Children's Hospital Group

Operational Plan 2016

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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

Children's Hospital Group Values, Vision and Mission Statements

In living our values we will be:
Child-centred
Compassionate
Progressive

and we will act with:
Respect
Excellence and
Integrity

Our Vision is:
Healthier children and young people throughout Ireland

Our Mission is:
To promote and provide child-centred, research-led and learning informed healthcare, to the highest standards of safety and excellence, in partnership with each other, with children, young people and their families through a network of children's services in Ireland.

Contents

Executive Summary

Introduction

The Children's Hospital Group Board was established on an administrative basis by the Minister for Health in August 2013. The Children's Hospital Group consists of Our Lady's Children's Hospital, Crumlin, Temple Street Children's University Hospital and the National Children's Hospital at Tallaght Hospital and is one of seven hospital groups established as part of the acute health sector reform programme.

Children's Hospital Group	2016 Available Budget €m
Our Lady's Children's Hospital, Crumlin	123.794
Temple Street Children's University Hospital	89.474
National Children's Hospital at Tallaght Hospital	15.781
Children's Hospital Group	1.359
Total	**230.408**

Impact of Demographics Nationally

The demand for acute paediatric services will continue to grow as the population grows. 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:

- Our population aged 5-19 will increase by 2% an additional 19,500 children between 2015 and 2016.
- Currently 25% of all three year old children and nine year old children are overweight or obese. By 2016 this would equate to:
    - 18,960 three year olds
    - 17,460 nine year olds.
    - Chronic disease management is a huge driver of health care cost, with 90% of health care cost being spent on 30% of the population with chronic disease
- High unit cost of health for those less than 1 year of age – in 2015 nearly 1/3 of those under 1 year attending Emergency Department were admitted. This rate decreases proportionally with age.

Emergency department attendances in children's hospitals in 2014 numbered 207,983. Of these the admission rate of those under one year was 31%; for those aged 1 – 5 the admission rate was 20% and for those aged 6 – 16, the admission rate was 15% of the total attendances for this age group. The total number of attendances at paediatric emergency departments will remain relatively unchanged during 2016.

Paediatric inpatient days are predicted to increase by 3,470 bed days for the 6 – 16 age group from 2014 – 2016 and demand for paediatric surgical procedures is predicted to increase by c. 3,000 nationally.

Development and Challenges

The three children's hospitals provide a range of secondary services for children 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, neurosurgery, 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 congenital heart disease, to ensure that all children on the island will have access to the highest standard of congenital cardiac care. The Group has multiple academic partners and is planning for an integrated paediatric academic health sciences network to provide a main centre for paediatric research and innovation as well as paediatric professional education and training in the Irish health service.

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 and acuity of service as that delivered in 2015 whilst acknowledging that the financial challenges are significant. Substantial cost control and cost reduction by hospitals will be required with a focus on controlling the total pay and non pay costs, as well as, maximising income.

The Children's Hospital Group will work with the acute hospital division and the three children's hospitals, with support from the rest of the HSE, to control costs, reduce waste and improve efficiency aimed at minimising any impact on services.

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 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%

Across the hospitals in the group there are access challenges to specific specialities, specifically in ENT, orthopaedics, dermatology, ophthalmology, cardiology, urology, rheumatology and clinical genetics. Activity targets are included in "Appendix 3, Key Performance Indicators". These challenges will continue to be addressed throughout 2016 with some specialties supported by additional investment in service development funding (see Service Delivery p. 24). Similarly developing palliative care for children and the development of a children's ambulance service will also be the focus of work with relevant stakeholders during 2016.

Clinical Strategy and Programmes

The Group is working closely with the HSE National Clinical Leads for the National Model of Care for Paediatrics and Neonatology to ensure existing and future services align with the developing national model of care for paediatrics and neonatology. For the Children's Hospital Group, contributing to the implementation of the HSE National Model of Care for Paediatrics and Neonatology and to the Integrated Programme of Care for children and young people are key priorities in 2016.

Conclusion

Monthly performance meetings will continue with the three children's hospitals in relation to the quality and safety of services, access to those services, by effectively harnessing the efforts of its overall workforce and by doing this within the financial resources available.

The Group will work with the three hospitals to oversee their integration and transition to a new legal entity in advance of the move to the new satellite centres and children's hospital. In addition, the Children's Hospital Group is the client for the new children's hospital capital project, the largest capital investment in healthcare. It will 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 and its remit as client for the new children's hospital and satellite centres. 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 is the subject of further dialogue with the HSE, DoH and the Children's Hospital Group.

Improving Quality and Reforming Service Delivery

Strategic Priorities for 2016

The Children's Hospital Group places 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 its constituent hospitals to enhance and improve the overall quality and safety of services with measurable benefits for patients and service users. The development of the Group's Quality, Patient Safety and Risk Management Framework will continue in 2016 and will be led by the Group's incoming Director of Quality and Patient Safety.

In line with the recently published 'Framework for Improving Quality' the Children's Hospital Group will work with the Quality Improvement Division to make progress in the following areas:

1. **Lead for Improvement:** Build capacity in 'leadership for improving quality of care' including participation on Leadership programme for executive management teams, and further support our staff trained in QI to network and build on their improvement skills.

2. **Engage patients**: Establish structures and processes to listen to and engage service users and patients; test new ways of promoting personalised compassionate care

3. **Engage staff**: Listen to staff and adopt new ways of working with staff to ensure opportunities for them to make and implement solutions for improving quality and their work environment and enhance their ability to do so.

4. **Govern for Quality**; Put in place structures and processes to oversee the quality and safety of care being provided (as part of the reform process) by having clear lines of accountability on quality and safety matters at all levels of your service.

5. **Measure for Improvement**: develop a profile of the quality of our services based on robust process and outcome indicators, and use this information to demonstrate and drive service improvement

6. **Use Improvement Science**: Identify how the aspects of the following safety programmes and initiatives can be implemented within our services.
    - HCAI prevention: Hand Hygiene; antimicrobial stewardship (Stop campaign); Safe use of devices/lines and decontamination
    - Medication safety: National network of safer meds leaders
    - Nutrition and hydration: Support Nourish programme
    - Promote the use of repository of nationally mandated PPPGs
    - Implementation of NCEC Guidelines e.g. early warning scores
    - Support and act on national audits carried out under NOCA
    - Support and act on the Specialty QI programmes in Histopathology, GI endoscopy and Radiology

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

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 and Healthcare Associated Infections (HCAIs).
- 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
- 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

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 or in the case of the Children's Hospital Group in conjunction with the Ombudsman for Children's Office) and commence patient experience surveys in primary care and community services
- Develop and implement a national person-centred care Programme which engages, enables and empowers people to be at the centre of service delivery
- Continue to develop access to advocacy for all patients and service users

Health Service Reform

The Children's Hospital Group will continue to establish its governance and management structures in line with its Strategic Plan which will be finalised during 2016. The arrangements between the Hospital Group and relevant academic partners will be considered and relevant governance structures defined. The Children's Hospital Group Strategic Plan will be developed with the children's hospitals in conjunction with Systems Reform.

Operational Framework – Financial Plan

Introduction

The Children's Hospital Group 2016 net allocation amounts to €230.408m, inclusive of funding for opening run rate deficit and national pay awards but excluding 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 (See Appendix 1 for breakdown by hospital in the Children's Hospital Group.)

	2016 Available Budget €m	2015 Closing Budget* €m
Our Lady's Children's Hospital, Crumlin	123.794	127.104
Temple Street Children's University Hospital	89.474	91.981
National Children's Hospital at Tallaght	15.781	16.889
Children's Hospital Group	1.359	1.352
Total	**230.408**	**237.326**
**less historical deficit allocation*		

Incoming Deficit

In 2015 acute hospitals nationally 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 nationally. The figures are shown below and it is estimated 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, we have discounted the offered prices to hospitals 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. We know that we will have 'price' effects in the following areas. This means that our underlying price will rise, but we will not obtain any additional service 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 we know that we will have 'volume' pressures in 2016 due to the nature of our demographic etc. Our 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. We do not have funding to exceed that level of service - and in fact we have already discounted by 2% the prices available.

We 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, we have 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 the Acute Hospitals Division, HSE anticipates a shortfall in the region of €175m across the hospital system nationally again for these items and based on its assessment it 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 nationally is the €225m in the table below.

			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 and Staff Numbers 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 Children's Hospital Group monthly performance meeting with the three children's hospitals 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 Programme 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.

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. Details of service developments in the Children's Hospital Group are included in the Delivery of Services section.

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 the introduction to this chapter, 2016 is the year when the system 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. 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 Children's Hospital Group 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 Hospital Group and the Acute Hospital 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 Children's Hospital Group's "People Strategy" which is being 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 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 the Hospital Group to operate within the funded pay envelope is a key priority, alongside the management of risk and service implications. The Group has experienced headcount growth in staffing levels in 2015 of 2.6% and the only approved increases to headcount in 2016 are for new service developments. There is minimal reliance on agency staff within the Hospital Group but this element of costs will be of particular focus in 2016. Payroll is a significant cost in the delivery of acute services and therefore the Group will place robust emphasis in relation to the management of headcount and rosters. Each hospital in the group is required to develop appropriate plans for agency conversion and reduction in overtime expenditure across all services and staff categories, to deliver appropriate and cost effective services.

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 within the Children's Hospital Group are identifed in Appendix 2.

2016 Developments

The planning, approval, notification, management, monitoring and filling of new 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 Children's Hospital Group 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 Children's Hospital Group will engage in high quality workforce planning, ensuring that funded workforce plans are developed, at 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)

The Children's Hospital Group will continue to work with the three children's hospitals, the Acute Hospitals Division and other Hospital Groups to develop a comprehensive framework plan to support the achievement of full compliance with EWTD targets. This may require the consolidation of specific services across the Hospital Group.

Recruitment

The Children's Hospital Group will continue to work with the three children's hospitals to support them to recruit and retain highly skilled medical and nursing staff to approved positions to support services.

The Group will support the work of the Acute Hospital Division and 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 National Model of Care for Paediatrics and Neonatology
- 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 Children's Hospital Group 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.

Employee Engagement

As outlined previously, the Children's Hospital Group will support the implementation of The People Strategy throughout the hospitals. 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 Children's Hospital Group will continue to actively engage with staff and will continuously seek to identify opportunities to involve more staff in planning and decision making in particular through the Clinical Directorate structure. The establishment of a new legal entity will require specific support to ensure the successful integration of our staff as a single workforce and to standardise processes across the multiple locations of paediatric services in Dublin. 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

Improving staff health and wellbeing is also a key strategic priority and the three children's hospitals will continue education campaigns to 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. Part 1 of the Service Arrangement has been signed off in 2015 covering a two year period (2015-2016) meaning that only Part 2 of the Service Arrangements needs sign off in 2016. 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 and
- implement Government policy on child health.

Delivery of Services

Acute Services

The Children's Hospital Group will deliver on the following goals in 2016 in association with the three children's hospitals and the Acute Hospitals corporate team (in addition, specific goals particular to the Children's Hospital Group and Programme are italicised at the end of each section):

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**
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 in smoking cessation	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
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 acquired new cases of C Difficile infection	Ongoing
Integrated Care Programme for Children and Young People	*Working with CHOs, GPs, Primary Care and Mental Health Services, contribute to the development of an integrated care programme for children and young people for child health*	*Q1-Q4*

Goal 2	**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 including 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 urgent or planned care locally and more complex care managed in the larger hub hospitals • Shift care to the most appropriate setting including increased day surgery rates and redirection of minor operations from hospitals to primary care • 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. • Musculoskeletal (MSK) and Dermatology out-patient pathways to be completed, with proof of concept in hospital groups • Ophthalmology and neurology out-patients pathways of care to be commenced • Finalise roll-out of e-referrals (Phase 1) to all hospitals • Initiate formal audits of Outpatient Services, as per OP KPIs • Develop an Outpatient Patient Satisfaction Tool • Review and update protocol for the management of Outpatient Services	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 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 Full escalation response will be activated 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	Q1-Q4 Q1-Q2
Quality	Continue to implement the *National Standards for Safer Better Healthcare in Acute Hospitals (NSSBHC)* Complete first and second assessments against NSSBHC in all hospitals and develop action plans to address any gaps identified All Acute Hospitals to report and publish monthly hospital patient safety statement	Q1-Q4 Q2 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
	Work with the Acute Hospital Division to enhance processes and governance structures 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 • 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
	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)	Q2-Q4
	Continue to develop the hospital's capacity to respond to Category 4 (e.g. Ebola) type threats	Q1-Q4
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)	Ongoing
	Support the phased implementation of the policy when published on Trauma Networks for Ireland within existing resources	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 Programme for the Prevention and Management of Chronic Disease 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 : • asthma, • Diabetes.	Q1-Q4
	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 and 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 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 NAS.	Q1-Q4
Organ Donation	Continue to develop an improved organ donation and transplantation infrastructure with a view to achieving target donation and transplant rates. Support the continued development of national organ donation and transplant service	Q1-Q4 Q1-Q4
Cancer Services	Support improvements in diagnosis, medical oncology, radiation oncology, surgery and multi-disciplinary care for cancer.	Ongoing
Opening Of Satellite Centres in 2017	*Planning to ensure centres opening on time, with the required resources*	*Q1-Q4*

New Children's Hospital Development	*Continue input into the Definitive Business Case for the capital project*	*Q2*
CHG Prioritised Areas of Service Delivery:		
▪ *Winter Initiative*	*Opening of 8 Short Stay Observation Unit at the National Children's Hospital, Tallaght* *Opening of 14 Bed ward (St. Philomena's TSCUH)*	*Q1*
▪ *Paediatric Scoliosis Service*	*Continue to enhance Paediatric Scoliosis Services in Our Lady's Children's Hospital, Crumlin to address ongoing capacity deficits* *Support additional new theatre capacity for orthopaedics*	*Q1-Q4*
▪ *Paediatric Cardiology*	*Develop All Island Paediatric Congenital Heart Disease Service in conjunction with health partners in Northern Ireland and congenital cardiac service in Mater Hospital.*	*Q1-Q4*
▪ *General Paediatric Service*	*Develop a general paediatric consultant-delivered service to ensure greater efficiencies in acute care delivery and scheduled care following the review of paediatric and neonatology services and framework for future development.*	*Q1-Q4*
▪ *Duchenne's Muscular Dystrophy*	*Develop services for Duchenne's Muscular Dystrophy in the Children's Hospital Group.*	*Q1-Q4*
▪ *Palliative Care*	*Provide funding for Palliative Care Consultant previously funded by Irish Hospice Foundation*	*Q1*
▪ *Forensic Medicine*	*Continue to develop the acute Forensic Medicine Service for children with alleged sexual abuse*	*Q1-Q4*
▪ *ENT*	*Enhance access to ENT service delivery across OLCHC and the National Children's Hospital Tallaght*	*Q1-Q4*
▪ *Dermatology*	*Funding for additional consultant dermatologist post in TSCUH to stabilise service*	*Q1*
▪ *Spina Bifida*	*Continue to develop model of care for Spina Bifida services at TSCUH with an additional consultant.*	*Q1-Q4*
▪ *Emergency Medicine*	*Develop Advanced Nurse Practitioners in Emergency Medicine*	*Q1-Q4*
▪ *MRI*	*Increase access to MRI services at OLCHC*	*Q1-Q4*
▪ *Pathology*	*Additional Chemical Pathologist to replace existing historical cover arrangements and increase service provision at TSCUH*	*Q1-Q4*
▪ *Haemophilia*	*Increase psychology provision in Haemophilia services in OLCHC*	*Q1-Q4*
▪ *Reform*	*Implement the ongoing reform programme across the Children's Hospital Group.*	*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	Q1-Q4
	Develop the Children's Hospital Group Strategic plan in conjunction with the Acute Hospitals Division and the Systems Reform Group.	Q2
	Plan for consolidation of arrangements between the Children's Hospital Group and Academic Partners as per Reform Programme.	Q1-Q4
	Comply with recommendations from local audits and potentially systemic recommendations in accordance with HSE Internal Audit procedures.	Q1-Q4
	Complete Service Arrangements as appropriate in accordance with HSE Governance Framework for Funding Non-Statutory Provided Services.	Q1

	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-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 HIQA and DOH 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 Acute and Children's Hospital Services**, National Clinical Guideline No. 11 Develop self-audit schedules and follow-up action plans in each of the hospital groups for: • PEWS -Paediatric Early Warning Score	Q1 Q2
Protection of Children and Vulnerable Persons	Ensure the appropriate staff are apprised of the Children First Act and their 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
People Strategy and Plan	*Continue to develop CHG People Strategy, embed agreed Values, Vision and Mission Statements across sites and implement a series of initiatives to ensure cultural alignment across the three 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**
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 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.	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4

	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
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
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
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
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	Q1-Q4 Q1
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

General Paediatrics	*Develop a short Stay Observation Unit at Tallaght; plan for similar units in Our Lady's Children's Hospital, Crumlin and Temple Street Children's University Hospital in preparation for opening the satellite centres in 2017*	*Q1-Q4*
Support Services	*Children with end stage kidney disease and for transition to adult services* *To transfer adults with metabolic disease to the adult services in the Mater Hospital*	*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	
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	
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 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%
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

Access	Expected Activity / Target 2016
Discharge Activity ∞	
• Inpatient Cases	24,931
• Inpatient Weighted Units	28,933
• Daycase Cases	27,730
• Daycase Weighted Units	35,832
• Total inpatient and daycase Cases	52,661
Outpatients	
• No. of new and return outpatient attendances	108,684
• Outpatient attendances – New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	1:2
Inpatient, Day Case and Outpatient Waiting Times	
• % 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	

Access	Expected Activity / Target 2016
• % 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

∞*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*

Appendix 1: Activity and Financial Data

Hospital	ABF Revenue (note 1)	Special Purpose Payments (note 2)	Income Targets	Total
	€'000	€'000	€'000	€'000
Our Lady's Children's Hospital, Crumlin	153,421	873	30,500	**123,794**
Temple Street Children's University Hospital	104,381	460	15,368	**89,473**
National Children's Hospital at Tallaght Hospital	22,312	189	6,720	**15,781**
Children's Hospital Group	1,352	7	-	**1,359**
Total	**281,466**	**1,529**	**52,588**	**230,407**

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

Hospital Activity Targets 2016	Inpatient Cases	Weighted Units	Day Cases	Weighted Units
Our Lady's Children's Hospital, Crumlin	10,870	16,408	17,379	22,381
Temple Street Children's University Hospital	7,959	9,342	7,632	9,882
National Children's Hospital at Tallaght Hospital	6,102	3,183	2,719	3,569

Appendix 2: HR Data

Children's HG

Hospital	WTE Dec 14	WTE Oct 15	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care
Temple St. Children's University Hospital	968	1,016	135	393	182	208	60	40
Our Lady's Children's Hospital, Crumlin	1,631	1,660	211	684	277	257	143	88
NCH at Tallaght Hospital	185	213	50	110	16	33	1	3
Children's HG	**2,783**	**2,889**	**395**	**1,187**	**474**	**498**	**204**	**131**

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**
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

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**
Elective Inpatient Discharges	New	Monthly	New PI 2016	18,172	13,625	9,838	21,812	8,543	16,591	6,849	95,430
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

∞*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 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%
Access to Services % of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	Existing	Monthly	79.8%	90%
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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
Adverse Events				
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
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
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	Existing	Monthly	69.4%	75%
Reduction in bed day utilisation by acute surgical admissions who do not have an operation **	Existing	Monthly	10% Reduction	5% Reduction
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
Re-admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of	Existing	Monthly	10.8%	10.8%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
discharge				
% of surgical re-admissions to the same hospital within 30 days of discharge	Existing	Monthly	2.0%	< 3%
Medication Safety No. of medication incidents (as provided to the State Claims Agency) in acute hospitals reported as a % of bed days	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 PEWS (Paediatric Early Warning Score) **	New PI 2016	Quarterly	New PI 2016	100%
Clinical Guidelines				
% of acute hospitals with implementation of the guideline for clinical handover	New PI 2016	Quarterly	New PI 2016	100%
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%
% 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
Asthma				
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

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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%
% 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				
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%

** *KPIs included in Divisional Operational Plan only*

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

Appendix 4: Capital Projects

Facility	Project details	Project Completion	Fully Operational	Capital Cost €m	
				2016	Total
Our Lady's Children's Hospital, Crumlin, Dublin	Provision of a catheterisation laboratory unit.	Q3 2016	Q4 2016	1.14	5.60
	Provision of an additional interim orthopaedic theatre as part of the catheterisation laboratory project.	Q3 2016	Q4 2016	1.90	2.40