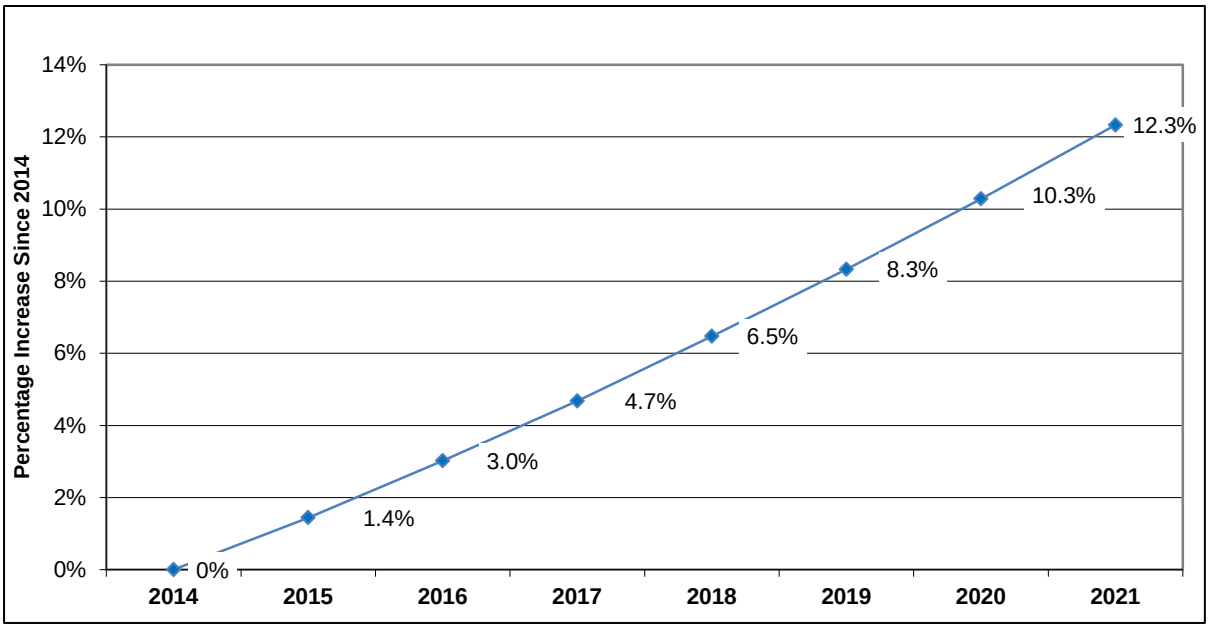
The increase in the population and the higher increase in the population over 65 is putting increasing pressure on hospital resources. Combining in-patient and day case discharges provides a view of total cost pressures facing publicly funded acute hospitals in managing their in-patient workloads over the period to 2021. This shows average annual demographically driven pressures of around 1.7% for the years from 2014 to 2021 with a rising rate reflecting the acceleration in population ageing over the period.

From 2015 to 2016, demographically driven cost pressures of 1.6% are predicted. Figure 2 below represents total in-patient and day case cost pressures for 2014 to 2021 and shows the trend line in costs in the acute sector based upon CSO data and the use of Hospital Pricing Office (HPO) cost data adjusting for the impact of ageing.

This equates to €64m of the net 2015 allocation to keep up with the demographic pressure. Clearly model of care changes relating to the frail elderly area and chronic conditions are key to addressing this challenge.

However in 2016 the pressure will continue to fall directly upon hospitals with limited additional financial provision.

Figure 2: Total in-patient and day case cost pressures, 2014 to 2021.



- *Source: HPO and CSO.*

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

Developments and Challenges 2016

The services outlined in this operational plan are based on those agreed in the National Service Plan 2016, which aims to deliver an equivalent volume of activity as that delivered in 2015 whilst acknowledging that the financial challenges are significant. Substantial cost control and cost reduction by the groups and hospitals will be required with a focus on controlling the total pay and non pay costs as well as maximising income. The 2015 HSE National Framework on Pay-bill Management and Control as issued on the 13th March 2015 sets the direction for 2016 with a number of modifications. These modifications include the revised 2016 Accountability Framework and a bottom-up approach being adopted, subject to national approval, in the development of Funded Workforce Plans at Division and Service Delivery Unit level. The specific challenges in meeting the financial and activity targets will be detailed within the group operational plans with an emphasis on delivering safe care at the 2015 volumes.

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

Options to address the remaining €100m funding shortfall have been considered during the service planning process, including aligning activity levels to the funding available, albeit this is considered as very much a last resort. In summary, this view is based on the significant risks inherent in operationalising such an option and more importantly on the negative impacts for patient access to services and for staff morale. The acute hospital division, with support from the rest of the HSE, will take a number of measures to control costs, reduce waste and improve efficiency aimed at minimising any impact on services.

The targets that need to be achieved in relation to these measures are very challenging and carry significant delivery risk although each of the measures represent areas of focus that the Acute Hospital Division would have intended to pursue in 2016 in any event. It is for the Acute Hospital Division and the Hospital Groups to ensure that appropriate management effort and attention is applied to maximising the delivery of savings measures and overall budgetary performance. Thereafter the HSE and DoH acknowledged the shared risks inherent in the extent of the savings targets and the assumptions underpinning them, which have been mutually agreed following extensive engagement in light of the alternative which is service reductions, within the service planning process. This is considered preferable in light of the alternative which is service reductions. With regard to inpatient activity it is recognised that the imperative is to continue to shift to day case activity in terms of enabling optimum access at the most efficient cost. The planned work undertaken by the system will give priority to urgent and complex cases. In terms of activity the division will also seek to optimise existing capacity through reducing length of stay and shifting care to appropriate settings including primary care.

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

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

∞: Discharge Activity in Divisional Operational Plan target 2016 is based on Activity Based Funding (ABF) and weighted unit (WU) activity supplied by HPO. Discharge Activity in NSP 2016 was based on data submitted by hospitals to Business Intelligence Unit

In Patient and Day Case Activity 2016

The National Service Plan 2016 set out the inpatient and day case activity based on projected activity outturn for 2015 using data returns from the hospitals to the Acute Business Intelligence Unit (BIU). 2016 sees the migration from BIU data to Hospital In- Patient Enquiry Scheme (HIPE) which determines the inpatient and day case activity that can be delivered within the envelope of funding available.

Traditionally hospitals submitted monthly data to BIU from reports generated by the Patient Admissions Systems (PAS) which often have to be manually adjusted to provide a full data set. The HIPE data are validated, available at discharge level and include administrative, demographic and clinical information. Each record on HIPE is grouped to a diagnostic related group (DRG) and a complexity-weighted unit of activity is applied, allowing for comparison in resource use, in addition to simple comparisons of numbers of discharges. While BIU data are available more quickly than HIPE data, it is less granular and it is not possible to drill down to individual discharges.

As part of the reconciliation of BIU and HIPE data in preparation for the transition in 2016 to ABF, 2.3% additional discharges (inpatient and day cases) were noted to have been reported to BIU in 2015 from a number of hospitals. 63% (1.5% total activity) of the additional discharges can be attributed to patients being treated as an inpatient in ED prior to being transferred to a ward bed, acute psychiatry patients and outpatient procedures being inadvertently reported as day cases. Whilst the HSE address the financial challenges of achieving increased efficiency, value for money and budgetary control in 2016, it is imperative to have full alignment between activity and costs. Therefore only HIPE activity will be used for measuring and monitoring inpatient and day case activity and this is reflected in activity projections included in this operational plan and in the Hospital Group Operational Plans.

Risks to the delivery of Acute Hospitals plan within funding available

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

- Capacity to cap the introduction of drugs and medical devices including transcatheter aortic valve implantations (TAVIs)
- Capacity to control activity volumes to the targeted level under ABF
- Capacity to maintain and collect income
- Capacity to achieve pay and non-pay cost control at the level required while demographic impacts drive demand for services
- Ability to contain activity to 2015 levels for emergency care and urgent and routine elective treatments
- Delayed discharges are not reduced to and maintained at <500 during 2016
- Service risks related to limited capacity in Intensive Care (ICU)
- Continued or accelerated demographic pressures over and above those already planned for in 2016
- The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce
- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system constraints
- Pay cost growth which has not been funded
- Risks associated with the delivery of procurement savings targeted at €9.9M
- Lack of contingency funding to deal with unexpected service or cost issues

Children's Hospital Development

The detailed resource plan on specific deliverables required in 2016 in relation to meeting the programme to design the new Children's Hospital and satellite centres and to integrate the three children's hospitals in time to open the satellite centres, is dependent on the level of funding in 2016.

The resource requirements of the Children's Hospital group are currently being reviewed in order to ensure that the project delivers against agreed timelines and this will be the subject of further dialogue with both the DoH and the Children's Hospital Group.

Clinical Strategy and Programmes

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

Clinical and Integrated Care Programmes

In 2016 the Clinical and Integrated Care Programmes will lead a number of priority programmes to design, develop and progressively implement models of care which will incorporate cross service, multi-disciplinary care and support which will facilitate the delivery of high quality evidence based and coordinated care. The Acute Care Division will collaborate with the Clinical and Integrated Care Programmes to ensure the changes implemented are consistent with frameworks, models of care, pathways and guidelines designed by the integrated and clinical care programmes.

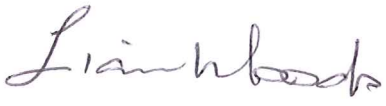
Integrated Care Programme for Older Persons

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

Conclusion

Notwithstanding the challenges ahead, the Acute Hospitals Division will strive to achieve key service objectives for 2016 which include:

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



Liam Woods
National Director (Interim)
Acute Hospitals Division

Improving Quality and Reforming Service Delivery

Strategic Priorities for 2016

The Acute Hospitals Division places a significant emphasis on the quality of services delivered and on the safety of those who use them and therefore will work in close collaboration with Quality Improvement Division (QID) and Quality Assurance and Verification Division (QAV) to improve the overall quality and safety of services with measurable benefits for patients and service users.

The four objectives which underpin the quality and patient safety programme led by QID and QAV are:

- Services must be relevant to the needs of the population
- Patients and service users must be appropriately encouraged and empowered to interact with the service delivery system
- Health services must work to a set of clear quality and safety standards that are based on international best practice
- Services must be safe and a strong focus must be placed on ensuring quality and safety is improved through a combination of improvement programmes and formal accountability for ensuring safe services

Progress on patient safety, clinical effectiveness and quality improvement continues to enable integrated care and promote services that are appropriate, delivered with the patient / service user at the centre, and are based on best clinical practice and integrated care pathways. In this context the objectives for 2016 include:

Leadership and Governance for Quality and Safety

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

- Establish positive and effective staff engagement as a keystone of quality improvement and person centred care by partnering with services to develop and test methodologies, build organisational leadership capacity and share learning

Safe Care

- Acting to promote the reduction of risk to the public, staff and healthcare services by adopting a risk based approach to predicting, identifying and responding to service areas where significant performance, quality and safety concerns may exist
- Improve monitoring, investigation and learning processes from serious incidents across all service areas. Progress the implementation of recommendations from major reports and serious incidents across all service areas
- Continue support and commitment to the process of development, implementation and monitoring of National Clinical Effectiveness Committee (NCEC) National Clinical Guidelines and Audit in all appropriate services including Early Warning Systems, Clinical Handover, Healthcare Associated Infections (HCAIs) and Sepsis
- Putting in place an effective system to identify, manage, investigate and implement the learning from serious safety incidents, safety investigations and regulatory investigations and inspections
- Strengthening the HSE's regulatory capacity to fulfil its responsibilities in the area of medical ionising radiation
- Continue the implementation, control and prevention of HCAIs / antimicrobial resistance (AMR) in accordance with HCAI standards across all service areas including decontamination standards
- Reduction in medication errors
- Establish a National Independent Review Panel with an independent Chair and Review Team members as part of the HSE's enhanced arrangements for investigations. The Review Panel will focus on serious incidents that occur in disability services across the HSE and HSE funded services

Effective Care

- Continue to prioritise improvements in the quality and safety of care in maternity and perinatal services
- Prioritise the safeguarding of service users, and support improvements in services in residential intellectual disability services
- Provide leadership and support to enable the services develop capacity and capability to deliver on key national patient safety programmes in primary care, social care and acute settings to address internationally recognised causes of harm to people (including HCAI, medication safety, pressure ulcers, falls prevention and nutrition and hydration)
- Develop a national policy framework for Policies, Procedures, Protocols and Guidelines (PPGs) including education training and support and commence the development of a document control system national repository for PPPGs

Service User Experience

- Listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals
- Conduct a service user and patient experience survey in each hospital (in conjunction with Health Information and Quality Authority- HIQA) and commence patient experience surveys in primary care and community services
- Develop and implement a national person-centred care Programme which engages, enables and empowers people to be at the centre of service delivery

- Continue the development of a patient-centred and improvement culture in the HSE that will deliver on sustainable quality improvement with the implementation of a framework for improving quality which provides a structured approach to improving health and social care service delivery by enabling staff to focus on the key drivers for quality improvement
- Continue to develop access to advocacy for all patients and service users within, Hospital Groups and Ambulance Services; work to ensure that advocacy is available to older people in all settings; and provide advocacy services to patients, including work with Patient Focus
- Leading a national person-centred programme (including listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals)

Health Service Reform

The Hospital Groups will continue to establish their governance structures and management teams in line with the Strategic Plans for each Group which will be finalised early in 2016. The arrangements between the Hospital Groups and relevant Academic partners will be consolidated and clinical governance structures defined. The Acute Division National Strategic Plan will be developed in conjunction with Systems Reform Group.

Operational Framework – Financial Plan

Introduction

The Acute Hospital Division 2016 net allocation amounts to €4,137.4m, inclusive of funding for opening run rate deficit, national pay awards and new prioritised initiatives.

Significantly 2016 is the year when the funding model is migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for public hospital care covering inpatients and day-cases.
Breakdown of ABF allocation by Hospital Group is attached at Appendix I.

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

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

Incoming Deficit

In 2015 hospitals spent some €150m more than their available budget delivering services. While it is acknowledged that the 2016 letter of allocation includes €100m to support this level of service delivery, there is a residual unfunded amount of €50m. The figures are shown below and it is expected that cost containment plans can deliver savings in the region of €33m to €43m against this shortfall.

			Measures to address shortfall – range: stretch to best case	
Opening 2015 Funding Shortfall – Before savings measures proposed	€m		From €m	To €m
Current 2015 funding level	4,011.1			
Winter Plan 2015 funding	9.0			
Provision of 2015 deficit funding in 2016	100.0			
Funding relevant to 2015 spend	4,120.0			
Projected 2015 spend (excluding waiting list initiative)	4,170.0			
Opening 2016 funding shortfall / measures to address	50.0		32.6	43.5

In order to deliver the same volume of service as 2015 the offered prices to hospitals has been discounted by 2% compared with their existing cost level for 2015. This discount applies before any incremental costs related to 2016 are factored in.

Existing Level of Service / Cost pressures

The cost of providing the 2015 level of service will grow in 2016 due to a variety of factors. Under Activity-Based Funding cost growth is considered under two headings - 'price' and 'volume'.

1. It is acknowledged that there will be 'price' effects in the following areas. This means that the underlying price will rise, but no additional service will be obtained for that expenditure:-
   - National pay agreements
   - Public pay policy requirements such as increments
   - Quality and safety requirements
   - New drugs and improved medical technologies
   - Supplier price increases, and potentially some price savings if oil prices translate into our energy bills

2. In addition to the 2015 level of service there will be 'volume' pressures in 2016 due to the nature of the demographics, over 85 population etc. The challenge in this context is that the ABF targets have been locked with a price to fit within the funding envelope. Those targets are based on the rolling 12 months to the end of October 2015. There is no funding to exceed that level of service - and in fact the prices available have already been discounted by 2%.

The Acute Hospitals must not grow volume in 2016 as this will lead to increased non-pay expenditure on bloods, laboratory, medical consumables etc. It can also lead to increased expenditure on variable pay such as overtime. Further to these price and volume pressures, there is a further €50m challenge to be addressed in 2016. This relates to historic income-collection targets which have now been included in the expenditure budget.

As shown below it is anticipated that there will be a shortfall in the region of €175m for these items and based on our assessment we can seek to address from €149m to €173m of the shortfall. When the €50m incoming problem and the expected growth are added together the total shortfall to be addressed is the €225m in the table.

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

The HSE and the Hospital Groups will ensure that appropriate management effort and attention is applied to maximising the delivery of the savings measures set out above and in the overall budgetary performance of the hospitals. Thereafter the HSE and the Department of Health have acknowledged the shared risks inherent in the extent of the savings.

The Financial Control framework for 2016 will consist of four major components:-

1. Headcount and other pay controls
2. Management of activity volume and clinical non-pay
3. System-wide approach to non-clinical non-pay
4. Maximising delivery of income targets

1. Headcount and other pay controls

Following a number of years of economic recession, the hospital system did fill a range of risk-related posts in 2015 which has been vacant due to the recruitment moratorium. The strategy to deliver the EWTD and efforts to reduce agency premium also involved increases in headcount. It is clear that the financial envelope which is available in 2016 does not allow for any further recovery of vacant posts, and indeed efforts will have to be made in some circumstances to carefully manage staff numbers in line with savings targets - particularly in hospitals which filled significant posts in 2015.

The HSE has already given hospital groups a pay framework for 2016 which will require them to improve the governance of headcount, further specific agency conversion where appropriate and manage expenditure on variable pay at 2015 levels - particularly through controlling activity volumes.

2. Management of activity volume and clinical non-pay expenditure

The three critical components of clinical non-pay expenditure are:-

1. Activity volume
2. New drugs and increased volume of existing drugs due to treatment regimes
3. Improved medical technologies

- Increases in workload involve expenditure on consumables, medical and surgical devices, bloods, laboratory etc. The prices which have been offered to hospitals for 2016 under ABF are already discounted by 2% which means that hospitals cannot afford the levels of expenditure already being incurred and must make savings on these. Critically, there is no scope to increase clinical non-pay expenditure by growing volume.

  The monthly performance meetings with the Hospital Groups will focus heavily on the volumes being produced to ensure that these are within the targeted levels for the year which have been locked in place with prices to fit the funding envelope. To the greatest extent practical and consistent with the safe delivery of services hospitals will deliver services at 2015 levels.

- New drugs are an intrinsic element of hospital systems and good progress has been made in recent years in the area of high-cost cancer drugs supported by the National Cancer Control Program and their protocol-driven reimbursement system. So called 'orphan' drugs such as enzyme replacement therapy can increase expenditure steeply and are among some of the most expensive drugs in the system. Additional funding has been provided in the service plan for this aspect of hospital expenditure.

Increased volume of drugs is a more difficult issue and can arise due to volume of patients and/or changes in treatment regimes which require more frequent administration of certain chemotherapy drugs. These types of cost will have to be managed carefully in the context of savings targets.

- Improved medical technologies such as the capacity to deliver thrombectomy in stoke care or transcatheter aortic valve implantation (TAVI) can suddenly bring considerable additional cost to the system and these items will have to be isolated and monitored during 2016 given the funding available.

3. System-wide Approach to Clinical Non-pay

   Working with colleagues in other Divisions of the HSE, the Acute Hospital Division will review all areas of non-clinical expenditure to achieve savings.

4. Maximising Delivery of Income Targets

   The changes in legislation in relation to bed designation have allowed the hospital system to increase its income generation. Private patient billing and other income-generation is now supporting service costs to the level of €987m. This is a significant income target and is a considerable increase on the 2015 outturn. The €50m accelerated income target is a part of the increased target together with other factors such as an expected 4.55% growth in the private patient market.

   Some hospitals grew their income billing quite significantly in 2015 and the targets build in a level of this expectation for those which did not. Work is already taking place to assess the resources and systems available to maximise billing and to share processes and apply resources to assist hospitals to achieve these very stretched targets.

HSE Prioritised Initiatives

A total of €13.1m has been prioritised for new initiatives in 2016 including opening of newly commissioned units, maternity services, children's hospital developments and blood and organ transplantation. The full year cost of these initiatives in 2017 is €27.3m. This represents an additional investment of €14.4m in 2017 and approval of NSP 2016 is taken as confirmation that these initiatives can be commenced in 2016 on the basis that this additional funding will be provided in 2017.

Furthermore, additional funding has been allocated to NCCP - 2016 €10m of which €7m is for drugs 2017 FYC €16.4 – which is projected to be available to Acute Hospitals in due course. This additional NCCP funding has been included in table below for completeness.

New Initiatives

	2016 €m	2017 €m	2017 Incremental Funding Requirement €m
Opening of commissioned new units	2.8	5.9	3.1
Maternity services	3.0	9.3	6.3
Hospital service developments	3.0	4.1	1.1
Paediatric service developments	3.8	5.8	2.1
Cancer services	10.0	16.4	6.4
Organ transplantation	0.5	1.9	1.4
Grand Total	23.1	43.4	20.4

Activity Based Funding

As indicated in Introduction section above, 2016 is the year when we are migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for public hospital care covering inpatients and day-cases. ABF involves a 'revenue' stream being offered to each group/hospital for specified inpatient and day-case activity, together with a block grant for other work. The combined total can be referred to as the budget, but with a very different underlying construction - *if the specified work is not delivered, the ABF revenue will not be paid.* We recognise that we will have to work with exceptions to this principle - for example a serious outbreak in a hospital might prevent them from delivering work; however the core principle is being established:

- A specified price will be paid for each weighted unit of inpatient work and each weighted unit of day-case work up to the limit of the specified activity target
- If specified work is not delivered, ABF revenue will not be paid
- If excess work is delivered further ABF revenue will not be paid

A national envelope of funding has been determined based on the exchequer funding allocation. Inpatient and day case care is being purchased using price and activity volume, with transition adjustments. The remaining activity such as emergency care, out-patients etc will remain in the block grant allocation.

The overarching management approach to ABF within a hospital should be to deliver "efficiency within the financial cap". The Irish health system operates with a financial cap so ABF cannot fund unlimited increases in volume. What it can do, and is doing, commencing in 2016, is to reward those hospitals which clearly have unit costs below the national average.

Operational Framework – Workforce Plan

Introduction

The Acute Hospital Division recognises and acknowledges its people as its most valuable resource and key to service delivery. Recruiting and retaining motivated and skilled staff is a high priority for the division as specialist skills deficits within health care pose a serious threat to the delivery of services and many workforce planning initiatives are in progress to address these concerns. 2016 will see a focus on the "The People Strategy" which has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. This strategy is underpinned by a commitment to engage, develop, value and support people, thereby creating a culture of high trust between management and employees, supporting the achievement of performance. Through supporting and facilitating continuous professional development and learning, embracing leadership and teamwork and accepting and managing change, service delivery and performance will improve. The Acute Hospital Division will support the implementation of The People Strategy throughout the Hospital Groups.

The Workforce Position

Government policy requires that the number of people employed in Acute Hospital Services is within the limit of the available funding. The management of funding for human resources in 2016 will continue to be based on the Pay bill Management and Control Framework. Compliance with the framework and the requirement for Hospital Groups to operate within the funded pay envelope is a key priority for the Acute Hospital Division, alongside the management of risk and service implications. This approach sees a transition from moratorium to an accountability framework designed to support creation of annual and multi-annual workforce plans based on models of care that will deliver services within allocated pay resources. Hospital Groups that meet budget targets will have greater discretion and flexibility in how they manage their workforce and payroll costs, while ensuring services are delivered in line with the National Service Plan. The Division is currently working collaboratively with National HR and Finance in consultation with the Hospital Groups to develop comprehensive workforce plans into 2016 that are closely aligned to funding projections.

Hospitals Employment Levels

The whole time equivalent numbers employed by the acute sector fell significantly during the years of austerity and by Oct 2015 have returned to 2009 levels (Government Moratorium on public sector recruitment) but over that period there has been a reconfiguration of the skills mix. The data demonstrates a shift in the mix of staff reflecting an increase in medical staffing while there have been reductions in nursing and support services. The hospitals nationally will need to reduce total staff numbers in 2016 to achieve the financial targets contained within this plan. The specific staff levels will be identifed in the operational plans of the Hospitals Groups. The range of adjustment will vary depending upon the outurn for each group in 2015. Where hospitals are achieving a balanced financial position for 2015 current staff numbers may be affordable. Agency costs reduced in between 2014 and 2015 by over €19.5M and this trend is expected to continue in 2016.

Reducing Agency and Overtime Costs

The Acute Hospital Division will continue to focus on further reductions in the cost and reliance on agency staff and overtime during 2016. This will involve services developing appropriate plans for agency conversion and reduction in overtime expenditure across all services and staff categories, to deliver appropriate and cost effective services.

The division will continue to monitor and review agency and overtime costs whilst working to support the Hospital Groups with implementing initiatives to reduce costs, such as redeployment, skill mix review, and changes in work practices including the establishment of staff banks.

2016 Developments

The planning, approval, notification, management, monitoring and filling of service development posts will be in line with the existing process for approved and funded new service developments as specified in National Service Plan. Other workforce additions, not specifically funded at the outset of the year, will be implemented only where offset by funding redirection within the allocated pay envelope.

Public Service Stability Agreements 2013-18

The Lansdowne Road Agreement 2015 builds upon the agreement set out in the Haddington Road Agreement (HRA) until 2018. This includes an extension of the enablers, such as additional working hours, to support reform, reconfiguration and integration of services. This will also involve skill mix initiatives, systematic review of rosters, de-layering of management structures, restructuring and redeployment of existing workforce, new organisation structures and service delivery models. The new agreement includes a strengthened oversight and governance arrangement for dealing with matters of implementation and interpretation in the event of disputes that may arise. The Acute Hospital Division will implement actions agreed under the Public Service Agreements 2013–2018 through which change is achieved and is a central element of the strategy for recovery and a sustainable future for acute hospital services.

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

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

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

In 2016, as per the Final Agreement for Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement the following tasks will transfer from Medical to Nursing staff in line with associated National Framework and Task Transfer Verification Process (December 17th 2015):

- Peripheral cannulation
- Phlebotomy
- Intra Venous drug administration — first dose; including in the appropriate setting
- Nurse led delegated discharge of patients.

Workforce Planning

The Acute Hospital Division will engage in high quality workforce planning, ensuring that funded workforce plans are developed, at both Hospital Group and Hospital level, which are practical, reasonable and aligned to best practice. This will require ongoing review of skill mix requirements and effective staff deployment to manage workforce changes. The funding for these plans will be managed through the Pay Bill Management and Control framework. This will also address the impact of skills shortages, support improved capacity within acute hospitals by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals. There will also be a focus on workforce design based on service design and delivery, driven by clinical care pathways and efficient and effective staff deployment alongside the development of leadership and management competencies.

European Working Time Directive (EWTD)

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 currently working jointly with National Human Resources in consultation with the Hospital Groups to develop a comprehensive framework plan to support the achievement of full compliance.

Recruitment

The Acute Hospitals continue to work with national HR to recruit and retain highly skilled Medical and Nursing staff to approved positions to support services.

The division will support the work of the HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including:

- Developing an agreed Hospital Group strategy for specialties within each Group to meet demand and demography whilst acknowledging neighbouring group services, recognising established national specialties and matching developing national strategies such as the provision of trauma services
- Developing a statement on shared service division within the relevant specialty
- Compiling information on the precise allocation of available facility resources including, for example, allocation staffed theatre time, protected beds, Outpatients (OPD), endoscopy sessions, Non consultant hospital doctor (NCHD) staffing, specialist nursing, allied health staffing and administrative resources

Attendance and Absence Management

The Acute Hospital Division will continue to maintain and build upon the progress achieved during the past year in improving attendance levels through the consistent implementation of the Managing Attendance Policy and Procedures. The performance target for 2016, remains at less than or equal to 3.5% staff absence rate. In addition, the Division will continue to support the implementation of an agreed performance management framework. In doing so, managers will receive support to manage absenteeism and performance appropriately.

Employee Engagement

As outlined previously, the Acute Hospital Division will support the implementation of The People Strategy throughout the Hospital Groups. Particular emphasis will be placed on the employee experience and increased levels of engagement through ensuring that each staff member is aware of how their role links to the organisational objectives.

Efforts will be made to ensure that the “employee voice” is heard and their views considered with appropriate feedback being given, alongside the further development of people management practices. In this context, the Acute Hospital Division will continue to actively engage with staff and will continuously seek to identify opportunities to involve more staff in planning and decision making. Mechanisms will also be developed to improve effective internal communications to enable responsiveness. In addition, discussions between staff and managers, concerning professional and career aspirations will take place, which will inform learning and development.

Health and Safety at Work

In 2016 there will be a corporate emphasis on: reviewing and revising the Corporate Safety Statement, developing key performance indicators (KPIs) in Health and Safety Management and Performance, launching a new statutory Occupational Safety and Health training policy, and developing and commencing a national proactive audit and inspection programme. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established. Improving staff health and wellbeing is also a key strategic priority and education campaigns will include specific information and supports to help staff improve their own health and wellbeing.

Accountability Framework

Introduction

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

The key components of the Performance Accountability Framework for the Health Services 2016 as they relate to the acute hospital services are as follows:

- Continued strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group Chief Executive Officers and the CHO Chief Officers
- Completion of Formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers
- A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance
- Continued cooperation with the National Performance Oversight Group with respect to accountability responsibilities with the focus on the balanced scorecard
- Accountability arrangements will be put in place in 2016 between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Operational Business Plans

Accountability Framework

In the second half of 2015 a review of the operation, effectiveness and application of the Accountability Framework was commissioned and completed. The learning from this and recommendations arising will be taken on board during 2016 as appropriate and the acute hospital division will roll out the associated implementation plan once finalised.

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

Areas for development and improvement during 2016 include:

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

As part of the Performance Accountability Framework 2015 an enhanced Escalation and Intervention Framework and process was developed for implementation during 2016. The HSE's Escalation and Intervention Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels.

Accountability Levels relevant to Acute Hospital Services

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

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

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

Service Arrangements and Compliance

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

These agencies are required to enter into a formal Service Arrangement with the Executive. The Service Arrangement is the contract between the Executive and each individual Provider and comprises the general terms and conditions set out in the Service Arrangement and a number of schedules prepared on an annual basis that specify the services to be delivered, budget, staffing, quality and safety, monitoring requirements, etc. Under the Service Arrangement, Providers are obliged to give certain undertakings in relation to compliance with a range of standards and statutory requirements.

Given the level of investment by the State in services provided by the non-statutory sector, the Provider Board must, in respect of the Service Arrangement for 2016 and subsequent years;

- Submit a formal Annual Compliance Statement
- Adopt and implement core governance standards

Delivery of Services

Acute Hospital Division Key Priorities and Actions to Deliver on Goals in 2016

Acute Services

The seven hospital groups, RCSI Hospital Group, Ireland East Hospital Group, Dublin Midlands Hospital Group, Children's Hospital Group, South/South West Hospital Group, Saolta University Health Care Group and University of Limerick Hospital Group, will each deliver on the following goals in 2016 in association with the Acute Hospitals corporate team:

 Promote Better Health and Wellbeing as part of everything we do so that people will be healthier		
Priority Area	Action 2016	Target/ Date
Healthy Ireland	Promote healthy lifestyle for patients and staff, reduce incidence of disease and support best management of chronic diseases such as diabetes, COPD and coronary heart disease through the development and phased implementation of hospital group *Healthy Ireland* plans	Q1-Q3
	All hospital Groups complete Healthy Ireland Plan	Q3
	Appoint Healthy Ireland Implementation Plan Lead in each Hospital Group	Q1-Q4
	Increase the number of hospital frontline staff trained in brief intervention	Q1-Q4
	Promote increased uptake of seasonal flu vaccination by hospital staff	Q1
	Implement the HSE Policy on Calorie Posting in all hospitals	Q1-Q4
	Support Health and Wellbeing Division in the development of a *Hospital and Patient Food Policy* and contributing to the development of the NCEC guideline for *the Identification and Management of under nutrition in Acute Hospital settings*	Q1-Q4
Cancer Screening	Support the expansion of BreastCheck from 65–69 years and develop the BowelScreen Programme in 2016 to support a two year screening round by 2017	Q1-Q4
Healthcare Associated Infections	Ensure control and prevention with compliance with targets of healthcare associated infections/AMR with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms, underpinned by the implementation of HIQA *National Standards for the Prevention and Control of Healthcare Associated Infections*	Ongoing
	Commence monthly reporting of key performance indicators on the number of patients colonised with multi-drug resistant organisms (MDRO) that cannot be isolated in single rooms or cohorted with dedicated toilet facilities	Ongoing
	Monthly reporting of hospital acquired S Aureus bloodstream infection and hospital	Ongoing

	acquired new cases of C Difficile infection	
Models of Care	Develop a national model of care for haemachromatosis In collaboration with Primary Care	Ongoing

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

Priority Area	Action 2016	Target/ Date
Scheduled Care	Improve performance in relation to scheduled care by ensuring active management of waiting lists for inpatient and day case procedures and reduce waiting times by strengthening operational and clinical governance structures including: • Monitor and report chronological scheduling for routine inpatient and day case procedures • Commence monitoring of waiting lists for a range of diagnostic procedures • Adherence to National Treatment Purchase Fund (NTPF) guidelines in relation to scheduling of patients for surgery • Commence monitoring of Scheduled waiting list cancellation rate • Reorganise hospital group services with an increased focus on small hospitals managing routine or planned care locally and more complex care managed in the larger hub hospitals • Optimise capacity by reducing length of stay in line with the surgical programme targets and increasing day of surgery rates • Shift care to the most appropriate setting including increased day surgery rates and redirection of minor operations from hospitals to primary care • Improve day of surgery admission rates for all hospitals • Improve day case rate for laparoscopic cholecystectomy • Reduce bed day utilisation by acute surgical admissions who do not have an operation, in all hospitals • Collaborate with the Primary Care Division in relation to the transfer of appropriate minor surgery procedures to be undertaken in the primary care setting • Identify minor surgical procedures currently undertaken in theatre that could be undertaken in other hospital settings such as procedure room or OPD • Ensure that all procedures are carried out in the most appropriate clinical setting and are coded accurately	Ongoing
Out Patient Improvement Programme	Continue to roll-out the outpatient reform programme with an emphasis on the new minimum dataset, improved pathways of care and efficiency measures through the outpatient services performance improvement programme. • Complete Musculoskeletal (MSK) and Dermatology out-patient pathways, with proof of concept in hospital groups • Commence Opthalmology and neurology out-patients pathways of care • Finalise roll-out of e-referrals (Phase 1) to all hospitals • Initiate formal audits of Outpatient Services, as per Outpatient KPIs • Develop an Outpatient Patient Satisfaction Tool • Review and update protocol for the management of Outpatient Services • Refine New to Review metrics to exclude Obstetric and Warfarin Clinics	Q1-Q4

Unscheduled Care	Improve performance in relation to unscheduled care by continuing to implement the Emergency Department (ED)Task Force report recommendations in conjunction with the Acute Hospitals Division and community healthcare services to ensure that all patients are admitted or discharged from ED within 9 hours but in particular those > 75 years of age	Q1-Q4
	Alleviate pressures on the hospital system over the winter period enabling achievement of the targeted reduction in trolley waits by opening a number of additional beds	Q1-Q2
	Activate Full escalation response in the event of red status on trolleygar or any patient breaching the 9 hour maximum trolley wait as per *Mandatory National Directive 27/11/15*	Ongoing
	Implement the Irish Hospital Redesign Programme in Limerick University Hospital in 2016 and continue to implement the programme in Tallaght Hospital, which has been established to improve healthcare delivery in Irish hospitals, using a redesign approach in conjunction with the integrated programme for patient flow.	Q1-Q4
Quality	Continue to implement the *National Standards for Safer Better Healthcare in Acute Hospitals (NSSBHC)*	Q1-Q4
	Complete first and second assessments against NSSBHC in all hospitals and develop action plans to address any gaps identified	Q2
	All Acute Hospitals to report and publish monthly hospital patient safety statement	Q1-Q4
	Implement the aspects of Memo of Understanding between State Claims agency and HSE as it relates to Acute Hospitals to ensure the timely sharing of actual and potential clinical risk information (once approved)	Q1-Q4
	Co-operate with Quality Assurance and Verification Division on the roll out Phase Two of the National Incident Management System	Q1-Q4
	Establish processes and governance structures in Hospital Groups which reduce the incidence of and support the management of Serious Reportable Events (SREs) and Serious Incidents (SI s)	Q1-Q4
	Establish defined patient safety and quality framework in all hospitals that will address: • Patient experience /satisfaction • Clinical Governance and Accountability • Performance Monitoring: Incident Reporting • Mortality/Morbidity Review • Complaints management • Service improvement	Q1-Q4
	Commence Reporting of additional indicators of Safe Care with the measurement of adverse events monthly in relation to: • Postoperative wound dehiscence • In-hospital fractures • Foreign body left during procedure • Pressure Ulcer Incidence • Falls Prevention	Q1-Q4

	The Acute Hospitals Division will work with the Quality Improvement Division to: • Improve the safe management of medicines • Ensure nutritional assessment of vulnerable inpatients and good nutritional management of those at risk • Ensure our services are truly person centred • Ensure the governance arrangement in hospital groups has a clear structure and process to prioritise the focus on the quality of care provided. • Improve the measurement and analysis of quality in the acute sector • Further develop the role of clinical leadership in the hospital system • Train staff in quality improvement methodology Based on the findings of the HIQA Portlaoise Report: • Each Hospital Group will undertake a risk assessment of clinical and corporate governance within their Group with a view to identifying and stratifying immediate risks and mitigating actions, (in particular the transfer policy for high risk patient cohorts) • Each Hospital should implement on-going mandatory clinical training programmes for all clinical staff in respect of day-to-day care of pregnant women where such programmes do not already exist Continue to develop the hospitals' capacity to respond to Category 4 (e.g. Ebola) type threats Continue to support the implementation of the Major Emergency Response function in Acute Hospitals.	Q2-Q4 Ongoing Q1-Q4 Ongoing Ongoing
Maternity Services	Implement maternity service improvements in line with HIQA recommendations and other relevant reviews including: • Commence implementation of the National Maternity Strategy once published • All 19 maternity units to report and publish monthly maternity patient safety statement • Implement the Maternity Charter which will be informed by the Maternity Strategy • Appoint Programme Lead, Clinical Lead and Director of Midwifery for the Women and Infants Health Programme • Appoint Directors of Midwifery to all maternity units • Implement the midwifery workforce planning study (Birthrate Plus) • Continue to establish the Coombe Clinical Network and develop maternity clinical networks within all other hospital groups • Plan and develop the provision of equitable access to antenatal anomaly screening in all Maternity Units in the context of emerging clinical maternity networks • Develop bereavement specialist teams in all maternity units • Progress plans for the relocation of Dublin Maternity Hospitals and Limerick Maternity Hospital • Progress maternity service developments in South Tipperary General Hospital as recommended in the Flory Report	Q1-Q4 Q1 Q2-Q4 Q1 Q1-Q3 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Ongoing Ongoing
National Specialty Services and Care Pathways	Develop a detailed national implementation plan for targeted hip ultrasound screening programme for infants at increased risk of developmental dysplasia of hip (DDH) Support the phased implementation of the policy when published on Trauma Networks for Ireland within existing resources	Ongoing Q1-Q4

	Continue to support the progress made in 2015 by the National Rare Diseases Office with the further development of the rare diseases webpage and Information Helpline for patients and health care providers and the development of a database of centres of expertise in Ireland as part of the rare disease portal	Q1-Q4
	Continue to work with the National Renal Office to: • Increase the number of patients accessing Renal Home Therapy (Peritoneal Dialysis and Home Haemodialysis) treatments • Establish a National Plan for Haemodialysis Patient Transport	Q1-Q4
	Establish a National Endoscopy Working group to target improvements in endoscopy services nationally. This working group will be clinically led and will target actions to improve current capacity and demand management	Q1-Q2
Clinical and Integrated Care Programmes	Support the development of implementation plans for integrated care pathways across all hospitals in collaboration with the Clinical and Integrated Care Programmes	Q1-Q4
	Integrated Care for Patient Flow Support the establishment of the Integrated Care Programme for Patient Flow and prioritised work-streams	Q1-Q4
	Merge the Irish Hospital redesign Programme to support the planned and phased implementation of a pilot project to design, test and deploy the application of scientific management practices in healthcare to tackle patient flow.	Q1-Q4
	The Clinical Strategy and Programmes will lead in the design and phased implementation of new service delivery models and methods supported by the Acute Hospital Division: • Emergency service communication project • Enhancing Acute surgical Assessment Services • Enhancing Musculo-skeletal physiotherapy services • Phased implementation and planned rollout NQAIS	Q1-Q4
	Integrated Care for Older People Support the phased implementation of evidence based, integrated care pathways for older persons in conjunction with the Integrated Care Programme Older Persons (ICP OP) and National Clinical Care Programme older People (NCCOP) to improve quality, access and value for older persons requiring acute care. This includes; • NCCOP and ICP OP will engage with CHO and Hospital Group Leadership to prepare pioneer areas to work towards shifting models of care, building on local initiatives and combining the ICP operation framework. • NCCOP and ICP OP will support the establishment of local Integrated Care Team. • NCCOP and ICP OP will establish project work streams to develop and evaluate model.	Q1-Q4
	Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD) Support the phased implementation of integrated care pathways across all hospitals in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease for patients with : • COPD • asthma • ischaemic heart disease	Q1-Q4

	• diabetes Collaborate with ICPCD and the Office of the Chief Information Officer (OCIO) in the design of chronic disease registries for use in primary, secondary and continuing care Integrated Care Programme for Children • Support the establishment of the Integrated Care Programme for Children and associated work-streams. • Contribute to the design a phased implementation of a pilot scheme for general paediatric consultant-delivered service • Complete the roll-out of PEWS in all hospital groups.	Q1-Q4 Q1-Q4
Ambulance Service	Develop a performance indicator which will monitor time taken for clinical handover of patients in ED that will be based on the National Ambulance Handover Protocol for the Handover of Ambulance Patients in EDs and differentiates between completion of clinical handover and the time ambulance crew are available for next call, in conjunction with National Ambulance Service.	Q1-Q4
Organ Donation	Continue to develop an improved organ donation and transplantation infrastructure with a view to achieving target donation and transplant rates. Recruit additional co-ordinator for Organ Donation and Transplant Ireland service.	Q1-Q4 Q3
Cancer Services	Improve rapid access services for patients where there is a high index of suspicion of prostate or lung cancer. Improve access for patients attending Symptomatic Breast Disease services who are triaged as non-urgent within a 12 week timeframe. Support improvements in diagnosis, medical oncology, radiation oncology, surgery and multi-disciplinary care for cancer. Implement the National Clinical Guidelines – No. 7 Diagnosis, Staging and Treatment of Patients with Breast Cancer, No. 8 Diagnosis, Staging and Treatment of Patients with Prostate Cancer and No. 13 Diagnosis, Staging and Treatment of Patients with Gestational Trophoblastic Disease. Appoint Advanced Nurse Practitioners to support consultants in cancer services	Q1-Q4 Ongoing Ongoing Q1-Q4 Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Governance	Embed the hospital group structures within Acute Hospital Services Develop the Hospital Group Strategic plans and The Acute Division National Strategic Plan in conjunction with Systems Reform Group. Consolidate arrangements between Hospital Groups and Academic Partners as per Reform Programme. Comply with recommendations from local audits and potentially systemic	Q1-Q4 Q2 Q1-Q4 Q1-Q4

	recommendations in accordance with HSE Internal Audit procedures. Complete Service Arrangements as appropriate in accordance with HSE Governance Framework for Funding Non-Statutory Provided Services. Align Emergency Management structures for emergency planning and crisis response to new Hospital Groups. Appoint Hospital Group Leads for Emergency Management. Working with the emergency management function of the HSE, ensure emergency management structures across hospitals continues to develop.	Q1 Q1 Q1-Q4
Patient Experience	Implement plans to build the capacity and governance structures needed to promote a culture of patient partnership across acute services. Use patient insight to inform quality improvement initiatives and investment priorities Undertake Patient Experience Surveys in conjunction with Health Information and Quality Authority (HIQA) and Department of Health in all acute hospitals on a phased basis within available resources. Support the implementation of the HSE Open Disclosure National Guidelines.	Q1-Q4 Q1-Q4 Q3-Q4 Q1-Q4
National Clinical Guidelines	Continue implementation of the National Clinical Guidelines: • Communication (Clinical Handover) in Maternity Services, o National Clinical Guideline No. 5 • Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No. 11 • Sepsis Management, National Clinical Guideline No. 6 o Hospital Group Sepsis leads will complete a gap analysis of the implementation of the guideline in each Hospital. o Sepsis Leads will develop an action plan informed by GAP analysis for implementation of the Guideline in each Hospital Group. o Develop performance indicators that will provide assurance of compliance with the Guideline Develop self-audit schedules and follow-up action plans in each of the hospital groups for: • NEWS -National Early Warning Score • IMEWS -Irish Maternity Early Warning System • PEWS -Paediatric Early Warning Score	Q2-Q4 Q1 Q2 Q1-Q4 Q2
Protection of Children and Vulnerable Persons	Ensure the appropriate staff are appraised of the Children First Act and their associated duties and responsibilities. Provide training to relevant staff in conjunction with Children First development officers. Implement the policy on Safe-guarding Vulnerable Persons at Risk of Abuse in conjunction with Social Care Division.	Q1-Q4 Q1-Q4
Staff Engagement	Use learning from the employee survey to shape organisational values and ensure that the opinions of acute hospital staff are acknowledged.	Ongoing

 Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them		
Priority Area	Action 2016	Target/ Date
People Strategy 2015-2018	Implement the People Strategy 2015-2018 within each Hospital Group. Develop Staff engagement programmes which aim to involve staff in service delivery planning. Support improved capacity within acute hospitals by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals within current resources Support the National HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including: • Develop an agreed Hospital Group strategy for specialties within each Group • Develop a statement on shared service division within the relevant specialty • Compile information on the precise allocation of available facility resources for consultant services Continue to work with National HR on Nursing Recruitment and Retention initiatives Ensure that health education campaigns will include specific information and supports to help staff improve their own health and wellbeing Implement the Healthy Workplace Policy and support initiatives to encourage staff to look after their own health and wellbeing.	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4
Public Service Agreement	Establish Local Implementation Groups (LIG) which will oversee the local implementation of the Final Agreement of the *Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement December 17th 2015*	Q1-Q2
Nursing Services	Support phase 1 pilot of the framework on staffing and skill mix for nursing related to general and specialist medical and surgical care in acute hospitals in conjunction with the Office of the Nursing and Midwifery Services. Monitor and report through the Office of the Nursing and Midwifery Services: • The number of nurses registered to prescribe medicinal products. • The number of nurses registered to prescribe ionising radiation. • The number of ED and AMAU nurses who receive clinical skills and competence education to improve patient flow. • The number of oversees nurses who completed a mandatory adaptation programme.	Q1-Q4 Q1-Q4
EWTD	Ensure compliance with the European Working Time Directive within all Hospital Groups and provide reports on; • Maximum 24 hour shift • Maximum 48 hour week	Q1-Q4
National Guidelines on Accessible Health and Social Care Services	Participate on Working Group to oversee the implementation of the strategy for People with Disabilities as it applies to the HSE. Work with services to ensure that they are examining their services for accessibility, in line with the national guidelines.	Q1-Q4 Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Activity Based Funding	Move to the next phase of transition to an Activity Based Funding model of funding hospital activity with the initial focus on inpatient and day cases. All hospitals will complete HIPE coding within 30 days of patient discharge	Q1-Q4 Q1-Q4
Pay-Bill Management and Control	Ensure compliance with the Pay-bill Management and Control Framework by providing a Hospital Group compliance statement to verify that the conditions of the *Pay-Bill Management and Control HSE National Framework* has been adhered as set out by the HSE National Leadership Team memorandum dated 13th March 2015.	Q1-Q4
Surgery Improvements NQAIS	Continue to use to monitor and measure surgical activity across all hospitals using the National Quality Assurance Information System (NQAIS) Surgery.	Q1-Q4
Acute Medicine NQAIS	Continue the development and implementation of NQAIS medicine: • Continue the pilot in Mercy University Hospital. • Adopt a quality improvement approach to the further development and roll-out of the system to all acute hospitals in conjunction with HSE Health Intelligence Unit. • Provide training and education on NQAIS Medicine to key staff in Acute Hospitals. • Provide support and advice to Clinical Directors and Senior Managers in the application of the system.	 Q1 Q1-Q4 Q1-Q4 Q1-Q4
NQAIS-Mortality	Continue the roll out of the NQAIS-NAHM (National Audit of Hospital Mortality) Module to all hospital groups.	Q1-Q4
NQAIS-Radiology	Continue to support the development of Radiology Clinical Programme in NQAIS radiology system.	
Health Business Services	Acute Hospitals continue to collaborate with Health Business Services to embed and adapt the HBS customer relationship model	Q1-Q4

RCSI Hospital Group

Introduction

RCSI Hospitals Group was established in 2015. A wide range of emergency, diagnostic, treatment and rehabilitation services are provided by the hospitals in the Group, serving a population of over 1.03 million people. The Group also provides tertiary services in several specialties including neurosurgery, cochlear implant, renal transplant, living donor programme, cancer services. Our aim is to develop a single effective corporate and clinical governance structure providing high quality and safe care.

Acute Services	
2016 Budget €m	
RCSI Hospital Group	627.935

The Group comprises of the following hospitals:

- Beaumont Hospital
- Connolly Hospital
- Cavan and Monaghan Hospital
- Our Lady of Lourdes Hospital
- Louth County Hospital
- Rotunda Hospital

The Academic Partner for the Group is the Royal College of Surgeons in Ireland (RCSI).

RCSIHG focus in developing the group strategy encompasses:

- Having patients at its centre.
- Portraying a strong ambition for the Group with an exciting strategic direction.
- Clearly articulating our key objectives.
- Portraying a journey of which staff will be proud and supportive.
- Setting out a clear roadmap for the Group.
- Being informed by the latest leading international practice.
- The Hospital Group and its staff need to be clear on objectives and understand each individual's role on this journey.

The RCSI Hospital Group focus is to develop tangible implementation plans with explicit accountability and timelines to deliver successful results.

The Hospital Group is committed to sharing capacity and workload in order that patients receive the earliest possible appointment/treatment regardless of their geographic location.

RCSI Additional Key Priorities and Actions to Deliver on Goals in 2016

 Promote Better Health and Wellbeing as part of everything we do so that people will be healthier		
Priority Area	Action 2016	Target/ Date
Healthy Ireland	Establish structures to support development of Group HI plan	Q1

 Provide fair, equitable and timely access to quality, safe health services that people need		
Priority Area	Action 2016	Target/ Date
Service initiatives	The initiatives planned for delivery in last quarter 2015 will be maintained into 2016 and include: • Beaumont Hospital - extend Elderly Day Hospital to 5 day service and cohort patients to specialty wards realigning 35 beds to Medicine • OLOL - Open 4 bed Surgical Assessment Unit and 12 inpatient beds in Modular Unit. Commence build of Phase 2 with 60 single ensuite rooms and new theatre block together with extended ED. • LCH - Open 10 additional inpatient beds as Elderly Rehab unit. • Connolly - Utilise Cherry Ward as surge capacity together with streaming of benign urology and gynaecology from Beaumont Hospital. • The individual plans for the three focus hospitals in terms of the Emergency Taskforce are in place and being progressed with support from the SDU. A critical element of delivering on elements of this plan together with Waiting Lists is the IT infrastructure which is severely limited in the statutory hospitals in particular.	Q1-Q2
Winter Initiative	Alleviate pressures on the hospital system over the winter period enabling achievement of the targeted reduction in trolley waits by opening a number of additional beds. Provision of MDT approach to Frail/elderly in conjunction with CHO. Complete the Modular Build for CDU and SAU/increase in medical beds by 8 in Our Lady of Lourdes Drogheda. Day hospital Beaumont extension from 2 to 5 day service.	Q1 Q1 Q1 Q1
Living Donor / Renal Transplant Programme	Recruitment of consultant staff for the Living Donor /Renal Transplant Programme at Beaumont Hospital.	Q2-Q4
Cochlear Implant Programme	Complete the recruitment of staff for Cochlear Implant programme at Beaumont Hospital. This includes Clinical Psychologist, Teacher of the Deaf and an Audiologist posts to further develop both the new implant programme and the replacement/upgrade of existing implants.	Q2
Pancreatic Transplant Programme	Effect transfer of programme to St Vincent's Hospital	Q1
	The newly established Quality and Safety Group Directorate of the RCSI Hospitals	

Quality	Group will progress the following goals in 2016: • Complete a review of the Quality and Safety functions in each Hospital of the RCSI Group, identifying areas for improvement as part of this review. • Standardise the processes for Serious Reportable Events (SREs) and Serious Incidents (SIs) across the RCSI Hospital Group. • Standardise the Risk Register Process within the RCSI Hospital Group in line with HSE Policy.	Q4 Q3 Q3
Maternity	Implement recommendations of the Flory Report. Develop Maternity Clinical Network within the Group. Implement Phase 1 of the Maternal and Newborn Clinical Management System at Rotunda Hospital.	Q2 Q1-Q4 Q2-Q4
Integrated Care Programme for Older Persons	Initiate implementation of the Model for Integrated Care Programme for Older Persons at Our Lady of Lourdes Hospital in association with local CHO, Clinical Strategy and Programmes and Social Care Division.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Governance	Embed the hospital group structures within Acute Hospital Services Complete Hospital Group Strategic plan Introduce Executive Safety Walk-rounds	Q1-Q4 Q2 Q2

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

Priority Area	Action 2016	Target/ Date
Joint Management Forum	Continue to improve IR and HR arrangements within the Joint Management Forum.	Ongoing
Staff Development	Develop Workforce Planning Strategy and Training and Development Programmes.	Ongoing
Engagement Strategy	Establish Staff Consultation and Engagement strategy	Q2-Q4
Awards Scheme	Establish CEO and Chairman Awards Scheme	Q1
Future Leaders Programme	Establish future leaders programme	Q1-Q4

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	
Priority Area	Action 2016	Target/ Date
Financial Systems	Continue to embed strong governance structure to support the move towards Trust status	Q1-Q4

Ireland East Hospital Group

Introduction

The Ireland East Hospital Group provides services covering the full range of clinical tertiary and a number of quaternary services to upwards of 1 million people. IEHG tertiary services include: the National Centre for Cardiothoracic Surgery, the National Spinal Surgery Centre, National Cystic fibrosis and Pulmonary Hypertension centres as well as national centres for Heart, Lung, Liver, Pancreas, and Cornea transplantation.

Acute Services	
2016 Budget €m	
Ireland East Hospital Group	814.065

The Group includes the following hospitals:

- Mater Misericordiae Hospital
- National Maternity Hospital, Holles Street
- Cappagh National Orthopaedic Hospital
- Royal Victoria Eye and Ear Hospital
- St. Columcille's Hospital
- St. Vincent's University Hospital
- Midlands Regional Hospital, Mullingar
- Our Lady's Hospital, Navan
- Wexford General Hospital
- St. Luke's General Hospital, Kilkenny
- St. Michael's Hospital, Dun Laoghaire

University College Dublin is the academic partner for IEHG.

The establishment of the IEHG is supported with a detailed Work Programme which provides a comprehensive framework for delivering the Groups key strategic priorities as it works towards strengthening the Hospital Group initially and ultimately as the Group aims to deliver an integrated Hospital Trust.

The work programmes include:
Governance, Quality and Patients Safety, Clinical Services Design and Re-organisation including the development of an Academic Health Centre, Corporate Services, Communication, Innovation, Integration with Community Healthcare Organisations and Influencing.

The IEHG will work with the Systems Reform Office to progress relevant programmes within the Group. A steering group will oversee the development of a Strategic Plan for service configuration and integration consistent with national objectives for delivery of patient services. At present the Group is mapping services across each of the 11 hospitals as part of the strategic plan.

Ireland East Additional Key Priorities and Actions to Deliver on Goals in 2016

Goal 1	Promote Better Health and Wellbeing as part of everything we do so that people will be healthier	
Priority Area	Action 2016	Target/ Date
National Screening Services	Ensure compliance with the National Screening Services e.g. Colonoscopy and Colposcopy	Q3
Clinical Pathways	Develop Clinical Pathways for elderly patients across hospitals and CHOs to support positive ageing	Q3
Healthy Ireland	The IEHG HI Steering Committee will provide governance and direction for the Healthy Ireland (HI) Implementation Plan 2015 – 2017 including: • Develop a Health Ireland implementation plan for the IEHG. • Establish local implementation teams within each hospital to support implementation.	Q3

Goal 2	Provide fair, equitable and timely access to quality, safe health services that people need	
Priority Area	Action 2016	Target/ Date
Unscheduled Care)	The IEHG Unscheduled Care Governance Committee (USGC) was established in 2015. The priority for the UCGC is to: • Minimise the numbers of patients waiting for admission for a hospital bed and to engage with Community Healthcare Organisations to minimise the numbers of frail elderly requiring admission to hospital. • Roll out of ED transformation programme to other EDs in the Group with a view to continuing improvement in efficiencies. • Successfully achieve Group and hospital KPIs as set out in IEHG Winter Escalation Plan. • Have systems in place to advise the public of activity∞ levels in Emergency Departments.	Q1-Q4
GEMs Projects	• Pilot two frail elderly programmes in St. Vincent's University Hospital Dublin and in St. Luke's Hospital Kilkenny • Develop new pathways and enhance existing pathways for frail elderly between primary, continuing and community care and IEHG.	Q3
Acute and CHO Integration	The IEHG GP network advisory group will identify innovative ways for Primary and Secondary Care integration including: • Establishment of Local Integrated Care Committees within each IEHG acute hospital (where these do not already exist). • Establishment of an integrated forum with GPs and CHOs to address frail elderly, chronic disease management and ED avoidance • Review initiatives for improving integration across primary/secondary care within the HG. • Undertake a review of the implementation of the National Clinical Care Programmes across the Group with a particular focus on Surgery, ED and Acute Medicine Clinical Programmes.	Q2

New Developments	Open new units as per NSP 16 in Kilkenny and in Wexford • Open new expanded ED and AMAU in Kilkenny in early 2016 • Transfer all day surgery to the new stand-alone Suzi Long Day Surgery Unit • Open two new endoscopy suits • Appoint new ED consultants in Kilkenny and Mullingar • Open additional delivery suite in Wexford. Open 3rd maternity theatre in Wexford •	Q2-Q4
Winter Initiative	Open all additional beds as per Winter Initiative 2015/2016 • 22 additional medical beds – SVUH • 13 beds (10 bedded ward and 3 isolation rooms) - Loughlinstown • 12 additional beds – Kilkenny • 10 bedded ward – Wexford • 15 additional rehab beds in Navan/Mater • 10 additional beds - Cappagh	Q1
Scheduled Care	Establish a Scheduled Care Governance Committee Develop a work programme to: • Redesign existing services to increase elective capacity within the Group. • Undertake a demand and capacity profile of diagnostic resources across the group.	Q1-Q4
Policies Procedures Protocols and Guidelines	Review existing PPPG's to align these to national PPPG's	Q4
National Pancreatic Transplant Programme	Transition of the pancreatic transplant programme from Beaumont to St. Vincent's University Hospital will continue in 2016 subject to the availability of sufficient funding: • Appointment of new consultant transplant surgeon and national pancreatic transplant lead. • Appointment of pancreatic co-ordinators/clinical nurse specialists . • Development of clinical audit and MDT links with Edinburgh Royal Infirmary to support pancreatic transplant services in Ireland. • Development of agreed pathway of care between Beaumont and SVUH for management of patients requiring simultaneous kidney and pancreatic transplants.	Q1 – Q4
Cancer Services	Establish a Clinical Academic Directorate for Cancer services across the Group. This will include: • Integration of cancer services between the Mater and St. Vincent's University Hospitals. • Establishment of new pathways for patients in IEHG. • Seeking European accreditation in SVUH as a centre of excellence for the treatment of Neuroendocrine tumours. •	Q3 Q4
Maternity Services	Progress the relocation of the National Maternity Hospital, Holles Street – commence enabling works in St. Vincent's University Hospital. Establish an IEHG maternity network across the four maternity units . Implement Phase 1 of the Maternal and Newborn Clinical Management System at Holles Street Hospital.	Ongoing (Q1-Q4) Ongoing Q2-Q4

Metabolic Service	Continue to develop the adult metabolic service in the Mater Misericordiae University Hospital for the transition of adolescents from paediatric services subject to the provision of adequate additional funding: Expand staffing in Mater to accommodate the transfer all remaining adult PKU and LSD patients to the Mater Hospital.	Q3
2015 Service Development	Continue the roll out of approved 2015 service developments • Appointment of additional consultants in MMUH & SVUH Acute Medical Assessment Units • Appointment of a TRASNA stroke post to support stroke telemedicine within the Group	Q1-Q3

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

Priority Area	Action 2016	Target/ Date
Patient Engagement Strategy	• Development of an IEHG patient engagement strategy and complaints management plan. • Monitor and review patients satisfaction.	Q3
Quality & Patient Safety	Establish a quality and patients safety Group directorate which will, inter alia, oversee the implementation of the National Standards for Safer Better Healthcare and the recommendations of the Portlaoise Report (and other reports and investigations). Establishing a clinical governance framework will be a priority in 2016. This will include: • Developing a Group QPS structure with internal and external stakeholders. • Developing a Group strategy. • Implementing a monitoring framework incorporating continuous quality improvement initiatives.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Workforce Planning	• Develop a workforce plan for the Group.	Q4
Staff Engagement Strategy	• Develop a staff engagement strategy as part of the IEHG internal communications plan. • Develop an IEHG integrated multimedia communication strategy including a range of social media platforms to improve staff and public communication including provision of live data on ED waiting times.	Q2
Staff Performance and Development	• Develop a performance management framework for staff across the Group. • Develop an Executive Leadership Programme for CEO/GM/Clinical Directors and Senior Managers across the Group. • Develop, in conjunction with UCD, a strategy for education, training research and innovation.	Q1-Q4
Nursing & Midwifery Bank	• Establish a Nursing and Midwifery Bank for the IEHG to ensure the provision of quality safe patient care by the appropriately qualified competent healthcare professionals within a cost effective structure. • Ensure that appropriate systems are in place for measuring quality of outcomes and the effective use of resources.	Q1-2

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	
Priority Area	Action 2016	Target/ Date
Group Structure	• Implement a robust organisation structure which will encompass service delivery, academic partnership and research priorities for the IEHG.	Q1-Q4
Data Analytics Capacity	• Development of ~~a~~ data analytics capacity to assess the effectiveness of investment in terms of long term patient outcomes and effective day to day operational management. • Develop health analytics capacity within the IEHG to support deliver of evidence based care and direct planning for service provision.	Q3
Service Reorganisation	• Lean Academy: The Mater/UCD lean Academy will be extended across the Group in 2016 and will be a key strategic objective for the Group to support process improvement.. • Increase training of staff in white and green belt level across IEHG. • Development of appropriate evidence based clinical care pathways (including diagnostic pathways) across the group.	Q1 – Q4

Dublin Midlands Hospital Group

Introduction

The Dublin Midlands Hospital Group (DMHG) began development in early 2015. The group CEO was appointed in November 2014 with the Senior Management Team being established in Q2, 2015. Hospitals in the Dublin Midlands Hospital Group serve a population of approximately 800,000 people.

Acute Services	
2016 Budget €m	
Dublin Midlands Hospital Group	769.950

The Dublin Midlands Hospital Group includes the following hospitals:

- St. Luke's Radiation Oncology Network
- Adelaide and Meath incorporating the National Children's Hospital (Tallaght Hospital)
- Coombe Women and Infants University Hospital
- St. James's Hospital
- Naas General Hospital
- Midlands Regional Hospital Portlaoise (MRHP)
- Midlands Regional Hospital Tullamore

Trinity College Dublin is the Academic Partner for the Group.

The Group will finalise its Strategic Plan for 2016 – 2018 in 2016 with the focus on improving clinical performance in scheduled and unscheduled care and in the development of clinical networks and delivery systems to improve access to excellent care in accordance with the HIQA National Standards for Safer Better Healthcare and in alignment with the National Committee on Clinical Excellence, the National Clinical Programmes and the National Cancer Control Programme Guidelines.

Dublin Midlands Additional Key Priorities and Actions to Deliver on Goals in 2016

 Promote Better Health and Wellbeing as part of everything we do so that people will be healthier		
Priority Area	Action 2016	Target/ Date
National Screening Services	Ensure compliance with the National Screening Services KPIs e.g. Colonoscopy and Colposcopy	Q1-Q4
Positive Aging Projects	Work with community partners on positive aging projects including admission avoidance and education in accordance with the National Dementia Framework. Develop Clinical Pathways for elderly patients across hospitals and CHOs to support positive aging	Q1-Q4 Q1-Q4
Health and Wellbeing Programmes	Evaluate and extend health and wellbeing programmes for chronic diseases including diabetes, obesity and alcohol related conditions	Q2-Q4

 Provide fair, equitable and timely access to quality, safe health services that people need		
Priority Area	Action 2016	Target/ Date
Irish Hospital Redesign Programme (IRHP)	Dublin Midlands Hospital Group will continue to support the IHRP team at Tallaght Hospital to continue to implement sustainable change that is improving patient flow and patient experience with regard to scheduled and unscheduled care.	Q1-Q4
Hospital Capacity	Conduct capacity review of access to diagnostics and formulate capacity plan Reduce endoscopy waiting times for non-urgent cases Increase capacity for spinal services at Tallaght Hospital Progress development of MRI Unit at Tullamore Hospital Enhance access to stroke telemedicine services at Tallaght Hospital	Q1-Q4 Q1-Q4 Q1-Q4 Q4 Q4
Portlaoise Hospital (MRHP)	Continue the implementation of recommendations of HIQA report at MRHP Enhance day case activity upon completion of capital development at MRHP	Q2-Q4 Q4
Winter Initiative	Open additional 16 beds in Tallaght Hospital and 11 beds at Naas Hospital Develop rehabilitation services in Laois/Offaly in conjunction with social care services Review and Plan for winter 2016/2017	Q1 Q2 Q3
Cancer Services	Commission the two additional linear accelerator capacity in St. Luke's Hospital Support the recruitment of additional staff for the phased increase in Radiation Oncology Services at St. Luke's Hospital, associated with commissioning of new linear Accelerators	Q3 Q4

Maternity Services	Progress plans for the relocation of Coombe Maternity Hospital to St. James site. Continue the development of the Coombe/Portlaoise maternity network with the recruitment of additional specialty staff (Neonatologists, Obstetricians, Perinatal Pathologist and Perinatal Psychiatrist).	Q1-Q4 Q1-Q4
Clinical Networks/ Pathways	Develop and implement prioritised clinical networks in accordance with DMHG Strategic Plan 2016 – 2018. Improve peri-operative clinical pathway by more efficient use of pre-assessment, pre-admission ward and operating theatre utilisation in all hospitals within the group.	Q3-Q4 Q1-Q4
Quality	Appoint a Director of Quality and Safety to lead the integration and development of quality and safety across the Group aligned with corporate identities. Establish a Quality Council for the Group. Roll out clinical audit in collaboration with National Office for Clinical Audit (NOCA).	Q1 Q1 Q1-Q4
Integrated Care Programme for Older Persons	Initiate implementation of the Model for Integrated Care Programme for Older Persons at Tallaght Hospital in association with local CHO, Clinical Strategy and Programmes and Social Care Division.	Q1-Q4

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Priority Area	Action 2016	Target/ Date
Governance	Continue to strengthen governance across the Group within the context of Service Level Agreements with the voluntary hospitals and in line with new group clinical and management structures in the statutory hospitals. Complete 3 year Strategic Plan. Communicate the core values of the HSE Corporate Plan in line with the roll out of the DMHG Strategic Plan.	Q1-Q4 Q2 Q3
Patient Advocacy	Pilot the development and implementation of patient and advocacy group engagement in MRHP with intent to roll out across all hospitals	Q1-Q4
Accountability	In accordance with the HSE Accountability Framework 2016 continue to improve performance management systems and processes across the Group to deliver improved patient care in the four domains of Quality and Safety, Access to Services, Financial Resources and Workforce.	Q1-Q4

Goal 4	Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	
Priority Area	Action 2016	Target/ Date
Recruitment	Streamline recruitment process in line with service need Appoint a lead person for Information Technology to develop and improve data management, analytics, business intelligence and informatics.	Q1-Q4 Q2
Nursing/ Midwifery	Sustain the benefits of the Florence Nightingale Initiative for Nurse and Midwife Managers	Q1-Q4

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	
Priority Area	Action 2016	Target/ Date
Laboratory	Finalise plans for integrated Laboratory Development on St. James's Hospital Campus for three hospitals	Q1-Q2

Children's Hospital Group

Introduction

The Children's Hospital Group Board was established on an administrative basis by the Minister for Health in August 2013.

Acute Services	
2016 Budget €m	
Children's Hospital Group	230.407

The Children's Hospital Group consists of the following Hospitals:

- Our Lady's Children's Hospital, Crumlin
- Temple Street Children's University Hospital (TSCUH)
- National Children's Hospital at Tallaght Hospital.

The Children's Hospital Group will continue to work with the three children's hospitals to oversee the integration and transition to a new legal entity in advance of the move to the new children's hospital and satellite centres. In addition, the Children's Hospital Group is the client for the new Children's Hospital capital project. It's role is to ensure that the new hospital and satellite centres are designed to enable future paediatric services to be delivered as efficiently and effectively as possible. The Children's Hospital Group has developed a comprehensive Children's Hospital Programme to deliver on the Board's key remits in terms of its integration programme, ICT Programme.

The three children's hospitals provide a range of secondary paediatric services for children and young people in the greater Dublin area (Dublin City and County, Wicklow, Kildare and Meath) in addition to tertiary and quaternary paediatric services for the rest of the country, with some specialties provided on an all island basis. National specialties provided include children's childhood cancers and blood disorders, cardiac diseases, major burns, cystic fibrosis, clinical genetics, rheumatology, paediatric ophthalmology, craniofacial, the national meningococcal laboratory, the national centre for inherited metabolic disorders and the national newborn screening centre. The Group continues to develop a single, all-island clinical network for paediatric paediatric heart disease, to ensure that all children on the island will have access to the highest standard of congenital cardiac care. The Group is working closely with the Clinical Leads of the Paediatric and Neonatology Clinical Programmes to ensure services align with the developing national model of care for paediatrics and neonatology. The Children's Hospital Group will continue to contribute to the development and implementation of the HSE National Model of Care for Paediatrics and Neonatology and the Integrated Care Pathway for children and young people as key priorities in 2016.

The Group has multiple academic partners and is planning to develop a paediatric academic health sciences network to enable an integrated approach to paediatric research and innovation as well as paediatric professional education and training in the Irish health service.

Across the hospitals in the Group there are access challenges, specifically in ENT, orthopaedics, cardiology, urology, rheumatology and clinical genetics. These challenges will continue to be addressed throughout 2016 with some services supported by additional investment in service development funding. Similarly developing palliative care for children and the development of a children's ambulance service will also be the focus of work with other relevant stakeholders during 2016.

Children's Hospital Group Additional Key Priorities and Actions to Deliver on Goals in 2016

In addition to the strategic goals for all groups, additional key priorities and actions for the Children's Hospital Group in 2016 are:

 Promote Better Health and Wellbeing as part of everything we do so that people will be healthier		
Priority Area	Action 2016	Target/ Date
Integrated Pathway for Children and Young People	Work with CHOs, GPs, Primary Care and Mental Health Services to contribute to the development of an integrated care pathway for children and young people	Q1-Q4

 Provide fair, equitable and timely access to quality, safe health services that people need		
Priority Area	Action 2016	Target/ Date
Opening Of Satellite Centres in 2017	Continue preparations to ensure the satellite centres in Blanchardstown and Tallaght open on time, with the required resources	Q1-Q4
Winter Initiative	Open 8 bedded Short Stay Observation Unit at the National Children's Hospital, Tallaght Open 14 beds (St. Philomena's Ward TSCUH)	Q1
Paediatric Scoliosis Service	Continue the development of Paediatric Scoliosis Services in Our Lady's Children's Hospital, Crumlin to address ongoing capacity deficits	Q1-Q4
Paediatric Cardiology	Continue the development of an All Island Paediatric Congenital Heart Disease Service in conjunction with health partners in Northern Ireland and adult congenital cardiologyservice in Mater Misercordia University Hospital Enhance paediatric intraventional cardiac surgery service with opening of new intraventional facility at Our Lady's Children's Hospital, Crumlin	Q1-Q4
General Paediatric Service	Commence the development of a general paediatric consultant-delivered service to ensure greater efficiencies in acute care delivery and scheduled care following the review of paediatric and neonatology services and framework for future development with the recruitment of two consultant paediatricians.	Q1-Q4
Duchene's Muscular Dystropia	Develop services for Duchene's Muscular Dystrophia in the Children's Hospital Group	Q1-Q4
Palliative Care	Permanent appointment of Palliative Care Consultant previously funded by Irish Hospice	Q2
Forensic Medicine	Continue to develop the acute Forensic Medicine Service for children with alleged sexual abuse	Q1-Q4

Orthopaedic Surgery	Additional theatre capacity with the opening of the new laminar flow theatre for orthopaedics	Q2
Reform	Continue to implement the ongoing reform programme across the Children's Hospital Group.	Q1-Q4
Transition from Child to Adult Services	Facilitate the transition to adult services for Children with end stage kidney disease as appropriate. Transfer adults with metabolic disease to the adult services in the Mater Hospital	Q1-Q4 Q1-Q4
Haemophilia Services	Increase in staff for Haemophilia services in Our Lady's Children's Hospital, Crumlin in order to meet service demands	Q4

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Priority Area	Action 2016	Target/ Date
People Strategy and Plan	Embed agreed Values, Vision and Mission Statements across Hospital Group and implement a series of initiatives to ensure cultural alignment across the three childrens' hospitals before transitioning to a new single legal organisation.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Workforce Planning and people integration	Build on preliminary Workforce Plan developed as part of the preliminary business case for the new hospital and satellite centres.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
General Paediatrics	Develop plan for Short Stay Observation Unit s in Crumlin and Temple Street in preparation for opening the satellite centres in 2017	Q2
Programme Governance Management	Further development of Programme Management Office for the Childrens' Hospital Programme ICT Programme of work developed	Q1-Q4
New Children's Hospital Development	Develop a Definitive Design Business Case for the New Childrens Hospital	ongoing

South / South West Hospital Group

Introduction

The South/South West Hospital Group is comprised of nine acute hospitals operating across the counties of Cork, Kerry, Waterford, Tipperary and Kilkenny. The Group serves a population of approximately 1.2 million and provides a wide range of inpatient, day case and ambulatory care services.
The Group has two cancer centres in Cork University Hospital and University Hospital Waterford.

Acute Services	
2016 Budget €m	
South / South West Hospital Group	708.085

The group comprises nine hospitals:

- Cork University Hospital/Cork University Maternity Hospital
- University Hospital Waterford
- Kerry General Hospital
- Mercy University Hospital
- South Tipperary General Hospital
- South Infirmary Victoria University Hospital
- Bantry General Hospital
- Mallow General Hospital
- Lourdes Orthopaedic Hospital, Kilcreene

The primary academic partner for the group is University College Cork.

The Board Chairperson for the South/South West Hospital Group is in place and the appointment of an interim Board of Directors is awaited. A Group Leadership Team is in place, which is led by the Group Chief Executive.

South/ South West Additional Key Priorities and Actions to Deliver on Goals in 2016

Goal 1	Promote Better Health and Wellbeing as part of everything we do so that people will be healthier	
Priority Area	Action 2016	Target/ Date
Improving Patient and Staff Wellbeing	Build on existing initiatives, identify areas for improvement and implement actions to improve patient and staff wellbeing	Q1-Q4

Goal 2	Provide fair, equitable and timely access to quality, safe health services that people need	
Priority Area	Action 2016	Target/ Date
Winter Initiative	Continue the provision of additional capacity in line with Winter Capacity 2015/2016: 18 Transitional Beds- MUH 10 additional beds CUH Expansion of ED South Tipp General Hospital – 4 additional bays Develop CIT in UHW 15 Transitional beds UHW	 Ongoing Ongoing Ongoing Q1 Q1
Improve and Develop services	Cancer Services • Rapid Access Lung Clinic – Achieve 95% target • Rapid Access Prostate Clinic UHW- Improve access to service Medical Services • AMAU/MAU – Extend service over 7 days in CUH • NQAIS medicine pilot in MUH Surgical Services • Peri-operative Service – Expand use of pre-admission assessment clinics • Peri-operative Service – Develop surgical care programme • Establish anaesthetic and recovery programme for nurses • Establish foundation theatre education programme for nurses Palliative Care • End of Life Care – Appointment of End of Life Co-ordinator	 Q1 Q1 Q1 Ongoing Q1 – Q4 Q2 Q1 – Q4 Q1 – Q4 Q2 Q1
Maternity Services	Progress Maternity Services Developments in South Tipperary General Hospital as recommended in the Flory Report including: • Establish maternity clinical network with CUMH as hub. Implement Portlaoise Report recommendations including: • Appointment of Risk Managers in BGH and MGH • Strengthen BGH and MGH management teams • Appoint Group Quality and Risk Manager • Conclude HIQA Portlaoise self assessments • Finalise Group ICT Plan Implement Phase 1 of the Maternal and Newborn Clinical Management System at Kerry	 Q1-Q4 Q2 Q2 Q2 Q1 Q2 Q2-Q4

	General Hospital and Cork University Hospital.	
Haemophilia Services	Increase in staff for Haemophilia services in Cork University Hospital in order to meet service demands	Q4
Unscheduled Care	Improve ED reporting mechanism, maximise use of SBAR (Situation, Background, Assessment Recommendation) tool ED ICT dashboards Implement Hospital Group Standardised Process Admission, Discharge and Transfer Process Review functionality of all AMAUs in the Group Implement *visual hospital* system across the Group Implement Hospital Group Navigation Hub	Q1 Q1 Q1 Q2 Q2 Q4
Scheduled Care	Implement performance management to improve patient access to scheduled care Monitor all hospitals to ensure that routine endoscopies are performed in a timely manner and in accordance with national KPIs Expand MSK triage lists for Rheumatology and Orthopaedics	Ongoing Ongoing Ongoing
Cancer Services	Improve rapid access services for breast, lung, prostate cancer and radiotherapy referrals Progress the recruitment of approved Consultant Urologist post in support improvement initiatives for Rapid Access services for Prostate Cancer Progress Phase 2 of National programme of Radiation Oncology	Q1-Q2 Ongoing Q1-Q4
Reconfig-uration of Services	Transfer of prostate cancer services from MUH to CUH Transfer of Rectal cancer services from MUH to CUH and remaining MUH Ophthalmic to SIVUH Transfer of Pain Medicine Service from MUH to SIVUH	Q3 Q3 Q2
Integrated Care Programme for Older Persons	Continue early implementation of the Model for Integrated Care Programme for Older Persons at Cork University Hospital in association with local CHO, Clinical Strategy and Programmes and Social Care Division.	Q1-Q4

Goal 3	Foster a culture that is honest, compassionate, transparent and accountable	
Priority Area	Action 2016	Target/ Date
Pathway for Management	Implement the Pathway for Management of the acute surgical patient in all hospitals	Q1 – Q4

 Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them		
Priority Area	Action 2016	Target/ Date
Education, Research and Innovation	Further growth and development of Clinical Research in conjunction with UCC and continued work with the Health Innovation Hub Appoint joint Professor of Clinical Nursing – HSE and UCC	Ongoing Q2/Q3
Learning and Development	Promote and develop learning and develop opportunities for staff across all hospitals in the group.	Q1 – Q4
Commun-ication	Develop a communications Strategy for the group Develop communication initiatives with staff throughout the group to ensure staff are informed regarding the group and directorate activities, opportunities and developments.	Q1

 Manage resources in a way that delivers best health outcomes improves people's experience of using the service and demonstrates value for money		
Priority Area	Action 2016	Target/ Date
Green Flag	Expansion of Green Flag programme across the group	Q1 – Q4
Safer Better Healthcare Standards	Ensure implementation and progression of Quality Improvement Plans across the group to meet the quality and safety standards	Q1 – Q4

Saolta University Health Care Group

Introduction

Acute Services	
2016 Budget €m	
Saolta University Health Care Group	655.699

Saolta University Health Care Group serves the population of Counties Donegal, Leitrim, Galway, Sligo, Mayo and Roscommon.

Saolta University Healthcare Group was established in September 2013 but the Hospital Group has been in place for over 3 years. The establishment of Saolta is part of a national programme of reform of the health services. While Saolta University Healthcare Group is more advanced in its development than most of the other hospital groups, there is a need to further develop this governance model through the establishment of a directorate based management system across the organisation. The Saolta Group will continue to contribute positively to the reform programme throughout 2016 and align it with our vision statement.

The Group comprises of the following hospitals:

- Letterkenny University Hospital
- Portiuncula University Hospital
- Galway University Hospitals (UHG and MPUH)
- Mayo University Hospital
- Rosommon University Hospital
- Sligo University Hospital

The Academic Partner for the Group is National University of Ireland Galway (NUIG).

Quality of service and patient safety go to the heart of everything the Saolta Group have been trying to achieve across over the last three years. Over recent years, a group wide approach to management of Quality and Patient Safety has been developed under the remit of the Chief Clinical Director. This approach will continue to be supported throughout 2016.

Saolta Additional Key Priorities and Actions to Deliver on Goals in 2016

 Promote Better Health and Wellbeing as part of everything we do so that people will be healthier		
Priority Area	Action 2016	Target/ Date
Healthy Ireland Implementation Plan	Continue work of Saolta Group Steering Committee and Local Hospital Site Implementation Groups in relation to Healthy Ireland implementation plans. Achieve and maintain Tobacco free Campus across all sites Achieve Baby Friendly accreditation across sites	Ongoing
Improving Patient and Staff Wellbeing	Build on existing good practices, identify areas for improvement and implement actions to reduce the burden of chronic disease while improving patient and staff wellbeing. Implement action plan to meet national standards for Nutrition and Hydration of patients across the Saolta Group	Q1-Q4 Q1-Q4
Retinal Screen Service	Continued development of the service	Ongoing

 Provide fair, equitable and timely access to quality, safe health services that people need		
Priority Area	Action 2016	Target/ Date
Key Capital Projects /Physical Infrastructure	Open Endoscopy Unit at Roscommon Continue New Block Development UHG Continue enabling works for Adult Mental Health Unit on GUH site 2016 Progress 50 bedded Block development Portiuncular UH Progress other funded projects across the Hospital Group sites.	Q1-Q4
Access	Work on sustainable plans to achieve and maintain national waiting list targets using available resources across the group. Review and identify increased access to diagnostics across the Group Build theatre capacity through the recruitment and retention of key staffing Develop acute surgical unit UHG site Ensure robust system is in place for follow up of Investigations	Q3
Winter Initiative	Provide additional capacity as per Winter Initiative 2016: • Additional 30 Medical Beds GUH • Additional 10 beds – Letterkenny • Additional 5 beds – Portiuncula • Additional 14 beds – Sligo • 5 x ANPs across sites for non-admitted patients	Q1 –Q2

	• Implementation of the Care of the Older Persons programme - Develop frail elderly pathway across Group to maximise all aspects of care. • Early Supported Discharge - National Stroke Programme Expand Capacity/Catchment Area	
Unscheduled Care	Participate in National Pilot re Patient Flow Integrated Care Programme. Full implementation of Saolta Winter Resilience plan	Q1-Q4
Clinical Services	Implement recommendations of ED and Cardiology review Complete Urology /Haematology reviews and implement recommendations Develop and implement an Integrated Group Clinical Strategy	Q3-Q4
Maternity Services	Implement maternity service improvements in line with HIQA recommendations and other relevant reviews.	Q3
Research	Develop and implement Research Strategy for the Group	Q4
Organ Donation	Continue development of Critical Care Organ Retrieval Service	Q1-Q4
Cancer Services including enhanced Radiation Oncology Services	Contribute to Altnagelvin radiation oncology service, as per Ministerial commitment to this cross border initiative to meet needs of patients in North West in collaboration with the NCCP Progress Radiation Oncology Phase II Capital project enabling works on UHG Site Continue to monitor access to urgent and non urgent Breast services at Letterkenny General Hospital and implement initiatives to improve same.	Q4 Ongoing Ongoing
Northern Ireland Collaboration	Progress North West Cardiology Cross border Service delivering Primary PCI with Altnagelvin Hospital	Q2

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

Priority Area	Action 2016	Target/ Date
Accountability	Foster a culture of honesty, compassion and patient centred care by: • Ongoing Education and Training for Staff • Audit of care • Response to feedback and complaints • Investigation of all incidents, adopting learning from outcomes and implementation of improvement plans Progress Clinical Directorate Governance Model. Develop Performance Management Framework within the Group incorporating Clinical Directorate	Q1-Q4

Strategic Partners	Develop and maintain relationships with key Strategic Partners a. Community Healthcare Organisations b. General Practitioners c. Academic Partners d. Cooperation and Working Together (Cross border) e. Western Health and Social Care Trust and Altnagelvin Hospital f. Charitable Organisations g. Private Hospitals	Q1-Q4
Audit	Implement robust Audit Programme and ensure learning from audits, serious incidents and local complaint reviews.	Q3
Public Patient Involvement Strategy (PPIS)	Continue to implement PPIS with the establishment of PALS (Patient Advice and Liaison Services) in all hospitals Continue to support and embed the Patient Council across Saolta	Q1-Q4
Caring Behaviours Assurance Scheme	Support and extend the scheme across all hospitals in the group	Q3
Annual Reports	Publication of reports.	Q2

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

Priority Area	Action 2016	Target/ Date
Human Resources Planning	Implement Saolta HR Strategy Deliver appropriate and timely recruitment through the Workforce Plan and enhance attractiveness of Saolta to improve staff retention Enable further roll out of the Clinical Directorate structure, incorporating better staff communication, engagement, attendance, succession management and talent development Continue the management and maintenance of downward trajectory in relation to absenteeism Continued focus on staff development programmes Continued development of a Workforce Plan to underpin proactive recruitment and retention of staff Develop a Nursing and Midwifery Manpower Plan in conjunction with the Chief Nursing Officer. A range of succession management initiatives are underway covering all grades of staff Schwartz Rounds - GUH Pilot site for HSE commencing January 2016	Q1-Q4

Employee Engagement Process	Local implementation of priorities derived from the Employee Engagement Process	Q1-Q4
Employee Recognition System	Continue with staff recognition awards	Q4

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

Priority Area	Action 2016	Target/ Date
OPD Self Registration	Introduce OPD self registration across the group to alleviate patient queues	Q4
Finance	Progress next phase of Activity Based Funding while maximising funding within the resources available in our hospitals	Ongoing
ICT	Implement IS Strategy Transition from a paper based Medical Records System to an Electronic System that will improve access to patient records and also reduce the high costs associated with the paper based system Appoint Group Chief Information Officer (CIO)	Q1-Q4
Performance Monitoring	Implement structure of site specific Performance Monitoring Meetings and review and develop existing performance management reporting. Develop Group Business Intelligence Unit	Q1 - Q2

University of Limerick Hospital Group

Introduction

University of Limerick (UL) Hospital Group is comprised of a group of six hospitals functioning collectively as a single hospital system in the Mid-West of Ireland providing a range of acute services and care to a population of 379,327 (Clare, North Tipperary and Limerick) people delivering a range of acute in-patient and ambulatory care services.

Acute Services	
2016 Budget €m	
University of Limerick Hospital Group	255.243

The UL group consists of the following hospitals:

- University Hospital Limerick (UHL)
- University Maternity Hospital (UMH)
- Croom Hospital (CH)
- Ennis Hospital (EH)
- Nenagh Hospital (NH)
- St. John's Hospital (SJHL)

The Academic Partner is University of Limerick.

UHL is the only Model 4 hospital for the region providing major surgery, cancer treatment and care, emergency department services, as well as a range of other medical, diagnostic and therapy services. It is where all critical care services are located and has the second busiest Emergency Department in Ireland with annual attendances of approximately 61,000 presentations and a 24/7 emergency service. It is also one of the 8 designated cancer services in the country and is the centre for a Primary Percutaneous Coronary Intervention (PPCI) and thrombolysis for the management of acute stroke.

The UL Hospital Group is governed by an interim Board of Directors pending the development of new legislation to establish a new legal entity. An Executive Management Team led by the CEO is supported by four Clinical Directorates (Medicine, Peri-Operative, Child and Maternal Health and Diagnostics) who are accountable for the operation of the services across the sites.

University Limerick Hospitals Additional Key Priorities and Actions to Deliver on Goals in 2016

 Promote Better Health and Wellbeing as part of everything we do so that people will be healthier		
Priority Area	Action 2016	Target/ Date
Health and Wellbeing	Review of facilities conducive to health and wellbeing lifestyles a) Completion of Group Employee staff survey to assess health and wellbeing needs of our staff with a response rate of 30% b) Engagement with Limerick Smarter Travel and National Travel Authority with regard to extension of bike lanes and Coca Cola Rent a Bike scheme to the Raheen – Dooradoyle area Review of health and wellbeing initiatives for the community a) Continue to support Hospitals Outreach Committee in developing initiatives to promote health and wellbeing in our community. b) Extension of MDT Health Information Road show to community and educational settings c) Ensure Public representative included on committee	Q1-Q4 Q1-Q4
Tobacco Free Campus	Continue to work towards compliance with the Tobacco Free Campus Policy • Hospital Group wide working group established • Ongoing audit of documentation of smoking status of all patients and brief intervention offered	Q1-Q4

 Provide fair, equitable and timely access to quality, safe health services that people need		
Priority Area	Action 2016	Target/ Date
Capital Develop-ments	Reduce delays with opening of new ED, UHL • Prepare for the planned opening of the new Emergency Department in early 2017. New Dialysis Unit • Develop Renal dialysis services to address current capacity issues in the University Hospital Limerick. Clinical Education and Research • Provide teaching space including a 150 seat lecture theatre and various tutorial rooms, library facilities, academic offices and research and development space in partnership with University of Limerick. Leben Building • Open the Leben building to provide new inpatient/outpatient unit with capital funded from charitable sources. It will include a 24 bed stroke unit, inpatient and outpatient Cystic Fibrosis units, a Specialist Breast Unit and a Dermatology Unit and restoration of the hospital's dining area.	 Q4 Q3 Q4 Q1-Q2

Winter Initiative	Continue to provide additional capacity as per Winter Capacity Initiative: • Additional 17 Medical Beds • Additional 5 Isolation Rooms To address some of the capacity issues on the UHL site, 22 patient beds will be opened, in addition the group will commence a phased opening of acute Stroke/Neurology beds, and five beds/rooms for the treatment of patients with Cystic Fibrosis.	Q1
Hospital Redesign	Implement the Irish Hospital Redesign Programme in Limerick University Hospital in 2016 which has been established to improve healthcare delivery in Irish hospitals, using a redesign approach in conjunction with the integrated programme for patient flow. A group lead has been appointed to progress our engagement with the Irish Hospital Redesign Programme in 2016.	Q1-Q4
Cancer Services	Continue to monitor access to Prostate and Lung Cancer Rapid Access services and support initiatives to improve same	Q1-Q4
Integrated Care Programme for Older Persons	Continue early implementation of the Model for Integrated Care Programme for Older Persons at University Hospital Limerick in association with local CHO, Clinical Strategy and Programmes and Social Care Division.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Open Disclosure and Good Faith Reporting	Embed a culture of transparency in the UL Hospital Group. Further promote a culture of Patient and public partnership through • Develop the UHL Strategy for Public and Patient Involvement • Initiate regular meetings of UHL Patient Council • Implementation of a systematic real time patient feedback programme • Enhanced staffing in PALS service to support patient and public engagement and greater promotion of Your Service Your Say Feedback process • Provide PALS service to the Emergency Department.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Education, Research and Innovation	Further development of Clinical Research Unit Further growth and development of the Clinical Research Unit (CRU), which is a joint initiative between UL and ULHG and which is a component of UL's recently established Health Research Institute.	Q1-Q4

Learning and Development	Roll out of performance management training Working with national colleagues to roll out performance management training in 2016 commencing with staff in the laboratory as part of accreditation.	Q1-Q4
Commun-ications	Encourage supportive communication between all staff To improve employee communications with a focus on: • The continuation of quarterly two-way communication between staff and management through CEO led and Directorate led roadshows • Continue to run Executive led Listening Forums for cross functional staff groups • Publication of a number of publications for all staff keeping them updated with information on Patients, People, Performance, Quality and Projects	Q1-Q4
IPC Staff training and development	Continue linkages with UL for IPC research and the provision of training and education.	Q1-Q4
Staff Recognition	Recognise and acknowledge hospital staff who go to extraordinary lengths to provide exceptional care and support to our patients, their families and friends. The CEO Awards will provide an opportunity to recognise the contribution of all staff through a number of awards and celebrate their achievements in such areas as: 1. Best Patient Experience 2. Caring and Compassionate Workplaces 3. Best Innovation – Clinical 4. Best Innovation – Non Clinical 5. Education and Training 6. Best Team 7. Unsung Hero	Q4

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	
Priority Area	Action 2016	Target/ Date
National ICT Systems	Continue to roll out iPMS (National Patient Management System)	Q3
Sustainability	Establish a sustainability programme to become more environmental friendly. The initiation of this programme will lead towards achieving the Green Flag in 2017 on waste management. Learning from a successful pilot programme will roll out across the UL Hospital site in 2016.	Q1-Q4
Equipment Management	Develop centralised medical equipment library facilities, in line with HSE recommendations. These facilities will support the Hospital in terms of patient safety, risk management and cost liabilities	Q4

National Cancer Control Programme

Introduction

Acute Services	
2016 Budget €m	
National Cancer Control Programme	71.5

Since its establishment in 2007, the National Cancer Control Programme (NCCP) has been steadily implementing cancer policy as outlined in "*A Strategy for Cancer Control in Ireland 2006*" using a programmatic approach to the management of hospital and community based cancer services across geographical locations and traditional institutional boundaries. Accountability for service delivery and expenditure has continued to rest with the designated cancer centres. The NCCP will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally. In 2014, the Department of Health commissioned the "*Evaluation Panel Report - National Cancer Strategy 2006*". Many of the initiatives in the 2016 Estimates Submission are a direct result of recommendation in the evaluation. Both the 2014 Evaluation Panel Report on the 2006 Cancer Strategy and the 2006 Strategy for Cancer Control will provide the foundation for the Department of Health's recently commissioned expert group tasked with developing a strategy for Cancer Control in Ireland 2016.

Quality and Patient Safety

Quality and patient safety are key components in the delivery of an integrated cancer control programme. The NCCP has established a number of quality and safety initiatives to improve the delivery of cancer care which will continue during 2016.

- Since 2010 the NCCP has delivered annual Audit Quality and Risk (AQR) forum for breast cancer. This was further extended in 2013 to prostate/lung and to gynae-oncology in 2015. Breast, prostate, lung and pancreas AQR forums will be held in 2016. In addition national Radiation and combined Medical and Haemato-oncology meetings are annual events.
- Procure and roll-out a national Medical Oncology Clinical Information System to support the care of medical oncology and haemato-oncology patients, including the provision of systemic anti-cancer therapy, in cancer centres, satellite centres and other locations where patients are receiving systemic anti-cancer treatment, to improve quality, safety and access to patient information.
- Tumour groups: Five national expert tumour groups (breast, lung, prostate, gastrointestinal and gynaecological cancers) have been established to drive and guide the development of national evidence based clinical practice guidelines. This work will continue for the next number of years, with the expected launch of the lung cancer clinical guidelines in 2016.
- Implementation of the National Clinical Guidelines for Breast, Prostate and Gestational Trophoblastic Disease which were adopted and launched in 2015 by the NCEC.
- Audit and annual reports: National specialist cancer services including pancreatic, upper gastro-intestinal and neuro-oncology services are required to produce annual reports outlining performance and activity within the services.
- The ongoing implementation of the NCCP Oncology Medication Safety review across the country within the systemic therapy centres.
- The NCCP's national oncology drug management system (ODMS) is directly linked to the development of nationally agreed drug protocols. All funding allocations to the acute hospitals for oncology drugs are based on an activity based model.
- National treatment protocols have been developed for all new cancer drugs introduced since 2012 and national protocols are in development for existing oncology drugs.

NCCP Additional Key Priorities and Actions to Deliver on Goals in 2016

Goal 1	Promote health and wellbeing as part of everything we do so that people will be healthier	
Priority Area	Action 2016	Target/ Date
Cancer Prevention	Collaborate with *Healthy Ireland* on a range of cancer prevention priorities	Q1-Q4
	Promote skin cancer prevention including greater awareness of risks, knowledge of suspicious moles and facilitate behaviour change towards better sun safety among key at risk groups i.e. schools, outdoor worker and recreational settings.	Q1-Q4
	Promote smoking cessation including engagement with national tobacco control initiatives and the inclusion of pharmacotherapy as a standard part of treatment.	Q1-Q4
	Engage with medical, nursing and Health and Social Care professional training programmes in relation to cancer prevention.	Q1-Q4
	Engage with academic and professional bodies such as RCPI in relation to lifestyle cancer prevention initiatives e.g. policies on alcohol and healthy weight.	Q1-Q4

Goal 2	Provide fair, equitable and timely access to quality, safe health services that people need	
Priority Area	Action 2016	Target/ Date
Cancer Services in Acute Setting	Continue to centralise cancer services to the eight designated Cancer Centres to maintain continued improvements in diagnosis, medical oncology, radiation oncology, surgery and multi-disciplinary care	Q1-Q4
	Progress multidisciplinary human resources planning, development of evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery, technology implementation and the introduction of a nationally funded oncology drugs and molecular testing programme.	Q1-Q4
	Continue to collaborate with Hospital Groups in relation to the implementation of Service Plan 2016 and the implementation of new Cancer Strategy 2016 – 2025.	Q1-Q4
	Develop a national plan for Hereditary Cancer	Q 3
	Develop a national plan for Head and Neck cancer management	Q3
	Collaborate with the EU Joint Action on Rare Cancers for the management of rare cancers	Q3
Cancer Services in Community Setting	Support and deliver cancer education and training programmes in the community for nursing and general practitioners.	Q1-Q4
	Develop and evaluate referral pathways that prioritise patients with greatest healthcare requirements.	Q1-Q4

	Monitor the appropriateness of urgent referrals to rapid access cancer services. Continue to collaborate with Community Healthcare Organisations in relation to the implementation of Service Plan 2016 and the implementation of new Cancer Strategy 2016 – 2025. Continue developing national GP referral guidelines and referral pathways for patients presenting to their GP with suspected cancer. Use results of the NCCP/ICGP National Survey of GP Experience Study to inform our work with the GP community. Continue working with the ICGP in developing e learning on cancer related topics for GPs. Develop and deliver education programmes for GPs. Promote influenza vaccination for household contacts of patients immunocompromised due to cancer treatment.	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4
Cancer Control Programme - Support to carry out National Cancer Strategy	Support practice guideline development, health promotion, preventive and survivorship activities. Advance the Cancer Survivorship Programme in line with the new Cancer Strategy 2016-2025: • Conduct a health needs assessment to ascertain the most suitable model of survivorship care. • Promote patient empowerment for self-management for survivors. • Develop a Patient Treatment Summary and Care Plan cancer survivors • Develop a mechanism for patient input into the development of survivorship programme. • Development of best practice education and guidance on survivorship care	Q1-Q4 Ongoing
Cancer Drugs	Continue to improve access to all Cancer Drugs including new cancer drugs through the national oncology drug management system (ODMS) Expand the scope of the activity based model for projected growth in existing high cost oncology drugs Continue the implementation of the NCCP Oncology Medication Safety report and recommendations for practice. Continue to fund molecular testing to support personalised medicines and targeted therapies.	Q1-Q4 Q1-Q4 Ongoing Q1-Q4
Radiation Oncology	Advance Radiation Oncology Cross Border initiative by contributing to Altnagelvin radiation oncology service to meet needs of patients in North West. Monitor and support the Phase II developments in Cork and Galway. Carry out manpower planning in relationship to the expansion of national radiation oncology services	Q3 Q1-Q4 Q3

Goal 3	Foster a culture that is honest, compassionate, transparent and accountable	
Priority Area	Action 2016	Target/ Date
Partnership	Continue to work in partnership with the Irish College of General Practitioners in relation to early diagnosis, rapid referrals, referral guidelines and electronic referral so as to meet patient needs Continued collaboration with the Major Academic Institutions and Major teaching hospitals across the country	Ongoing Ongoing
Patient Experience	Collaborate with HSE/HIQA/DOH Patient Experience study development , ensure inclusion of cancer specific questions	Q1-Q4
Audit	Continue the programme of Clinical Audit and Quality Meetings for each of the tumour sites which will facilitate peer review of NCCP KPI suites.	Q1-Q4

Goal 4	Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	
Priority Area	Action 2016	Target/ Date
Workforce Development	Develop professional staff knowledge, through education, research and collaboration with relevant colleges and educational bodies. Progress the development of GP referral guidelines, patient pathways to facilitate early diagnosis of cancer. Develop primary care skills in prevention, diagnosis, care, and follow up to facilitate safe, high quality care in the community Develop e-learning modules for GP's and community health care staff in addition to integrated education meetings via the ICGP unit.	Q1-Q4 Ongoing Ongoing Ongoing

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	
Priority Area	Action 2016	Target/ Date
Managing Performance	Procure and roll-out a national Medical Oncology Clinical Information System to support the care of medical oncology and haemato-oncology patients, including the provision of systemic anti-cancer therapy, in cancer centres, satellite centres and other locations where patients are receiving systemic anti-cancer treatment, to improve quality, safety and access to patient information.	Q1-Q4

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Service User Experience	
• Complaints	*System-wide PIs. See PI appendix*
Safe Care	
• Serious Reportable Events	
• Safety Incident Reporting	
• % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	100%
• % of maternity units / hospitals with implementation of IMEWS	100%
• % of hospitals with implementation of IMEWS for pregnant patients	100%
• % maternity units which have completed and published Maternity Patient Safety Statements at Hospital Management Team each month	100%
Healthcare Associated Infections (HCAI)	
• Rate of MRSA blood stream infections in acute hospital per 1,000 bed day used	< 0.055
• Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5
Colonoscopy / Gastrointestinal Service	
• % of people waiting < 4 weeks for an urgent colonoscopy	100%
Effective Care	
Stroke	
• % of patients with confirmed acute ischaemic stroke who receive thrombolysis	9%
• % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	50%
Acute Coronary Syndrome	
• % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	85%
Re-admission	
• % emergency re- admissions for acute medical conditions to the same hospital within 28 days of discharge	10.8%
• % of surgical re-admissions to the same hospital within 30 days of discharge	< 3%
Surgery	
• % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%
• % day case rate for Elective Laparoscopic Cholecystectomy	> 60%
• % of elective surgical inpatients who had principal procedure conducted on day of admission	75%
Emergency Care and Patient Experience Time	
• % of all attendees at ED < 24 hours	100%
• % of patients 75 years or over who were admitted or discharged from ED within 9 hours	100%
Average Length of Stay	
• Medical patient average length of stay	7.0
• Surgical patient average length of stay	5.2
• ALOS for all inpatient discharges excluding LOS over 30 days	4.3
Symptomatic Breast Cancer Services	
• Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer.	> 6%

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

Access	Expected Activity / Target 2016
Discharge Activity ∞	
• Inpatient Cases	621,205
• Inpatient Weighted Units	623,627
• Daycase Cases	1,013,718
• Daycase Weighted Units	1,010,025
• Total inpatient and daycase Cases	1,634,923
Outpatients	
• No. of new and return outpatient attendances	3,242,424
• Outpatient attendances – New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	1:2
Inpatient, Day Case and Outpatient Waiting Times	
• % of adults waiting < 15 months for an elective procedure (inpatient and day case)	95%
• % of adults waiting < 8 months for an elective procedure (inpatient and day case)	70%
• % of children waiting < 15 months for an elective procedure (inpatient and day case)	95%
• % of children waiting < 20 weeks for an elective procedure (inpatient and day case)	60%
• % of people waiting < 15 months for first access to OPD services	100%
• % of people waiting < 52 weeks for first access to OPD services	85%
Colonoscopy / Gastrointestinal Service	
• % of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	70%
Emergency Care and Patient Experience Time	
• % of all attendees at ED who are discharged or admitted within 6 hours of registration	75%
• % of all attendees at ED who are discharged or admitted within 9 hours of registration	100%
• % of ED patients who leave before completion of treatment	< 5%
Delayed Discharges	
• No. of bed days lost through delayed discharges	< 183,000
• No. of beds subject to delayed discharges	< 500
Acute Medical Patient Processing	
• % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	75%
Symptomatic Breast Cancer Services	
• No. of patients triaged as urgent presenting to symptomatic breast clinics	16,800
• % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals.	95%
• % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals *(% offered an appointment that falls within 12 weeks)*	95%
Lung Cancers	
• No. of patients attending the rapid access lung clinic in designated cancer centres	3,300
• % of patients attending the lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres.	95%

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

∞*Discharge Activity in Divisional Operational Plan target 2016 are based on Activity Based Funding (ABF) and weighted unit (WU) activity supplied by HPO. Dialysis activity is included in ABF day cases and WU. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU*

Appendices

Appendix 1: Hospital Group Budget

Table 1: Net 2016 Budget

Hospital Group	ABF Revenue (note 1)	Special Purpose Payments (Note 2)	Income Targets	Total
	€ 000's	€ 000's	€ 000's	€ 000's
Ireland East	1,018,848	7,155	(211,938)	814,065
Dublin/Midlands	961,618	7,829	(199,497)	769,950
RCSI	774,048	5,361	(151,474)	627,935
Children	281,466	1,529	(52,588)	230,407
SSW	887,809	7,656	(187,380)	708,085
UL	326,824	3,044	(74,625)	255,243
Saolta	761,329	4,606	(110,237)	655,699
Regional/National	27,670	48,488	0	76,158
Total	5,039,611	85,668	(987,738)	4,137,541

Notes

1. ABF Revenue in this table includes total of DRG based revenue plus adjustments for tertiary referral, specialist paediatric , high cost oncology drug ,agency pay ,transition plus block grant.

2. Special purpose payments include LRA, ED/Winter Plan 2016 and new prioritised initiatives

Appendix 2: HR Information

Hospital Group	WTE Dec 14	WTE Oct 15	Medical/ Dental	Nursing	Health and Social Care Professionals	Management/ Admin	General Support Staff	Patient and Client Care
Children's	2,783	2,889	395	1,187	474	498	204	131
Dublin Midlands	9,368	9,583	1,193	3,503	1,492	1,428	860	1,107
Ireland East	9,987	10,612	1,491	4,114	1,255	1,588	1,276	886
RCSI	7,618	8,130	1,151	3,027	994	1,268	1,021	669
Saolta Healthcare University	7,858	8,125	1,172	3,244	947	1,240	891	632
South/ South West	8,992	9,342	1,341	3,815	1,115	1,363	1,218	491
University of Limerick	3,109	3,369	432	1,410	332	556	239	399
National Services	27	31	2	2	1	25		2
Total Acute Services	49,742	52,081	7,177	20,303	6,610	7,965	5,709	4,317

Appendix 3: Performance Indicator Suite

System-Wide

System-Wide				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Budget Management including savings Net Expenditure variance from plan (within budget) Pay – Direct / Agency / Overtime	M	≤ 0%	To be reported in Annual Financial Statements 2015	0.33%
Non-pay	M	≤0%		0.33%
Income	M	≤ 0%		0.33%
Acute Hospitals private charges – Debtor Days – Consultant Sign-off	M	New PI 2016	New PI 2016	90% @ 15 days by 31/12/16
Acute Hospitals private income receipts variance from Actual v Plan	M	New PI 2016	New PI 2016	≤ 5%
Capital Capital expenditure versus expenditure profile	Q	New PI 2016	New PI 2016	100%
Audit % of internal audit recommendations implemented by due date	Q	New PI 2016	New PI 2016	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received	Q	New PI 2016	New PI 2016	95%
Service Arrangements / Annual Compliance Statement % of number of Service Arrangements signed	M	100%	100%	100%
% of the monetary value of Service Arrangements signed	M	100%	100%	100%
% of Annual Compliance Statements signed	A	100%	100%	100%
HR % absence rates by staff category	M	3.5%	4.19%	≤ 3.5%
% variation from funded staffing thresholds	M	New PI 2016	To be reported in Annual Report 2015	≤ 0.5%
EWTD < 24 hour shift (Acute and Mental Health)	M	100%	96%	100%
< 48 hour working week (Acute and Mental Health)	M	100%	78%	95%

System-Wide				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	New PI 2016	New PI 2016	15% increase
Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	M	75%	75%	75%
Serious Reportable Events % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	M	New PI 2016	New PI 2016	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	62%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	New PI 2016	New PI 2016	90%
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	New PI 2016	To be set in 2016

Hospital Care

Acute Hospitals											
Service Area	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016							
Activity				Ireland East Hospitals Group	Dublin Midlands Hospitals Group	RCSI Hospitals Group, Dublin North East	South/ South West Hospitals Group	University of Limerick Hospitals	Saolta Healthcare Group	Children's Hospital Group	National Target
Beds Available Inpatient beds **	Existing	Monthly	10,503								10,804
Day Beds / Places **	Existing	Monthly	2,024								2,024
Discharges Activity∞ Inpatient Cases	Existing	Monthly	621,205	128,488	94,669	95,207	120,480	45,502	111,927	24,931	621,205
Inpatient Weighted Units	New PI 2016	Monthly	623,627	133,632	110,892	94,948	118,750	40,440	96,030	28,934	623,627
Day Case Cases∞ (includes Dialysis)	New PI 2016	Monthly	1,013,718	181,415	213,957	145,858	202,988	56,470	185,300	27,730	1,013,718
Day Case Weighted Units (includes Dialysis)	New PI 2016	Monthly	1,010,025	197,773	192,818	138,455	197,076	66,569	181,503	35,832	1,010,025
Total inpatient and day case Cases∞	New PI 2016	Monthly	1,634,923	309,903	308,626	241,065	323,468	101,972	297,227	52,661	1,634,923
Shift of day case procedures to Primary Care	New PI 2016	Monthly	New PI 2016								Up to 10,000
Emergency Care - New ED attendances	Existing	Monthly	1,102,680	235,703	173,765	154,305	190,383	57,007	182,833	108,684	1,102,680
- Return ED attendances	Existing	Monthly	94,948	23,781	14,785	13,258	22,032	4,113	10,146	6,833	94,948
- Other emergency presentations	Existing	Monthly	94,855	14,155	2,768	6,709	22,318	27,375	21,249	281	94,855
Inpatient Discharges *(Note this section previously detailed Inpatient Admissions but has been modified to align with HIPE data which is discharge based)* Emergency Inpatient Discharges	New	Monthly	New PI 2016	82,077	58,877	62,681	80,149	29,799	77,214	18,082	408,879
Elective Inpatient Discharges	New	Monthly	New PI	18,172	13,625	9,838	21,812	8,543	16,591	6,849	95,430

Acute Hospitals											
Service Area	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016							
Activity				Ireland East Hospitals Group	Dublin Midlands Hospitals Group	RCSI Hospitals Group, Dublin North East	South/ South West Hospitals Group	University of Limerick Hospitals	Saolta Healthcare Group	Children's Hospital Group	National Target
			2016								
Maternity Inpatient Discharges	New	Monthly	New PI 2016	28,239	22,167	22,686	18,518	7,158	18,122	0	116,890
Outpatients Total no. of new and return outpatient attendances	Existing	Monthly	3,242,424	725,756	610,041	477,568	579,649	220,327	478,675	150,408	3,242,424
Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	New PI 2016	Monthly	New PI 2016	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2
Births Total no. of births	Existing	Monthly	65,977	15,198	10,019	13,583	12,748	4,726	9,703		65,977

∞*Discharge Activity in Divisional Operational Plan target 2016 are based on Activity Based Funding (ABF) and weighted unit (WU) activity supplied by HPO. Dialysis activity is included in ABF day cases and WU. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU.*

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Inpatient, Day Case and Outpatient Waiting Times % of adults waiting < 15 months for an elective procedure (inpatient and day case)	Existing	Monthly	90%	95%
% of adults waiting < 8 months for an elective procedure (inpatient and day case)	Existing	Monthly	66%	70%
% of children waiting < 15 months for an elective procedure (inpatient and day case)	New PI 2016	Monthly	95%	95%
% of children waiting < 20 weeks for an elective procedure (inpatient and day case)	Existing	Monthly	55%	60%
% of people waiting < 15 months for first access to OPD services	New PI 2016	Monthly	90%	100%
% of people waiting < 52 weeks for first access to OPD services	Existing	Monthly	85%	85%
Colonoscopy / Gastrointestinal Service % of people waiting < 4 weeks for an urgent colonoscopy	Existing	Monthly	100%	100%
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	Existing	Monthly	52%	70%
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within 6 hours of registration	Existing	Monthly	67.8%	75%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	Existing	Monthly	81.3%	100%
% of ED patients who leave before completion of treatment	Existing	Quarterly	<5%	<5%
% of all attendees at ED who are in ED < 24 hours	New PI 2016	Monthly	96%	100%
% of patients 75 years or over who were admitted or discharged from ED within 9 hours	New PI 2016	Monthly	New PI 2016	100%
Patient Profile aged 75 years and over % of patients attending ED > 75 years of age **	Existing	Monthly	12.6%	13%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 6 hours of registration **	Existing	Monthly	32.0%	95%
Acute Medical Patient Processing % of medical patients who are discharge ed or admitted from AMAU within 6 hours AMAU registration	Existing	Monthly	65.5%	75%
Access to Services % of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	Existing	Monthly	79.8%	90%
Ambulance Turnaround Times % of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	New 2015	Monthly	New 2015	95%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Health Care Associated Infections (HCAI) Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used	Existing	Quarterly	0.054	< 0.055
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	Existing	Quarterly	2.1	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	Existing	Bi- Annual	86.4	80
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	Existing	Bi- Annual	28	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	Existing	Bi- Annual	87.2%	90%
Hospital acquired S. Aureus bloodstream infection/10,000 BDU **	New PI 2016	Monthly	New PI 2016	<1
Hospital acquired new cases of C. difficile infection/ 10,000 BDU **	New PI 2016	Monthly	New PI 2016	<2.5
Percentage of current staff who interact with patients that have received mandatory hand hygiene training in the rolling 24 month **	New PI 2016	Monthly	New PI 2016	100%
Percentage of patients colonized with multi-drug resistant organisms (MDRO) that can not be isolated in single rooms or cohorted with dedicated toilet facilities as per national MDRO policy **	New PI 2016	Monthly	New PI 2016	0%
Adverse Events Postoperative Wound Dehiscence – Rate per 1,000 inpatient cases aged 16 years+ **	Existing	Monthly	Data not available Q4 2015	TBC
In Hospital Fractures – Rate per 1,000 inpatient cases aged 16 years+ **	Existing	Monthly	Data not available Q4 2015	TBC
Foreign Body Left During Procedure – Rate per 1,000 inpatient cases aged 16 years+ **	Existing	Monthly	Data not available Q4 2015	TBC
Activity Based Funding (MFTP) model HIPE Completeness – Prior month: % of cases entered into HIPE	Existing	Monthly	93%	> 95%
Average Length of Stay Medical patient average length of stay (contingent on < 500 delayed discharges)	Existing	Monthly	7.2	7.0
Surgical patient average length of stay	Existing	Monthly	5.5	5.2
ALOS for all inpatient discharges excluding LOS over 30 days	Existing	Monthly	4.6	4.3
ALOS for all inpatients **	Existing	Monthly	5.5	5.0
Outpatients (OPD) New attendance DNA rates **	Existing	Monthly	12.9%	12%
Dermatology OPD No. of new Dermatology patients seen **	Existing	Monthly	41,732	41,700
New: Return Attendance ratio **	Existing	Monthly	1:2	1:2

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Rheumatology OPD No. of new Rheumatology patients seen **	Existing	Monthly	13,818	13,800
New: Return Attendance ratio **	Existing	Monthly	1:4	1:4
Neurology OPD No. of new Neurology patients seen **	Existing	Monthly	16,994	16,900
New: Return Attendance ratio **	Existing	Monthly	1:3	1:3
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit **	Existing	Quarterly	67.8%	50%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	Existing	Quarterly	12.1%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	Existing	Quarterly	53.7%	50%
Heart Failure Rate (%) re-admission for heart failure within 3 months following discharge from hospital **	Existing	Quarterly	6.7%	20%
Median LOS for patients admitted with principal diagnosis of acute decompensated heart failure **	Existing	Quarterly	7	6
% patients with acute decompensated heart failure who are seen by HF programme during their hospital stay **	Existing	Quarterly	85.8%	80%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Existing	Quarterly	83%	85%
% of reperfused STEMI patients (or LBBB) who get timely PPCI	Existing	Quarterly	68.4%	80%
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	Existing	Monthly	69.4%	75%
% day case rate for Elective Laparoscopic Cholecystectomy	Existing	Monthly	38.3%	> 60%
Reduction in bed day utilisation by acute surgical admissions who do not have an operation **	Existing	Monthly	10% Reduction	5% Reduction
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	Existing	Monthly	84.5%	95%
Surgery Scheduled waiting list cancellation rate **	New PI 2016	Monthly	New PI 2016	New PI 2016
Hospital Mortality Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition **	Existing	Annual	Not Yet Reported	TBC

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Re-admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	Existing	Monthly	10.8%	10.8%
% of surgical re-admissions to the same hospital within 30 days of discharge	Existing	Monthly	2.0%	< 3%
% of all medical admissions via AMAU **	New PI 2016	Monthly	New PI 2016	35%
Medication Safety No. of medication incidents (as provided to the State Claims Agency) in acute hospitals reported as a % of bed days	Existing	Quarterly	0.12%	≤0.12%
Patient Experience % of hospital groups conducting annual patient experience surveys amongst representative samples of their patient population	Existing	Annual	Not yet reported	100%
Dialysis Modality Haemodialysis patients Treatments Δ **	Existing	Bi-Annual	271,638-275,226	288,096 - 295,428
Home Therapies Patients Treatments **	Existing	Bi-Annual	86,300 -87,161	90,647-93,259
Delayed Discharges No. of bed days lost through delayed discharges	Existing	Monthly	225,250	< 183,000
No. of beds subject to delayed discharges	Existing	Monthly	577	< 500
HR – Compliance with EWTD European Working Time Directive compliance for NCHDs - < 24 hour shift	Existing	Monthly	98%	100%
European Working Time Directive compliance for NCHDs - < 48 hour working week	Existing	Monthly	75%	95%
National Early Warning Score (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	Existing	Quarterly	100%	100%
% of all clinical staff who have been trained in the COMPASS programme	Existing	Quarterly	63.6%	> 95%
Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with full implementation of IMEWS	Existing	Quarterly	100%	100%
% of hospitals with implementation of IMEWS for pregnant patients	Existing	Quarterly	78%	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning Score) **	New PI 2016	Quarterly	New PI 2016	100%
Clinical Guidelines % of maternity units / hospitals with implementation of the guideline for clinical handover in maternity services	New PI 2016	Quarterly	New PI 2016	100%
% of acute hospitals with implementation of the guideline for clinical handover	New PI 2016	Quarterly	New PI 2016	100%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
National Standards % of hospitals who have commenced second assessment against the NSSBH	New PI 2016	Quarterly	New PI 2016	95%
% of hospitals who have completed first assessment against the NSSBH	Existing	Quarterly	80%	100%
% maternity units which have completed and published Maternity Patient Safety Statements and discussed at Hospital Management Team each month	New PI 2016	Monthly	New PI 2016	100%
% of Acute Hospitals which have completed and published Patient Safety Statements and discussed at Hospital Management Team each month **	New PI 2016	Monthly	New PI 2016	100%
No. of nurses prescribing medication	New PI 2016	Annual	New PI 2016	100
No. of nurses prescribing ionising radiation (x-ray)	New PI 2016	Annual	New PI 2016	55
COPD Mean and median LOS (and bed days) for patients admitted with COPD **	Existing	Quarterly	7.6 5	7.6 5
% re-admission to same acute hospitals of patients with COPD within 90 days **	Existing	Quarterly	27%	24%
No. of acute hospitals with COPD outreach programme **	Existing	Quarterly	15	18
Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	Existing	Bi- Annual	27 Sites	33 Sites
Asthma % nurses in secondary care who are trained by national asthma programme **	New PI 2016	Quarterly	New PI 2016	70%
No. of asthma emergency inpatient bed days used **	New PI 2016	Quarterly	New PI 2016	3% Reduction
No. of asthma emergency inpatient bed days used by <6 year olds **	New PI 2016	Quarterly	New PI 2016	5% Reduction
Diabetes Number of lower limb amputations performed on Diabetic patients **	Existing	Annual	Not Yet Reported	≤488
Average length of stay for Diabetic patients with foot ulcers **	Existing	Annual	Not Yet Reported	≤17.5 days
% increase in hospital discharges following emergency admission for uncontrolled diabetes. **	New PI 2016	Annual	New PI 2016	≤10%
Epilepsy Reduction in median LOS for epilepsy inpatient discharges **	New PI 2016	Quarterly	New PI 2016	2.5
% reduction in the number of epilepsy discharges **	Existing	Quarterly	11.4%	10% Reduction
Blood Policy No. of units of platelets ordered in the reporting period **	Existing	Monthly	21,000	21,000
% of units of platelets outdated in the reporting period **	Existing	Monthly	<5%	<5%
% usage of O Rhesus negative red blood cells **	Existing	Monthly	<14%	<14%

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
% of red blood cell units rerouted **	Existing	Monthly	<4%	<4%
% of red blood cell units returned out of total red blood cell units ordered **	Existing	Monthly	<1%	<1%
Reportable events % of hospitals that have processes in place for participative engagement with patients about design, delivery & evaluation of health services **	New PI 2016	Annual	Data not due to be reported until Q2 2016	100%
Outpatients (OPD) % of Clinicians with individual DNA rate of 10% or less **	New PI 2016	Monthly	New PI 2016	70%
Ratio of compliments to complaints **	New PI 2016	Monthly	New PI 2016	TBC
National Cancer Control Programme				
Symptomatic Breast Cancer Services No. of patients triaged as urgent presenting to symptomatic breast clinics	Existing	Monthly	16,800	16,800
No. of non urgent attendances presenting to Symptomatic Breast clinics **	Existing	Monthly	23,500	24,000
Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals **	Existing	Monthly	16,100	16,000
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals	Existing	Monthly	96%	95%
Number of attendances whose referrals were triaged as non- urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals (No. offered an appointment that falls within 12 weeks) **	Existing	Monthly	19,300	22,800
% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)	Existing	Monthly	82%	95%
Clinic Cancer detection rate: no. of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer **	Existing	Monthly	>1,100	>1,100
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer	Existing	Monthly	11%	>6%
Lung Cancers No. of patients attending the rapid access lung clinic in designated cancer centres	Existing	Monthly	3,300	3,300
Number of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres **	Existing	Monthly	2,800	3,135
% of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	Existing	Monthly	86%	95%
Clinic Cancer detection rate: Number of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer **	Existing	Monthly	>825	>825

Acute Hospitals				
Service Area – Performance Indicator	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015	Expected Activity/ Targets 2016
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer	Existing	Monthly	29%	>25%
Prostate Cancer No. of centres providing surgical services for prostate cancers **	Existing	Monthly	8	7
No. of patients attending the rapid access clinic in cancer centres	Existing	Monthly	2,600	2,600
Number of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres **	Existing	Monthly	1,630	2,340
% of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres	Existing	Monthly	62%	90%
Clinic Cancer detection rate: Number of new attendances to clinic that have a subsequent diagnosis of prostate cancer **	Existing	Monthly	>780	>780
Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of prostate cancer	Existing	Monthly	38%	>30%
Radiotheraphy No. of patients who completed radical radiotherapy treatment (palliative care patients not included) **	Existing	Monthly	4,900	4,900
No.of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care **	Existing	Monthly	4,153	4,410
% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	Existing	Monthly	84%	90%
Rectal No. of centres providing services for rectal cancers **	Existing	Monthly	13	8

** *KPIs included in Divisional Operational Plan only*

∆ *Dialysis data includes all hospitals, contracted units and Home therapies*

Appendix 4: Capital Infrastructure

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

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
ACUTE SERVICES									
RCSI Hospital Group									
Beaumont Hospital, Dublin	Provision of renal dialysis unit.	Q4 2016	Q1 2017	0	44	8.00	11.95	0	0.00
Beaumont Hospital, Dublin	Renal transplant unit (phase 1); upgrade and refurbishment of St. Damien's ward, extension of histocompatability and immunogenics laboratories and equipping of Theatre 12.	Q4 2015	Q1 2016	0	24	0.50	5.80	0	0.00
Ireland East Hospital Group									
Cappagh National Orthopaedic Hospital, Dublin	Provision of a recovery unit to serve the theatre department (co-funded with Cappagh).	Q1 2016	Q1 2016	0	0	0.10	1.00	0	0.00
Midland Regional Hospital, Mullingar, Co. Westmeath	Emergency Department (ED), phase 2b (stage 2).	Q1 2016	Q2 2016	0	0	0.30	3.56	0	0.00
St. Luke's General Hospital, Kilkenny	Redevelopment (phase 1) to include a new ED, medical assessment unit (MAU), day service (including endoscopy) including medical education unit, (co-funded by the Royal College of Surgeons of Ireland and the University of Limerick).	Q3 2015	Q2 2016 (phased opening)	10	12	2.50	26.00	0	0.00
	Conversion of day ward into a 12 bed inpatient ward [Winter capacity initiative]	Q1 2016	Q1 2016	12	0	0.10	0.10	0	0.86
Wexford General Hospital	Provision of an early pregnancy assessment unit, a foetal assessment unit and a urodynamics laboratory (co-funded by the Friends of Wexford Hospital)	Q4 2016	Q4 2016	0	0	0.10	0.10	0	0.00
	Upgrade and replacement of fire detection and alarm systems, emergency lighting and passive fire protection works. This project includes the fit-out of the vacated old ED as a decant ward to allow these works proceed.	Q4 2015	Q1 2016	0	0	0.15	5.24	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
Dublin Midlands Hospital Group									
Midland Regional Hospital, Portlaoise Co. Laois	Redevelopment (phase1), acute medical unit, day services.	Q2 2016	Q3 2016	0	20	2.10	5.50	0	0.00
Midland Regional Hospital, Tullamore, Co. Offaly	Provision of a replacement MRI and additional ultrasound.	Q4 2016	Q1 2017	0	0	2.05	2.57	0	0.00
Tallaght Hospital – AMNCH	Provision of an extended oncology/haematology day unit and relocate service from Burkitt Ward (16 beds back in use). Also link partially vacated Beech Ward to Lynn Ward creating 11 additional adult beds [co-funded from Winter capacity initiative].	Q4 2015	Q1 2016	16	11	0.4	1.20	0	1.90
Children's Hospital Group									
National Children's Hospital, Dublin	Enabling works for National Children's Hospital being delivered as part fit-out of the shelled out area to accommodate the National Centre for Hereditary Coagulation Diseases.	Q4 2016	Q4 2016	0	0	2.00	2.70	0	0.00
National Children's Hospital, Dublin	Enabling works being delivered as part of the Mercer Institute for Successful Ageing (MISA) project including accommodation for rheumatology and heptology.	Q4 2016	Q4 2016	0	0	3.70	6.85	0	0.00
Our Lady's Children's Hospital, Crumlin, Dublin	Provision of a catheterisation laboratory unit.	Q3 2016	Q4 2016	0	0	1.14	5.60	0	0.00
	Provision of an additional interim orthopaedic theatre as part of the catheterisation laboratory project.	Q3 2016	Q4 2016	0	0	1.90	2.40	0	0.00
South / Southwest Hospital Group									
Cork University Hospital	Reconfiguration of existing paediatric outpatients department (OPD) to provide additional isolation facilities in adjacent ward; provision of new paediatric OPD and medical education facility (funded by University College Cork); dedicated leukaemia and cystic fibrosis units within this development.	Q3 2016	Q4 2016	0	6	3.00	5.12	0	0.00
	Extension and refurbishment of existing pathology laboratory to facilitate management services tender [blood science project].	Q4 2016	Q4 2016	0	0	1.00	2.20	0	0.00
South Infirmary Victoria University Hospital, Cork	Refurbishment and upgrade of accommodation to facilitate relocation of ophthalmic surgery from Cork University Hospital.	Q3 2016	Q4 2016	0	0	0.70	2.19	0	0.00
St. Mary's Orthopaedic Hospital, Cork	Upgrade existing ward to facilitate the relocation of OPD, Mercy University Hospital to OPD, St. Mary's Orthopaedic Hospital.	Q3 2016	Q4 2016	0	0	0.70	1.00	0	0.00
University Hospital, Waterford	New decontamination facility for the day unit (endoscopy).	Q2 2016	Q3 2016	0	0	1.00	1.44	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
	Provision of replacement interventional (angiography) radiology room.	Q1 2016	Q2 2016	0	0	0.50	1.00	0	0.00
Kerry General Hospital, Tralee, Co. Kerry	Extension and refurbishment of existing pathology laboratory to facilitate management services tender [blood science project].	Q3 2016	Q4 2016	0	0	0.30	0.70	0	0.00
Mercy University Hospital, Cork	Provision of 18 transitional care beds [Winter capacity initiative].	Q4 2015	Q4 2016	0	0	0.20	1.00	0	0.90
Bantry General Hospital, Co. Cork	Provision of a MAU to enable reconfiguration of acute hospital services.	Q4 2015	Q1 2016	0	0	0.10	1.15	0	0.00
South Tipperary General Hospital	Provision of 4 additional ED treatment places [Winter capacity initiative].	Q4 2015	Q1 2016	0	0	0.10	0.40	0	0.15
	Extension of the radiology department to accommodate a CT (purchased) and future MRI.	Q3 2016	Q3 2016	0	0	1.46	1.96	0	0.00
Saolta Hospital Group									
Sligo Regional Hospital	Upgrade of boiler plant and boiler room.	Q4 2016	Q4 2016	0	0	1.70	2.30	0	0.00
	New Medical Education Centre.	Q3 2015	Q12016	0	0	0.15	2.40	0	0.00
Sligo Regional Hospital	Upgrade of building fabric (roofs, windows, etc) and fire compartmentation works.	Phased 2016	Phased 2016	0	0	0.40	1.26	0	0.00
Galway University Hospital	Interim emergency ward to replace 17 beds lost due to the construction of the clinical ward block and the creation of 18 additional beds within vacated areas to address service difficulties.	Q4 2015/Q1 2016	Q1 2016	18	17	0.70	2.20	0	0.00
Galway University Hospital *(contd.)*	New clinical block to provide replacement ward accommodation. Initial phase is provision of a 75 bed block.	Q4 2016	Q1 2017	0	75	10.00	17.60	0	0.00
Letterkenny General Hospital, Co. Donegal	New medical education centre.	Q1 2016	Q2 2016	0	0	0.30	2.00	0	0.00
	Restoration and upgrade of the critical care unit, haematology and oncology units, damaged in 2013 flood (part-funded by Insurance).	Q4 2016	Q1 2017	0	0	2.00	2.70	0	0.00
	Restoration and upgrade of central staff changing facility, damaged in 2013 flood.	Q4 2016	Q4 2016	0	0	1.51	2.11	0	0.00
	Restoration and upgrade of mortuary damaged in 2013 flood (part-funded by Insurance).	Q4 2016	Q1 2017	0	0	0.00	0.23	0	0.00
	Restoration and upgrade of underground service duct (and services) damaged in 2013 flood.	Q4 2016	Q4 2016	0	0	0.01	2.46	0	0.00
	Restoration and upgrade of laboratory department damaged in 2013 flood.	Q4 2015	Q1 2016	0	0	0.22	1.84	0	0.00
Mayo General Hospital, Castlebar, Co. Mayo	Expansion of existing endoscopy suite to provide a new decontamination facility, also works to main concourse including replacement lift.	Q4 2016	Q4 2016	0	0	1.50	1.80	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
Roscommon County Hospital	Provision of endoscopy unit.	Q4 2015	Q1 2016	0	2	0.26	5.48	0	0.00
University of Limerick Hospital Group									
Ennis Hospital, Co. Clare	Redevelopment of Ennis General Hospital (phase 1) to include fit out of vacated areas in existing building to accommodate physiotherapy and pharmacy and development of a local (minor) injuries unit.	Q4 2016/Q1 2017 (phased)	Q1 2017 (phased)	0	50	0.45	1.19	0	0.00
University Hospital, Limerick	Construction and fit out of renal dialysis unit over ED.	Q3 2016	Q4 2016	13	11	1.50	7.20	0	0.00
	Acute MAU and OPD reconfiguration. Ward 1B reverts to a 29 bed ward and the acute MAU will be accommodated in the (old) Ward 6A.	Q4 2016	Q1 2017	5	0	0.50	1.00	0	0.00
	Clinical education and research centre (co-funded with University of Limerick).	Q4 2016	Q4 2016	0	0	2.80	11.20	0	0.00
	Equipping of Leben building - breast unit, dermatology, stroke and cystic fibrosis OPD.	Q4 2015	Q1/Q2 2016	0	0	1.00	4.50	0	0.00
NATIONAL CANCER CONTROL PROGRAMME									
St. Luke's Hospital, Dublin	Provision of interim facilitates, (phase 2 – radiation/oncology project).	Q2 2016	Q3 2016	0	0	3.58	7.00	0	0.00
Altnagelvin Hospital, Londonderry	Provision of additional radiation oncology facilities (part funded by the National Development Plan).	Q3 2016	Q4 2016	0	0	8.00	19.00	0	0.00