Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive

Community Healthcare Organisation - Area 1

Operational Plan 2016

Cavan, Donegal, Leitrim, Monaghan & Sligo

Contents

Foreword

I am delighted to present the 2016 Operational Plan for the newly established Community Health Organisation (CHO) covering the five counties of Cavan, Donegal, Leitrim, Monaghan and Sligo. This area is designated CHO 1.

The CHO 1 area has a population of 389,048 with a dispersed rural population spanning beautiful inland lakes, urban centres and the Wild Atlantic Way. It shares a long border with Northern Ireland, offering opportunities to develop and deliver services on a cross border basis. Despite many challenges our communities are resilient with a tradition of innovation and developing solutions to address the needs of the area.

Our ambition for the health services include:

- Promoting health and wellbeing as part of everything we do
- Providing fair, equitable and timely access to quality, safe health services
- Fostering a culture that is honest, compassionate, transparent and accountable
- Engaging, developing and valuing our workforce to deliver the best possible care and services
- Managing resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money

The plan reflects the priorities outlined in the National Service Plan HSE 2016 and the work currently underway across the five counties. The plan is subdivided into the main areas of work incorporating Health and Wellbeing, Primary Care, Social Care including Disability Services & Older Peoples services and Mental Health Services.

The CHO 1 budget for 2016 is €358 million, a 2.8% increase on 2015.

There are over 4,646 full time people (posts) delivering community health services across the five counties who share a commitment to improve services and work in partnership with communities and the voluntary sector. We also work in partnership with colleagues in the Saolta Hospital Group, RCSI Hospital Group, other state agencies including local authorities and the educational sector to improve healthcare delivery and the health of our population.

Our Guiding Values

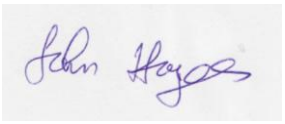
- Respect - we aim to be an organisation where privacy, dignity, and individual needs are respected, where staff are valued, supported and involved in decision-making, and where diversity is celebrated, recognising that working in a respectful environment will enable us to achieve more.
- Compassion - we will treat patients and family members with dignity, sensitivity and empathy.
- Kindness - whilst we develop our organisation as a business, we will remember it is a service, and treat our patients and each other with kindness and humanity.
- Quality – we seek continuous quality improvement in all we do, through creativity, innovation, education and research.

- Learning - we will nurture and encourage lifelong learning and continuous improvement, attracting, developing and retaining high quality staff, enabling them to fulfil their potential.
- Integrity - through our governance arrangements and our value system, we will ensure all of our services are transparent, trustworthy and reliable and delivered to the highest ethical standards, taking responsibility and accountability for our actions.
- Team Working – we will engage and empower our staff, sharing best practice and strengthening relationships with our partners and patients to achieve our Mission.
- Communication - we aim to communicate with patients, the public, our staff and stakeholders, empowering them to actively participate in all aspects of the service, encouraging inclusiveness, openness, and accountability.

These values shape our strategy to create an organisational culture and ethos to delivery high quality and safe services to those we serve and for which staff can rightly be proud.

I look forward to working with all of our staff and colleagues across the HSE, the independent and voluntary sector, Oireachtas and Health Forums in implementing this operational plan in 2016.

Best wishes



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John Hayes
Chief Officer
Community Healthcare Organisation (CHO) Area

Introduction

The operational plan for 2016 outlines the key new service delivery priorities across Community Healthcare Organisation (CHO) Area 1 within allocated resources. Delivery of services in Area 1 with the associated demographics, rurality and geography of the area, reforms of organisational structure and governance and continued efforts in quality improvement and provision of person centred services will present challenges. Over the last number of years we have relied on staff at all levels of the organisation to deliver on these challenges and over 2016 we will build on the service developments and quality improvement initiatives delivered heretofore and advance the service delivery agenda.

Quality Improvement and Quality Assurance

CHO Area 1 strives to continuously improve quality and provision of services. There are a range of initiatives currently in place across every service division in delivering on the quality improvement and quality assurance agenda. A range of initiatives have been included within the divisional operational plan chapters that address quality improvement and quality assurance to be delivered in 2016 and build upon the existing quality improvement areas.

Funding

The budget allocation for Area 1 for 2016 is €358.0m; a €9.8m or 2.8% increase on 2015 budget. This increase addresses, to an extent, the 2016 opening deficit, additional demands and the unique demographics of the region; however, significant financial challenges and risks remain. Provision of services to rural, deprived populations will inevitably place additional funding pressures on the area. Service delivery pressures are further compounded by the demographics of area 1 with high dependency rates.

Accountability Framework

The accountability framework allows for greater accountability at each level of the organisation to deliver services in accordance with the corporate plan, National service plan, divisional operational plans and local CHO level operational plans. Within CHO Area 1, service managers are accountable to the Chief Officer and their line managers for the delivery of the operational plan. Escalation processes are in place with regard to underperformance at each level of the organisation. Details of the escalation process are contained within the accountability framework section.

Health Service Reform

The health service reform programme is multifaceted and will be driven at both a local and national level. The reform programme will drive the delivery of person centred, integrated care with better outcomes for patients and service users. The key priorities for 2016 pertaining to CHO Area 1 include:

- Supporting the integrated care programmes including older people, prevention and management of chronic disease, patient flow, children and maternity care
- Establishment of a programme management resource within the CHO
- Supporting the delivery of Healthy Ireland in the Health Services National Implementation Plan

Workforce

The health sector's workforce is at the core of the delivery of healthcare services. Continuing to nurture, support and develop a workforce that is dedicated to excellence, welcomes change and innovation, embraces leadership and teamwork, fosters inclusiveness and diversity and maintains continuous professional development and learning. The *People Strategy 2015–2018* has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. The strategy is underpinned by its commitment to engage, develop, value and support the workforce. In addition to key objectives such as recruitment and retention of staff, maintaining a motivated workforce is of paramount importance in ensuring the quality of services delivered to the public. This requires effective workforce planning and resource allocation arrangements, together with appropriate structures for positive engagement with staff in an environment of significant reform.

Government policy focuses on ensuring that the number of people employed is within the pay budget available. The management of human resources in 2016 will be based on the Paybill Management and Control Framework. This approach is a transition from the moratorium to an accountability framework designed to support workforce plans based on models of care that will deliver services within allocated pay resources. CHO 1 will operate control mechanisms to monitor staff numbers and work with services to evaluate vacancies in the context of workforce composition, skill mix, cost and capacity to deliver high quality client centred services.

Risks to the Delivery of the Operational Plan

As with all plans, there are risks to the delivery of the CHO 1 operational plan. A number of these are outlined below:

- Increased demographic pressures and changing client expectations
- The capacity to respond to the population of the area and their needs given the deprivation, rurality and complexity of delivering services across a low density population
- The capacity to recruit skilled and specialist workforce, particularly in rural areas such as CHO 1
- Changing organisational structures and processes alongside the pressures of "business as usual"
- The complexities of establishing a singular delivery structure where systems and processes lean towards former LHO areas
- Capacity and resources in delivering business as usual whilst improving quality, changing structures and working within resources available
- Capacity and resources to comply with regulatory requirements in public long stay residential facilities, mental health and disability sectors
- The capacity to exert control over pay costs and staff numbers in the context of safety and quality, regulatory, volume and practice driven pressures
- The opening financial deficit
- The impact of pay growth on budgets

Conclusion

The delivery of the operational plan for 2016 will be challenging. New structures and delivery arrangements will become operational whilst service improvements will be implemented. This will be built upon new arrangements locally for governance, management and accountability. Notwithstanding the risks to delivery of the operational plan, Area 1 has continually strived to deliver quality services to those in the area and 2016 bring opportunities to build upon the work and developments to date, share expertise, streamline services and improve quality throughout services.

Quality and Patient Safety

Introduction

The primary objective for CHO Area 1 is delivering high quality safe services for all our patients and clients. We are focussed on the development and implementation of safe quality healthcare, where all service users receive high quality treatment at all times, are treated as individuals with respect and dignity, are involved in their own care, are kept fully informed, have their concerns addressed, and are treated / cared for in a safe environment based on best international practice. We are also focussed on the delivery of care in an environment that is safe for our staff.

The *National Standards for Safer Better Healthcare* outline what can be expected from their healthcare services and also outline to service providers what is expected of them. The standards will help to drive improvements for patients by creating a common understanding of what makes a good, safe, health service. We seek to drive quality improvement in response to these standards.

The key focus for CHO Area 1 services is to deliver clinical and social care that is high in quality and that is safe and sustainable. Compliance with National Standards for Safer Better Healthcare underpins CHO Area 1's strategy for continuous quality improvement.

Quality and Patient Safety Governance Committees for the CHO Area 1 have progressed a number of initiatives to improve structures in place regarding quality, safety and risk .The Quality and Patient Safety Governance Committees have a number of sub-committee that focus on quality and patient safety. These include committees on Policies, Procedures and Guidelines (PPGC) which have made strides in terms of better documented procedures which address organisational responsibility. Other sub-committees include Drugs and Therapeutics Committees (DTC), Medical Devices/Equipment Management Committees (MDEMC) and Audit Committees which have been established with agreed terms of reference and all four sub-committees report to the Quality and Patient Safety Governance Committees.

Quality and Patient Safety Governance Committees have established and maintained the CHO area risk registers by ensuring that risks are systematically identified, reported, managed and analysed in accordance with agreed HSE policy.

Quality improvement and patient safety is everybody's business and is embedded in all work-practices across all services. CHO Area 1 is committed to promoting a "quality and safety" culture by ensuring effective governance, clear accountability and robust leadership.

Strategic Priorities for 2016

The key strategic priorities for Quality and Safety for 2016 are to:

- Ensure Quality, Safety & Risk Governance structures are in place for the CHO Area 1
- Prioritise the Quality, Safety and Risk agenda during the design phase and implementation phase of the restructuring of the CHO Area 1
- Ensure there are clear accountability arrangements for Quality, Safety & Risk Management within the divisions of CHO Area 1
- Supporting and promoting national safety and quality improvement programmes in line with the National Standards for Safer Better Health Care
- Encouraging person centred care through service user and staff engagement.
- Strengthen accountability for quality and safety through assurance and performance arrangements in relation to quality and safety of care.

- Enhance the existing system to identify, manage, investigate and implement the learning from serious safety incidents, safety investigations and regulatory investigations and inspections
- Enhance the capacity and capability of staff in relation to the management of risk and quality and safety in its entirety
- Improve prevention, control, and management of healthcare-associated infections and improve antimicrobial stewardship
- Implement a strong system of corporate and clinical governance
- Ensure there is a system-wide co-ordinated approach to the quality agenda that spans the spectrum of service provision and covers regulatory standards, clinical audit, recommended practices, and quality and safety issues.
- Engage with national Quality Management Information Systems and support the collection of QPS social care metrics
- Ensure there is a Quality Assurance Verification framework in place.
- Implement national and international standards and recommended policies / guidelines developed both by government and other regulatory bodies / HSE
- Strengthen patient and service user input through developing and implementing best practice models of customer care and service user involvement
- Further embed integrated risk management across all services. Utilise the risk register mechanism as part of the HSE control framework. Learning from the HSE incident experience will inform the work and set the priorities for the risk register and controls assurance
- Provide transparency and accountability to the public about quality and safety of care
- Provide assurance to the organisation on the implementation, monitoring, and evaluation of the above priorities

Financial Framework

Introduction

The CHO1 budget for 2016 is €358m, an €9.8m or 2.8% increase on 2015 budget. This is a significant resource and the increased funding to address elements of the incoming deficits is welcome. However, CHO 1 faces a considerable financial challenge. The dependent population is increasing, demand for more complex services to support people in the community is rising and the changing needs of our target population place further pressure on existing services.

CHO 1 fully acknowledges the requirement to operate within the limits of the funding notified to it and will ensure this receives the very significant management focus required in 2016. Given the scale of the demographic, regulatory and other service pressures, there is a substantial financial risk to be managed in delivering this operational plan.

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

The notified allocation for CHO 1 is set out below.

Division	Closing budget 2015 €000s	Opening budget 2016 €000s	Increase %
Primary Care	104,778	106,594	1.7%
Social Care	178,426	184,503	3.4%
Mental Health	64,927	66,865	3.0%
TOTAL CHO 1	**348,131**	**357,962**	**2.8%**

Note: This allocation excludes Social Care funding for contract, subvention and S39 Fair Deal beds of €2.6m.

Incoming Deficit / Cost Pressures

Additional base funding has been provided within the 2016 budget and this will assist in dealing with the underlying 2015 operating deficit, with the balance to be dealt with by way of additional savings and other financial measures to be agreed with each national division.

A critical service risk in 2016 is ensuring there is appropriate care pathways and effective flow through admission and discharge from our acute hospitals particularly for the very elderly and young disabled adults whose discharge can be complex and become delayed. Funding received to deal with these financial pressures includes:

- Complex Paediatric Cases €0.5m
- Help / Home Care Package €1.5m

In addition, an allocation of €2.0m has been provided to deal with incoming cost pressures associated with meeting HIQA regulatory requirements.

Existing Level of Service

The cost of providing the existing services at the 2015 level will grow in 2016 due to a variety of factors including national pay agreements / public pay policy requirements, quality and safety requirements, and other clinical non pay costs, price rises etc.

For example, €1m has been received to off-set the growth in pay costs associated with the Lansdowne Road Agreement, Labour Relations Commission recommendations and other pay pressures.

Further allocations provided to deal with service pressures in 2016 include:

- Primary Care – 2016 demand led pressures €0.9m
- Primary Care – GP Out of Hours €0.7m
- Short stay beds in Community Hospitals €1.1m

It is noted that some unavoidable pay-related costs, identified as part of the estimates process, were not funded within the overall allocation. The most significant of these relate to the net cost of increments, which must be paid in line with approved public pay policy. The HSE will continue to engage with DoH and DPER during 2016 to seek a sustainable solution for this ongoing issue in time for implementation in 2017.

Programme for Government Priorities

CHO 1 is engaging with national divisions in relation to new funding streams announced in the HSE service plan including,

- School Leavers - for the provision of a day centre place for young adults for persons with a disability who are exiting school or rehab training places.
- Home Respite Initiatives –for the development of community based home respite initiatives within the disability sector.
- The provision of therapeutic services for young people, including early intervention teams in line with Progressing Disability Services for Children and Young Adults (0-18s Programme)
- Service reform fund funding for a number of innovative projects in line with the *A Time to Move on from Congregated Settings* policy and wider Transforming Lives agenda that will facilitate individuals to transition into the community
- Mental health developments across a range children and adult services, the funding for which is held by the DoH pending agreement on the initiatives for which these monies can be spent.
- Health and well being screening programmes

The full year effect of 2015 developments for the above programmes already commenced has yielded the following additional allocation:

- Full year cost of School leavers €1.1m
- Social Care Safeguarding posts (2016) €0.1m

In addition, funding notified for Mental Health development posts not yet in place is €1.9m.

Savings and Extra Revenue Targets

The allocation is net of value for money and efficiency measures of €1m which will be targeted across all divisions. These reductions require

- general reductions in pay and non-pay spends, including savings to be made through the procurement process
- additional Value for Money / Efficiency Savings needed to cover the CHO 1 share of a national fund to support Integrated Care Programmes, Quality Improvement and Assurance Initiatives and support for CHOs/HGs which benefit all service users.

Approach to Financial Challenge

- Financial Risk Areas

Despite the additional allocation in 2016, there is a significant financial challenge in respect of maintaining existing levels of service within the net revenue allocation notified for 2016. The risk arises due to a combination of demographic factors, emerging demand and regulatory cost pressures including:

- Rising costs of demand led schemes
- HIQA-related costs
- External placements in disabilities and mental health
- Home help and home care packages
- Complex paediatric cases

CHO 1 is actively engaging with the national divisions in relation to these issues, however, the measures required to address the financial challenge may result in some restrictions to accessing services as demand grows.

- Measures to address Financial Risk Areas

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

The key components of CHO 1's approach to addressing this challenge involve achieving increased efficiency, value for money and budgetary control in 2016 and include:

- Governance – intensifying the focus on budgetary control across all divisions
- Pay – target agency / overtime conversion and skills mix initiatives in the context of implementing the Paybill Management methodology
- Non-Pay – implement targeted cost-containment programmes for specific high-growth /spend categories
- Income – sustain and improve where possible the level of income generation achieved in 2015

Other division-specific measures are outlined below:

Primary Care measures – Core Services

A range of measures has been identified to manage services within budget, they include the following:

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

Mental Health measures

The underlying cost pressures faced by mental health services (including increases to consultant pay scales, the cost of increments, unavoidable agency costs, and emergency placements) will be dealt with in 2016 from within the current base. This will be facilitated by the continued implementation of the multi-year programme for delivering improved models of care, including staffing and skill mix improvements already underway.

The approach requires the agreed and appropriate utilisation of available development funding from 2015 and prior years to address issues such as the premia cost in medical agency and the cost of external placements, pending the development of more sustainable solutions. It has been assumed that 2016 development monies will only be released to meet the agreed additional costs of new developments continuing this multi-year programme of service improvement.

Social Care measures

This area will identify savings requirements and put in place detailed, time bound, implementation plans for both statutory services and voluntary agencies to ensure sustainable delivery of services. These plans will be used as a key metric to manage both divisional and voluntary engagements and include:

- Adherence to the Paybill management framework including preparation of funded workforce plan
- Targeted cost containment plans for public residential units
- Waiting lists will be established for home care on a standardised basis to manage the allocation of services in as fair a way as possible
- Participate in the national review maximise the cost effectiveness, appropriateness and equity of provision of transport
- Working to ensure there is effective prioritisation of places including emergency residential requirements within allocated resources while maximising existing capacity and opportunity for reconfiguration.
- In addition to maximising opportunities for the reconfiguration of existing service, CHO 1 will finalise the implementation plan for Cregg Services to move to a more community based model of person-centred service

Activity Based Funding

CHO 1 has indicated its willingness to participate in activity based funding initiatives that may arise in 2016.

Workforce

Introduction

Staff of the health services continues to be its most valuable resource and are central to improvement in patient care, productivity and performance. A culture of compassionate care and a sense of belonging among staff will create and embed an organisation-wide approach to delivering a high quality, effective and safe service to our patients and clients. Recruiting and retaining motivated and skilled staff is a key objective in 2016. This has to be delivered in an environment of significant reform and against a backdrop of reductions in the workforce, longer working hours, reductions in take-home pay and other changes in the terms and conditions of employment for staff.

The effective management of the health services' workforce will underpin the accountability framework in 2016. This requires that the HSE has the most appropriate workforce configuration to deliver health services in the most cost effective and efficient manner to maximum benefit. The role of Human Resources (HR), working across the health system, will be to ensure that the organisation and the workforce has the ability, flexibility, adaptability and responsiveness to meet the changing needs of the service while at the same time ensuring a consistent experience of HR is delivered by a unified HR function. In collaboration with all stakeholders, work will continue in 2016 on the HR strategic intent and emerging operating model to ensure the organisation's strategic HR goals, initiatives and projects such as the people strategy 2015-2018 are delivered to best serve the needs of patients and service users.

The Workforce Position

In quarter 4, 2015 there were 4,646 WTE positions in place delivering Divisional services as shown in Table 1. This figure includes graduate nurses on the special graduate programme and the support staff intern scheme. An increase in wte ceiling is to be allocated as yet for these posts which are now included in the EMR census reporting.

Employment controls in 2016 will be based on the configuration of the workforce that is within funded levels. The funded workforce also includes agency, locum and overtime expenditure. The aim is to provide for a stable workforce which will support the continuity of care required for safe, integrated service delivery. Management of the workforce in 2016 must continue to transition from a focus on employment ceilings, targets and numbers, to one operating strictly by paybill management. At the same time services must be delivered to the planned level and service priorities determined by Government addressed. This requires an integrated approach, with service management being supported by HR and Finance. It further requires finance and HR workforce data, monitoring and reporting to be aligned. Planned service developments under the Programme for Government and prioritised internal initiatives will require targeted recruitment in 2016.

Reform, reconfiguration and integration of services, maximising the enablers and provisions contained in the *Haddington Road Agreement*, the implementation of service improvement initiatives and reviews, the reorganisation of existing work and redeployment of current staff, will all contribute to delivering a workforce that is more adaptable, flexible and responsive to the needs of the services, while operating with lower pay expenditure costs and within allocated pay envelopes. The funded workforce can be further reconfigured through conversion of agency, locum and overtime expenditure, where appropriate and warranted, based on cost and this can also be utilised to release additional required savings.

Table 1 - Staffing position by Community Health Area / Integrated Service Area

Community Healthcare Organisation Area 1							
Integrated Service	**Medical Dental**	**Nursing**	**HSCP**	**Clerical/ Admin**	**General Support Staff**	**Other Patient & Client Care**	**Total by WTE**
Primary Care & Social Incl.	78	285	276	306	47	79	**1,072**
Health & Wellbeing	-	-	-	-	-	-	
Social Care	23	851	94	172	218	1286	**2,644**
Mental Health	67	487	106	95	97	78	**930**
Total by grade	**168**	**1,623**	**476**	**573**	**362**	**1443**	**4,646**

Note 1: Dental for Cavan Monaghan is not recorded as they appear on Regional Dental WTE Census Data.
Note 2: Figures extracted from divisional plans

Reducing Agency and Overtime Costs

The cost and reliance on agency staff must continue to be reduced in 2016. A range of processes to contain and control the frequency and cost of agency staffing across both HSE and HSE funded services in the period from late 2014 into full year 2015 have been introduced.

Other supports for to assist better management of the workforce and costs may include:

- Greater use of e-rostering and time and attendance systems
- The development of an e-management strategy for the effective management of the workforce and its cost and leading to an integrated and unified technology platform in time.
- The option of the creation of staff banks, based on geographical or service clusters, initially if approved, on a pilot basis to provide evidence based evaluations.

All these measures and actions are to assist the most cost effective service delivery and to ensure the targeted savings from 2014 and 2015 levels, particularly in agency expenditure, continue to be achieved throughout 2016 as success here will determine capacity for targeted investment elsewhere in the health services.

HR Early Warning System

Continue to support the development and implementation of the HR Early-warning system currently piloted in CHO Area 1. This HR Early Warning project uses HR indices as a means to identify potential problems in service areas and prevent or mitigate risk to service users and staff. The data is collected, collated, analysed and responded to so that we may prevent deterioration of staff engagement and appropriate performance leading to adverse incidents for service-users and staff.

2016 Developments

Mental Health:
There are a number of posts identified for funding for service delivery and development. In addition to this there remains a number (14 as at 31st December 2015) of unfilled funded MHS Development posts from 2012-2014 for CHO Area 1 and it is expected they will be filled by Q2 2016 by the NRS. The CHO 1 additional budget for these 2013 & 2014 Development posts is €1,937,938. The 2015 posts are included in the National Mental Health National plan and the allocation for each CHO is to be finalised.

Details by grade of unfilled, funded MHS Development posts from 2012-2014 as at 31st December 2015:
5 posts for Medical Dental
1 post for Nursing
6 posts for Health & Social Care Professionals
2 posts for Management Admin

Primary Care Services:

- Primary Care Infection Control Nurse to develop and roll out primary care infection control standards and guidelines.
- Recruitment of physiotherapists, occupational therapists, speech and language therapists and primary care social workers to strengthen front line primary care services.
- Roll out of the diabetes cycle of care in the primary care setting supported by the recruitment of Clinical Nurse Specialists, Podiatrists and Dieticians aligned to each CHO.
- Nationally recruit 6 Clinical Nurse Specialists (Respiratory – Integrated Care) and 6 Senior Physiotherapists (Respiratory – Integrated Care) to extend the Respiratory Demonstrator Projects for the management of asthma and COPD patients in the primary care setting with links to specialist adults services.

Table 4 – Funded Headcount WTE Position CHO Area 1 all Divisions at 31st December 2015

Staffing Details	Medical Dental	Nursing	HSCP	Clerical/ Admin	General Support Staff	Other Patient & Client Care	Total
WTE's at 31st December 2015	167.09	1628.55	478.42	577.64	329.16	1444.69	4,679
Development posts – filled at 31st December 2015 but not started	-	-	7	1	-	-	8
Development posts – still to be filled at 31st December 2015	6	37	20	6	4	21	94
Replacement posts – filled at 31st December 2015 but not started	-	12	3	2	2	1	20
Replacement posts – Still to be filled at 31st December 2015	10	138	39	6	13	63	269

The Haddington Road Agreement 2013-2016

The *Haddington Road Agreement* (Public Service Stability agreement 2013-2016) has supported the achievement of significant cost reduction & extraction measures since its commencement. The focus in 2016 will be to continue to maximise the flexibility provided by the enablers and provisions so as to reduce the overall cost base in health service delivery in the context of the reform and reorganisation of our services as set out in *Future Health*, the VFM policy review and the other Public Service Reform Plans of 2011 and 2013.

It will continue to assist clinical and service managers to more effectively manage their workforce through the flexibility measures it provides.

The *Haddington Road Agreement* enablers and provisions include:

- Work practice changes for identified health care workers
- Systematic reviews of rosters, skill-mix and staffing levels
- Increased use of redeployment
- Further productivity increases
- Further development of the Nursing / Midwifery Graduate Programme
- Further development of the Support Staff Intern Scheme
- Targeted voluntary redundancy arising from restructuring and review of current service delivery
- Continued improvements in addressing absence rates
- Greater use of shared services and combined services focused on efficiencies and cost effectiveness
- Greater integration and elimination of duplication of functions of the statutory and voluntary sectors

Workforce Planning

Human resources development, a multi-disciplinary and integrated approach to workforce development planning is designed to ensure staff are highly motivated and retain high levels of job satisfaction, whilst delivering effective and compassionate care. Effective performance management and supporting the learning and development needs for all staff at all levels are central to enabling staff '*to be what they can be*'. Action to support new emerging senior teams and to further build managerial capacity include a *Coaching and Mentoring Framework* and structured, *Multidisciplinary (accredited) Leadership and Management Development Programmes,* succession management, new leadership programmes at senior management level and an integrated approach to middle management development. The HSE's actions in this area will be underpinned by a strong emphasis on performance management at all levels in the health system with frequent manager / staff engagement in developing a culture of teamwork, communication and innovation. Underperformance must be addressed in a timely and supportive manner to ensure such staff are brought back to an effective level of performance.

Attendance and Absence Management

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

Table 5 – Absence rates for CHO 1 by Division

Community Healthcare Organisation Area 1				
Divisional Data	**Primary Care & Social Incl.**	**Social Care**	**Health & Wellbeing**	**Mental Health Services**
Cavan Monaghan	2.71%	6.91%	-	4.72%
Donegal	3.48%	6.76%	-	4.76%
Sligo/Leitrim/West Cavan	4.39%	8.05%	-	4.41%

Table 6 – Absence rates for CHO 1 by grade category

Community Healthcare Organisation Area 1								
Area	Medical/ Dental	Nursing	Health & Social Care Professional	Mgt Admin	General Support Staff	Other Patient & Client Care	Total	Certified %
Area 1	1.32 %	5.31%	6.23%	4.38%	7.04%	6.75%	5.77%	94.39%

Employee Engagement

In order to find out the views and opinions of staff, the first ever Irish public health sector wide anonymous and confidential employee engagement survey was conducted between September and November 2014, which included all staff employed across both the statutory and voluntary sector. The data generated will be used to improve the working lives of staff, leading to better care for patients, and will provide a benchmark to build from in 2016, and in future years, to shape organisational values and culture. It will also form part of a health sector wide approach to the continued development and implementation of best practice HR policies and procedures.

A comprehensive people strategy has been developed for implementation in 2016 from the results of the survey. The people strategy will develop leadership and management capacity and skills, embrace and utilise modern technology to bring about efficiencies in our approach to tasks and ensure that workforce and career planning will be carried out openly and transparently. A follow up employee engagement survey will be conducted in 2016 to hopefully reflect changes and improvements. HR will also work with the Quality Improvement Division to ensure enhanced engagement with staff, particularly in front line services.

Health and Safety at Work

2016 will see the continued consolidation and further development of the national Health and Safety Support Function established in 2014. Key delivery areas will include policy, training, information and advice, inspection and auditing.

Accountability Framework

Introduction

The HSE's accountability framework approved by the Directorate and adopted by the Minister for Health sets out the means by which the HSE and in particular each CHO will be held to account for their performance in relation to access to services and the quality of those services within the financial resources available.

Accountability Levels

There are 5 levels of accountability as set out within the accountability framework. At a CHO level, accountability levels 4 and 5 are the most pertinent. The Chief Officer in Area 1 is accountable to the each of the National Directors for community services (Level 4 accountability). Service managers and Section 38 and 39 funded agencies are accountable to the Chief Officer (level 5 accountability).

Accountability Suite (Plans, Agreements and Reports)

There are a number of documents that form the basis of the accountability framework. These include the corporate plan 2015-2017, the National service plan and the divisional operational plans. A single CO performance agreement between the national divisions will be put in place in 2016. The Executive Management Committee (EMC) which is comprised of the four National Directors (i.e. Primary Care, Mental Health, Social Care and Health & Wellbeing) oversees community services performance. Liaison is through the CO of each CHO. Paralleling this, each division holds performance meetings with the CO and their team on an on-going basis. Performance reports are produced on a monthly and annual basis and submitted to the Dept. of Health in terms of the HSE's performance against National Service plan commitments.

Accountability Processes

The community services EMC will formally review the CHO Chief Officer performance agreement with the Chief officer and their team at monthly performance review meetings. It is principally by this mechanism that the progress against the CHO Chief Officer performance agreement and the operational plans are reviewed. Review meetings by the National Directors and Chief Officers will also be undertaken in terms of performance.

Within CHO's, Chief Officers will hold monthly performance meetings with their next line of managers. In terms of Section 38 and section 39 agencies (non-statutory sector), the service arrangement or Grant Aid agreement continues to be the principal accountability arrangement. There is a named manager responsible for managing the contractual relationship with each individual agency. This individual is responsible for managing the performance and financial management within the specified agreement.

Escalation, Interventions and Sanctions

As performance is measured, a process of escalation has been established whereby underperformance is reported and acted upon depending on the nature of the underperformance. In the context of the escalation and intervention framework underperformance includes performance that:

- Places patients or service users at risk
- Fails to meet the required standards for that service
- Departs from what is considered normal practice.

There are approved tolerance levels with regard to underperformance and a process identified for escalation of areas of underperformance. The 4 point escalation framework is used to escalate issues and incidents to the appropriate level from Level 1 (Yellow) at Chief Officer Level to Level 4 (black) at Director General level.

In level one escalation there is a continued failure to maintain or achieve one or more key deliverables. Intervention that ensues is likely to be focused on supporting improvement in particular areas but broader intervention can be deployed. As the level of escalation increases, the sanctions and intervention levels increase to an appropriate level.

Delivery of Services

Delivery of Services

Area 1 Overview

CHO Area 1 incorporates the five counties of Cavan, Monaghan, Donegal, Sligo and Leitrim (Figure 1) and is responsible for the delivery of primary and community based services within national frameworks responsive to the needs of the local community. The Area has a population of 389,048.

Key facts about CHO Area 1

Geography

- Area 1 includes 5 counties; Donegal, Sligo, Leitrim, Cavan, Monaghan
- The total population is 389,048 (8% of the total population of Ireland)
- It is a rural, bordered with Northern Ireland, sparsely populated (35 per km^2, Ireland 67 per km^2), and deprived area with poor transport infrastructure

Demography

- The highest levels of unemployment of all CHOs at 9.6% (national average of 8.5%)
- The highest dependency ratio of all CHOs (36 compared to 67 nationally).
- High levels of GMS/GP visit card
- The lowest level of educational status (14% not educated beyond primary – 10% nationally)
- The highest levels of deprivation (31.6% classified as deprived – 23.3% nationally)
- Higher proportions of older people (13% compared to 11.6% national average)
- Higher proportions of oldest old - >85 years (1.6% compared with national average of 1.3%

Health infrastructure

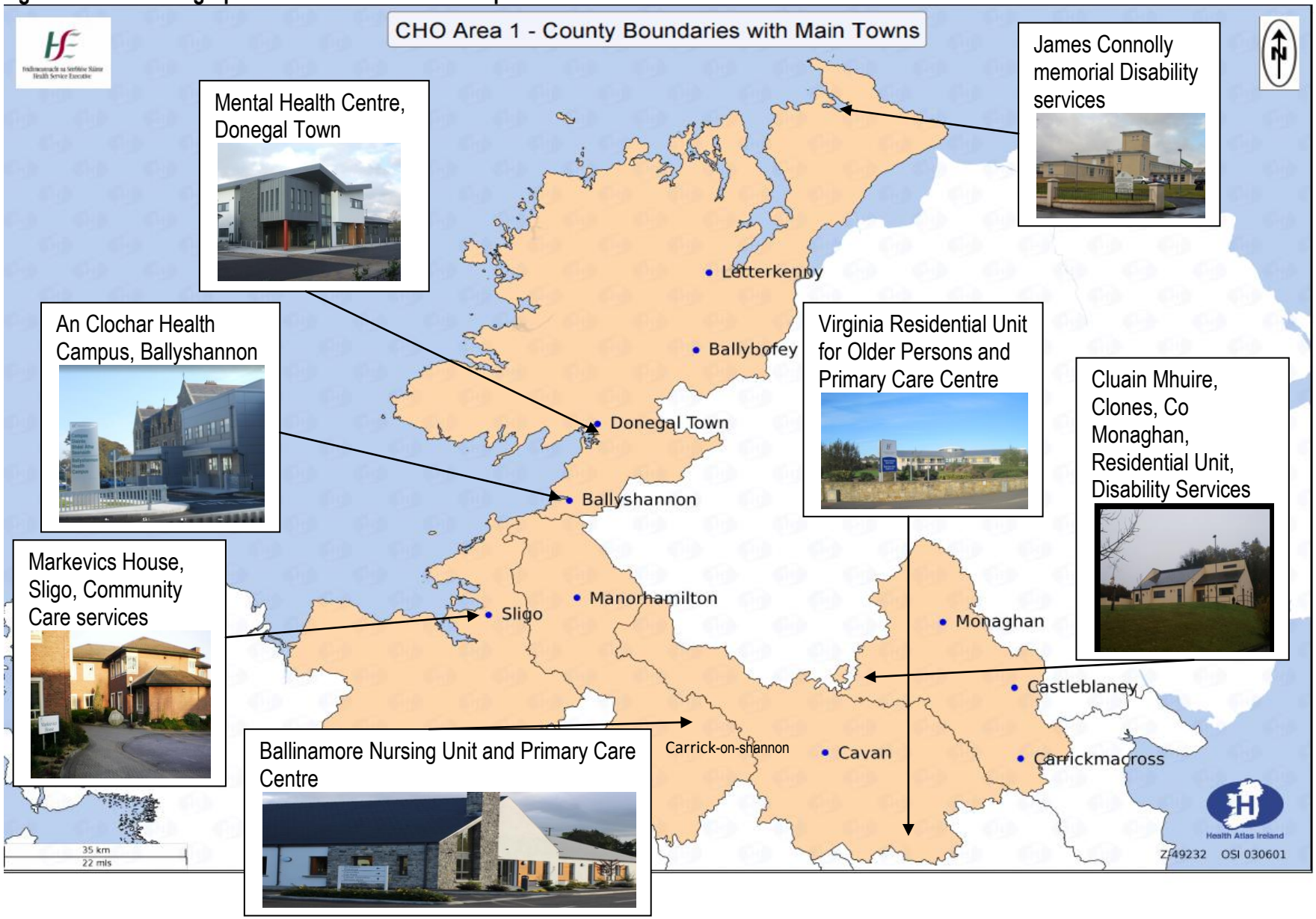
- There are 4 acute sector hospitals in the area under two hospital groups namely Soalta and RCSI and additionally, those residing within Area 1 also avail of acute hospital services in Area 8 and Area 2.
- Two regional health forums service the area (West and Dublin North East)
- There are 3 mental health acute units and 22 public older person's units
- There are numerous disability units providing a range of services including residential full time care and respite alongside community residential units and independent living and semi-independent living accommodation
- There are in excess of 37 primary care teams, 12 primary care networks and 459 electoral divisions within the area
- An overview of demography and health related indicators for Area 1 is contained in Appendix 5.

The health concerns in CHO Area 1 mirror those of the national population (circulatory and respiratory diseases, cancer, lifestyle behaviours of smoking and alcohol and mental health related diseases). These major health concerns are strongly correlated with lifestyle behaviours and socio-economic factors, levels of education, employment and housing (Healthy Ireland, 2012). Planning and delivery of health services in Area 1 must take account of these given that the area rates extremely poorly on each of these important influencing variables.

The major deliverables as they relate to the national initiatives and programmes are outlined within divisional chapters.

Note: "DOP" relates to divisional operational plan and "DDOP" relates to Draft divisional operational plan

Figure 1: Area 1 Geographic Area with a selection of premises



While the operational plan for 2016 focuses on new developmental areas, much of our work is in meeting the day to day healthcare needs of our population across the range of services including:

Mental Health

- Day hospitals, community mental health team appointments, out-patient appointments, day centres, residential care, inpatient care, mental health promotion, suicide prevention etc.

Health & Wellbeing

- Immunisation, sexual health services, health promotion, chronic disease management programmes, smoking cessation, self management etc.

Social Care

- Older Persons Services
  - Community hospitals, day hospitals and day centres, dementia care, carers support, respite provision, home support and home care packages, long and short term care etc.
- Disability Services
  - Early intervention teams and school aged teams, day services, respite services, residential services, pre-school inclusion teams, personal assistant support, respite support etc.

Primary Care

- Primary care team services (Occupational therapy, physiotherapy, public health nursing, dietetics, speech & language therapy etc.)
- Network services (podiatry, audiology, dental services, ophthalmology services)
- Palliative care services (hospice care, community palliative care nursing etc.)
- Social inclusion services (addiction services, homelessness, travellers and minority group care etc.)
- Aids and appliances (equipment for persons e.g. hoists, beds etc.)
- Diagnostics – community x-ray, ultrasound
- Other: primary care development, obesity and diabetes services

In 2015, the following figure provides a high level overview of the scale and scope of services delivered:

Overview of some of the key deliverables in 2015:

Mental Health

- > 1000 referrals for Child & adolescent mental health services were received with 63% seen within 12 weeks
- Over 3.6K referrals to adult community mental health teams were made and all were seen within 12 weeks
- Just under 1.5K referrals to psychiatry of old age teams were received with 95% of these seen within 12 weeks
- There were 1,253 admissions to mental health inpatient units
- Day centres, day hospitals and out-patient apointments were attended across the area
- A range of suicide prevention initiatives were undertaken
- A new Mental Health centre opened in Donegal Town & connected for Life was launched for Co. Donegal

Health & wellbeing

- 94% of children aged 2 years received the MMR
- 97% of newborn babies were visited by a PHN within 72 hours of discharge from hospital
- Almost 60% of older people received the flu vaccine
- Breastfeeding rates rose to 46%
- Over 2K people received smoking cessation support
- A range of initiatives around physical activity, obesity etc. were delivered including almost 6,000 5K parkruns
- Sexual health clinics were supported across the area

Social Care

- **Older persons services**
- 1274 people received a home care package, 1.3 million home support hours were delivered whilst over 2K people received long term residential care supported by NHSS
- Day hospitals and day centres were attended by many older persons over the year
- Dementia specific beds, dementia awareness and carers support was provided
- Respite for families was provided throughout the year
- **Disability services**
- 178 places of work/worklike activity was provided to people with ID/autism and a further 18 places provided for people with a physical and/or sensory disability
- Almost 700 people with ID/autism received residential services whilst 38 people with a physical and/or sensory disability received residential services
- Over 450 people with ID/autism and over 120 people with a physical and / or sensory disability received respite services
- In excess of 140K hours of personal assistant hours was provided to adults with a physical and/or sensory disability
- Over 240K hours of home support was provided to people with a disability
- School aged team and early intervention teams was progressed as well as assessments of need

Primary Care

- 16K physiotherapy referrals were received, in excess of 80% were seen within 12 weeks (114K face to face contacts/visits
- Over 11K occupational therapy referrals were received, between 80 and 90% seen within 12 weeks
- >3.6K referrals were made to dietetics, 1.4K referrals to psychology and 8.5K referrals to public health nursing
- 1,908 referrals were made to podiatry services and 6,029 referrals to speech & language therapy
- 6.2K referrals received by ophthalmology services and 1.8K referrals received by audiology
- A range of initiatives and services were provided to those with addiction issues, travellers, minority groups, those that are homeless etc.
- Numerous community and voluntary initiatives were supported
- A range of equipment was provided across the services including beds, hoists, dressing, bandages etc.
- Medical cards GP visit cards and long term illness cards provided needed support for people in the area
- The drug treatment scheme allowed for required drugs to be made available
- New infrastructure has been developed including the new primary care centre in Ballyshannon
- Access to diagnostics has become more avalable in the community through ultrsound, community X-ray etc.
- Specialist inpatient and community based palliative care services were provided

Health & Wellbeing

Introduction

Name of Division	
2016 Budget €m	
Central Funding	
Full details of the 2016 budget are available in Table 1 page 7	

The Health and Wellbeing Operational Plan for the communities of Donegal, Cavan, Monaghan, Sligo and Leitrim identifies the key actions to be delivered in 2016. Healthy lifestyles, the prevention of ill health and the reduction of health inequalities is a priority for Government with the adoption of the *Healthy Ireland (HI) Framework in 2013.* The Healthy Ireland goals are to:

- Increase the proportion of people who are healthy at all stages of life
- Reduce health inequalities
- Protect the public from threats to health and wellbeing
- Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland.

CHO Area 1 and Healthy Ireland priority areas are to:

- Increase healthy life expectancy at age 65 years by reducing morbidity; overall and premature mortality for four major non communicable diseases
- Decrease infant mortality
- Increase immunisation rates for all children
- Increase uptake of flu vaccination for all at risk groups and HSE staff

Increase participation in regular physical activity across all life stages

- Increase breastfeeding
- Increase the number of adults and children with a healthy weight
- Increase healthy eating
- Decrease alcohol consumption
- Reduce smoking initiation rates among young people
- Reduction in smoking prevalence among adults
- Improve mental health and well being of the population
- Improve the health and wellbeing of the HSE workforce
- Reduce health inequalities

The implementation of the Healthy Ireland Framework and in particular the delivery of a '*Healthy Ireland in the Health Services,' National Implementation Plan 2015–2017* published in July 2015, is a key priority area for this CHO. This plan outlines three strategic priorities for action:

- **Reducing Chronic Disease** - the biggest risk to our population's health
- **Staff Health and Wellbeing** - ensuring we have a resilient and healthy workforce
- **System Reform** - ensuring that the direction and the effect of the significant reforms underway result in a health system that prioritises health and prevention

2016 will see the further embedding of these priorities and agreed actions with the establishment of the Health and Wellbeing Division in CHO Area 1 and the appointment of a Head of Health and Wellbeing.

This area has a strong track record in pioneering, leading and implementing health and well being initiatives in across all service areas and in local communities.

We will continue to support initiatives to improve breastfeeding rates, to increase immunisation uptake for all vaccination programmes and to prevent overweight and obesity in childhood. We will continue to prioritise chronic disease prevention and management with the involvement in national demonstrator sites for implementing new models of care for COPD in Sligo/Leitrim and for self care and self management supports for individuals living with chronic disease in Donegal. The Long Term Conditions Programme in Donegal which aims to bring an evidence based model of care for chronic illness care provision in the community will continue. The Programme will be further refined in 2016 with the aim of rolling out the programme to the wider CHO area in 2016/2017.

Health and wellbeing of our population is not the responsibility of any one agency, it is through our joint working with every organisation that we will deliver improved health outcomes for the populations of Donegal, Cavan, Monaghan, Sligo and Leitrim. During 2016, partnerships and collaborative working will continue with local communities, the community and voluntary sector, third level colleges and other statutory agencies.

This area will continue to be represented on and work closely with the Local Community Development Committees (LCDCs) to ensure that health and well being priorities are included in the Local Economic and Community Plans (LECPs).

The HSE is firmly committed to full engagement with the Children and Young People's Services Committees (CYPSCs) which is the key structure identified by Government to plan and co-ordinate services for children and young people (0-24 years). The implementation of CYPSC Action Plans will continue to be a priority in 2016.

Quality and Safety: Patient and Service Users

The HSE Corporate plan places a significant emphasis on quality and safety from a patient and service user perspective and seeks to ensure that people's experience is not only safe and of high quality, but is also caring and compassionate. There are clear links between what is needed to be done to drive safer, higher quality services and improved health and wellbeing. Key actions identified for 2016 include commitments towards;

- Including health and wellbeing indicators when measuring patients' needs, experiences and outcomes of care.
- Involving patients in the development of programmes and initiatives to improve health and wellbeing
- Development of a Quality Profile framework for application within all Health & Wellbeing services ensuring all relevant sub-divisions and business units have appropriate governance structures in place to address quality and safety issues
- Developing and implementing quality indicators in 2016 building on the work undertaken to date.

These core national health and wellbeing quality and safety initiatives are supported by services in CHO Area 1.

Health & Wellbeing

Key Priorities and Actions to Deliver on Goals in 2016

CG	DOP No.	Short heading	High Level Goals	Action	End Q
	Goal 1	Promote health and wellbeing as part of everything we do so that people will be healthier			
		Healthy Ireland	Develop CHO implementation plan	• Identify Healthy Ireland Lead • Establish Healthy Ireland Implementation Steering Group • Commence development of a CHO implementation plan for Healthy Ireland	Q2
1	1.1.2	Healthy Ireland	Review and develop mechanisms to increase partnership working to improve health and wellbeing	• Review existing partnership working arrangements • Support implementation of joint health projects between PCTs and CHFs addressing health inequalities and health concerns identified in HI.	Q4
1	1.1.3	Healthy Ireland	Reduce chronic disease by focusing on the work of national policy priority programmes	• Reduce chronic disease by focusing on the work of national policy priority programmes including: • Support Healthy Eating Active Living (HEAL) programme • Undertake initiatives to tackle obesity • Undertake Diabetes prevention programmes • Deliver the Healthy families programme • Promote positive mental health • Support expansion of the Social Prescribing Initiative • Continue to support the sexual health clinics • Continue to support the work of the Alcohol Forum • Further develop and seek approval to strengthen the long term conditions programme & self management support framework • Support the development of the clinical care programmes	Q4
1	1.1.4	Healthy Ireland	Support HSE representatives on LCDCs	• Support HSE representatives on LCDCs • Support engagement with the LCDCs in the development of the LCDC Local Economic and Community Plans. • Work with members to ensure actions that address the broader determinants of health are included in Local Economic and Community Plans (LECPs)	Q4
1	1.1.6	Healthy Ireland	Support implementation of Framework for Brief Intervention/Health Behaviour Change	• Support implementation of Framework for Brief Intervention/Health Behaviour Change when published and available	Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
1	1.3.3	Tobacco Control & the Implementation of Tobacco Free Ireland	Support the continued roll out of the Tobacco Free Campus Policy in Mental Health, Disability and Social Care (Older Persons and Disability)	• Support any settings that have yet to implement Tobacco Free Campus Policy.	Q4
1	1.3.4	Tobacco Control & the Implementation of Tobacco Free Ireland	Build capacity among frontline healthcare workers to screen and support smokers to quit	• Deliver Brief Interventions for Smoking Cessation training as per target in NSP 2016. • Continued partnership working with Primary Healthcare workers re Smoke Free Homes with Traveller families.	Q4
1	1.3.5	Tobacco Control & the Implementation of Tobacco Free Ireland	Offer intensive smoking cessation support to smokers through specialist services and the national QUIT team	• Deliver Brief Interventions for Smoking Cessation training as per target in NSP 2016. • Release 5% of frontline staff to attend brief intervention training for smoking cessation	Q4
1	1.3.6	Tobacco Control & the Implementation of Tobacco Free Ireland	Continue to support the planning and delivery of QUIT campaign.	• Continue to support the QUIT campaign	Q4
1	1.4.1	Health Eating & Active Living	Support implementation of calorie posting in all relevant service settings	• Implement calorie posting for foodstufs in healthcare settings	Q4
1	1.4.2	Healthy hospital food & nutrition	Support the development of healthy hospital policy including under nutrition	• Continue to work in residential and hospital settings around nutrition and under nutrition	Q4
1	1.4.3	Education & support to improve nutrition	(i) Provide structured patient education programmes for Diabetes in Primary Care	• Continue to deliver DESMOND group education programme • Increase dietetic follow-up of all Type 2 diabetic patients. • Deliver training on Diabetes Management to all Primary Care Staff caring for patients with Diabetes. • Provide a public awareness service in partnership with Diabetes Ireland to provide information and personal risk assessment at health information days and public information events. • Initiate a register of Travellers with Diabetes to ensure safe, timely, client focussed engagement with services. • Co-delivery of Diabetes Prevention Programme. •Promotion of XPERT Diabetes Education Programme. • Support the delivery of community based cooking programmes	Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
1	1.4.3	Education & support to improve nutrition	(iii) Provide training on the Nutrition Reference Pack for infant 0-12 months to all PHNs	• Provide Training Sessions to PHN's in relation to Nutrition Reference Pack for Infants 0-12 months • Deliver training and education to staff groups and other health professionals on nutrition topics	Q4
1	1.4.4	NPAP	Implement actions from the NPAP	• Support and implement actions from the National Physical Activity Programme	Q4
1	1.4.5	Health Eating & Active Living	Develop HEAL Programme Implementation Plan (incorporating actions from National Obesity Policy and National Physical Activity Plan)	• Continue to manage obese clients referred to our service using Behavioural change techniques and 1-1 follow up (20% of our caseload referred for obesity management).	Q4
1	1.4.6	Health Eating & Active Living	Support community-based prevention and management of overweight and obesity in children	• Work with Children & Young People's Services Committees (CYPSCs) to implement a number of obesity prevention and management programmes. • Continued provision of 1:1 Dietetic service to children with obesity	Q4
1	1.5.1	Healthy Childhood	Breastfeeding: Support the phased implementation of the action plan for breastfeeding 2016-2021	• Continue Breastfeeding Working Groups to promote breastfeeding initiatives • Provide integrated and accessible support & information to parents and encourage & support new mothers to breastfeed. • Work towards each PC Network in SL having dedicated PHNs trained to Lactation Consultancy level. • Ensure staff that come into contact with mothers and babies avail of appropriate training to support breastfeeding • Ensure staff are familiar with the National Breastfeeding Policy. • Implement breastfeeding assessment and care planning tools in SL & ensure information resources are available • Develop and offer breastfeeding preparation classes in each network in SL. • Breast feeding Working Groups in NW will aim to address the advertising of breast milk substitutes and will develop a local conflict of interest policy related to the PHN service. • Continue to offer support and guidance to Breastfeeding Support Groups.	Q4
1	1.5.2	Healthy Childhood	Support schools in participating in the Healthy Ireland Agenda	• Link with schools in CM to address their health needs through Health Promoting Schools (HPS). • Develop Business Case for additional School Nurses in DL due to increasing population sizes across Network areas to SHIP Programme and deliver additional paediatric functions (Letterkenny 1.5, Finn Valley x 1.5, Inishowen x 1, South X 0.5)	Q4
1	1.5.3	Healthy Childhood	Maintain and further develop the Triple P (Positive Parenting Programme) with internal	• Develop model for universal parenting support in DL in collaboration with Children and Young People's Services Committee (CYPSC). • Identify suitable parenting programme for roll in Sligo/Leitrim • Continue the roll out of Parenting Plus Programme across Donegal.	Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
			and external partners in line with available resources	• Continue the 'Mothers Together Group' in Donegal which aims to maintain mental health and wellbeing of mothers in the post natal period in Inishowen	
1	1.5.4	Healthy Childhood	Commence the phased implementation of the revised Universal Child Health & Wellbeing Programme	• Provide CSAP (Childhood Safety Awareness) and refresher training to PHN's in CM . • In partnership with TUSLA continue to initiate partnership working to enhance integrated care pathways and communications to safeguard children in CM	Q4
1	1.5.6	Healthy Childhood	Commence the implementation of The Nurture Programme - Infant Health & Wellbeing Programme	• Commence the implementation of The Nurture Programme - Infant Health & Wellbeing Programme	Q4
1	1.6.2	Alcohol	Further progress a co-ordinated approach to prevention and education issues through drug & alcohol task forces and the Alcohol forum	•Undertake a needs assessment on family support services in partnership with the NW Drug and Alcohol Task Force. • Through a Service Arrangement with the Alcohol Forum deliver the Alcohol related Brian Injury Programme and support Hidden Harm Agenda • Deliver training programme to front line staff on alcohol and drug related issues through the Alcohol forum	Q4
1	1.6.3	Alcohol	Reduce alcohol consumption and related harms	• Commence pilot of Hidden Harm in the North West	Q4
1	1.7.1	Mental Health & Wellbeing	Connecting for Life: Develop and implement plans	• Support the implementation of HSE Suicide Prevention Action Plans across the area. • Establish a Steering Group to oversee Suicide Prevention Action Plan for CM • Hold a Connecting for Life event •Implement and integrate national communications campaigns e.g. Little Things • Organise community wide events to promote mental health and wellbeing • Deliver up to date information on local mental health support services and how to access them • Implement the Stress Control Programme •Provide co-ordinated support to Primary Schools to implement the new Wellbeing in Primary Schools Guidelines for mental health promotion • Deliver SafeTALK, ASIST, STORM and Understanding Self Harm training • Establish networks of ASIST trained individuals in partnership with FRCs •Provide support and signposting to families in the immediate aftermath of a suspected suicide death. •Deliver enhanced bereavement support services to families and communities affected by suicide •Implement the recommendations of the National Suicide Research Foundation (NSRF) Study into untimely deaths of Mental Health service users •Continue to implement and further develop the SCAN service to all GPs in the county.	Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
				•Develop and deliver a uniform procedure to respond to suicidal behaviour.	
1	1.7.2	Mental Health & Wellbeing	Continue the development of mental health promotion programmes with and for priority groups, including Travellers and the youth sector	• Link with schools to address their health needs through Health Promoting Schools (HPS) & support the implementation of the relevant guidelines for mental health promotion and suicide prevention across primary and post primary schools. • Develop the potential of sports clubs as a setting for positive mental health promotion. • Increase emotional resilience through interventions designed to promote self-esteem, life and coping skills through the promotion of positive mental health, raising awareness of the importance of mental health • Continue to develop and support the Social Prescribing Programmes to ensure that people with enduring mental health problems are referred to social prescribing where appropriate • Continue the early intervention Jigsaw service as an accessible and flexible service throughout County • Work with alternative services to reduce the stigma of mental health including Family Matters; Parents Plus and Family Resource Centres in Donegal • Support post-primary schools in DL to continue implementation of the Wellbeing Guidelines on mental health promotion and suicide prevention.	Q4
1	1.8.2	Positive Ageing	Support positive ageing and improve physical activity levels in partnership with social care.	• Support positive ageing and improve physical activity levels in partnership with social care • Continue to work with Development Companies to develop the Befriending Project across CHO area • Continue to work with Good Morning Services to develop the Befriending Project across Donegal and Leitrim	Q1-Q4
1	1.8.2	Positive Ageing	Support positive ageing and improve physical activity levels in partnership with social care.	• Support positive ageing and improve physical activity levels in partnership with social care • Continue to work with Development Companies to develop the Befriending Project across CHO area • Continue to work with Good Morning Services to develop the Befriending Project across Donegal and Leitrim	Q1-Q4
1	1.8.3	Positive Ageing	Improve outcomes for those with dementia and their carers	• Support the work of the social care division in delivery of local initiatives around dementia for example Dementia Aware Donegal	Q1-Q4
1	1.8.3	Positive Ageing	Improve outcomes for those with dementia and their carers	• Support the work of the social care division in delivery of local initiatives around carers	Q1-Q4
1	1.9.1	Sexual health	Develop and commence implementation of guidance to support clinical decision making for STI testing, screening and treatment.	• Continue to support the sexual health clinics across the area	Q1-Q4
1	1.10	Screening	Maximise the coverage of	• Support the PC division in provision of Traveller Primary Health Care Projects designed to raise awareness and give	Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
		Programmes	screening among the eligible population - Traveller Health	information to Travellers in relation to Breast Check and Screening Programmes	
1	1.11.1	Immunisation Programmes	Immunisation: Continue to implement recommendations from 2014 review of models of delivery and governance of immunisation services	• Implement recommendations from the review models of delivery and governance of immunisations. • Support the changes to primary childhood immunisation programme and schools immunisation programme as required	Q1-Q4
1	1.10.2	Immunisation Programmes	Improve national primary childhood immunisation uptake rates in partnership with Primary Care and all CHOs.	• Endeavour to meet targets and improve immunisation and primary childhood uptake rates.	Q1-Q4
1	1.10.3	Immunisation Programmes	Improve national school immunisation uptake rates with Primary Care and all CHOs	• Endeavour to meet targets and improve national school uptake rates.	Q1-Q4
1	1.10.4	Immunisation Programmes	Improve influenza uptake rate amongst persons aged 65 and over.	• Work towards improving influenza uptake rates amongst persons over 65	Q1-Q4
1	1.10.5	Immunisation Programmes	Further develop organisational response to influenza to improve influenza vaccine uptake rates amongst staff in frontline settings (acute and long term care facilities in the community).	• Work across services to improve influenza uptake rates amongst healthcare staff across CHO 1	Q1-Q4
1	1.11.1	Healthcare Associated Infections	Review organisational approach to HCAI and antimicrobial resistance in collaboration with the Quality Improvement Division and all stakeholders to produce	• Ensure work plans of PCCC Quality & Risk Group, PCCC Infection Control Group, & Health & Safety Committees are implemented across all services	Q1-Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
			an updated plan.		
1	1.11.2	Healthcare Associated Infections	Execute real time surveillance of emerging AMR threats in line with international benchmarks.	• Review existing HCAI / AMR committees / groups in situ and determine if a CHO wide group is more advantageous. • Ensure HCAI / AMR is included within CHO management team agenda / management reports • Ensure that HCAI/AMR is part of the remit of the forthcoming CHO head of Quality	Q1-Q4
1	1.12.1	Communication	Continue to support the delivery of health and wellbeing focused communication and education campaigns	• Continue to support the delivery of health and wellbeing focused communication and education campaigns	Q1-Q4
Goal 2		Provide fair, equitable and timely access to quality, safe health services that people need			
		Health Protection	Provide assistance and support in responding to public health incidents	• Support the work of the HWB division in addressing public health incidents	Q1-Q4
2	2.5.2	Emergency Management	Engage with the Principal Response Agencies (PRA)s on the implementation of the annual interagency work programme as agreed by the Interagency National Working group	• Continue to work with services and our partner agencies to ensure the Major Emergency Plan is in place and up to date	Q1-Q4
Goal 3		Foster a culture that is honest, compassionate, transparent and accountable			
		Quality & Patient Safety	Improve quality and safety of services across all divisions	• Through existing and forthcoming structures and resources, improve the quality and safety of services	Q1-Q4
3	3.1.3	Quality & Patient Safety	Implement uniform system for recording, collating and reporting Complaints and Compliments across Health & Wellbeing and services.	• Conduct patient experience surveys across services • Register all complaints and compliments on Consumer Services Complaints Register • Continue to utilise the Area 1 compliments and complaints register	Q4
3	3.2.2	Performance Management	Continue the development of measures	• Continue to collect, report and analyse performance measures and outcomes across all service divisions	Q1-Q4

CG	DOP No.	Short heading	High Level Goals	Action	End Q
			and indicators across Health and Wellbeing to facilitate a more comprehensive view of performance and support service improvement, building on the work undertaken in 2015.		
	Goal 4		**Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them**		
		Staff Health & Wellbeing	Support the National Healthy Ireland Workplace Physical Activity Challenge	• Support the National Healthy Ireland workplace physical activity challenge • Provide Fitwise: Healthy Eating & Walking Workshop for staff & promotion of Park Runs to staff. • Provide calorie posting at HSE food outlets.	Q1-Q4
4	4.1.2	Staff Health & Wellbeing	Support the development of Healthy Ireland Workplace framework	• Contribute if required to the development of Healthy Ireland Workplace framework.	Q1-Q4
4	4.1.2	Staff Health & Wellbeing	Ensure that health education campaigns support staff in improving their own health & wellbeing	• Support staff in improving health and wellbeing through physical activity, smoking cessation support, stress management control etc.	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**		
		National Child Health Information System	Support the National Child Health Information System	• Support the HWB division in progressing phase 1 of the National Child health information system	Q1-Q4

Primary Care

Introduction

Name of Division	
2016 Budget €m	
€m	106.6
Full details of the 2016 budget are available in Table 1 page 7	

The primary care operational plan for CHO area 1 encompassing Donegal, Cavan, Monaghan, Sligo and Leitrim, identifies the major developmental actions to be delivered in 2016 within primary care and associated divisions. Service integration and cross divisional working are central of effective service provision in keeping with the cross divisional health needs the population. Primary Care service delivery and development is the foundation for the majority of healthcare in Area 1.

Notwithstanding the variations in local delivery and current structures, each of the objectives and actions to be undertaken over the coming year follow the HSE Corporate plan and primary care operational plan. Service improvements, service developments and patient safety have been central to the development of local plans that allow for continuous development and improvements across the primary care division. A collaborative approach to the design and delivery of services has been a foundation of all developments whilst ensuring that services are based on need and delivered efficiently and safely.

Planning of primary care service delivery in Area 1 takes account of the current and emerging health concerns alongside the national primary care and other divisional planning strategies. The population of Area 1 is 391,994. This population group is largely rural, bordered by Northern Ireland and encompasses two Hospital groups. Delivery of services will be further challenged given the large geographical area, high levels of deprivation and dependency and high levels of GMS entitlements. Furthermore, population ageing and associated reductions in health status will place ever increased burdens of delivering services to meet these needs.

2016 will bring a major change in the delivery mechanisms of primary care services. The roll out of the recommendations contained within the Community Healthcare Organisations report will enable new governance and organisational structures in delivering responsive, high quality, person centred services. The development of primary care teams and networks across Area 1 are advancing.

The specialist role that the social inclusion aspect of the primary care plan plays is essential to ensuring that hard to reach groups can access services in accordance with need. Services for those in need of addiction and homelessness etc. are all core service delivery requirements across the area in varying quantities. Similarly, access to services for vulnerable groups must be prioritised in an effort to reduce health inequalities across the area. A range of initiatives are planned and are ongoing in co-operation with other statutory, community and voluntary agencies as well as families and carers. There are on-going needs and resourcing issues across the Area, particularly in Cavan and Monaghan to enable the expansion and extension of social inclusion services.

With all plans, there are risks to delivery. Risks to delivery of the proposed plans include resourcing issues, particularly front line staff and support staff and resources to enable delivery and reporting of activity. Demographic pressures in additional to those of the age profile of the area include demands on demand led schemes and PCRS.

Quality and Patient Safety (QPS)

The quality and patient safety agenda is central to the delivery of all primary care services in Area 1. There are a range of mechanisms for ensuring quality and patient safety from risk management to quality frameworks, governance groups and auditing etc. in place. Management frameworks also provide assurances in relation to quality and patient safety whilst the Health Charter centres attention around patient centred care.

The National standards for safer better Healthcare continue to be adopted across services through the initial assessment process and identification of Quality Improvement plans. Specific quality and patient safety plans span services to monitor compliance and proactively plan for the safety agenda. Primary Care quality and safety committees, risk management committees etc. identify and manage risk on an on-going basis. It is anticipated that risks and risk management logs will be updated within the quarterly reviews of operational plans across primary care services.

The local strategic priorities for Quality and Patient safety mirror those of the National QPS division and are contained within the QPS chapter overview. Additionally, quality and patient safety deliverables have been included within the action plans of each division, including primary care. The progress in delivering on these plans will be reviewed on an ongoing basis to ensure compliance and continuous development and adherence to this essential domain.

Financial Tables

2016 CHO Net Expenditure Allocations

CHO	Pay	Non Pay	Gross Budget	Income	Net Budget
	€m	€m	€m	€m	€m
Area 1					
Primary Care	59.9	19.2	79.1	-1.6	77.5
Social Inclusion	.3	1.9	2.2	.0	2.2
Palliative Care	4.7	1.6	6.3	-.5	5.8
Core Services	**64.9**	**22.7**	**87.6**	**-2.1**	**85.6**
Local DLS	.0	21.0	21.0	.0	21.0
Total	**64.9**	**43.7**	**108.6**	**-2.1**	**106.6**

HR Information

Primary Care Division – Staff Numbers by CHO (WTEs)

Primary Care	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care	Total	Projected Outturn Dec 2015
CHO 1	78	285	276	306	47	79	**1,072**	1,079

Primary Care

Key Priorities and Actions to Deliver on Goals in 2016

CG	DDOP No.	High Level Goals	Action	End Q
		**Promote health and wellbeing as part of everything we do so that people will be healthier**		
1	1.1.1	Develop implementation plan for *Healthy Ireland*(HI) if CHO 1 is a selected site	• Establish Healthy Ireland Steering Group and develop action plans • Support implementation of joint health projects between PCTs and Community Health Forums that address health inequalities and health concerns identified in HI around child Health, physical activity, obesity, carer support, mental health and dementia.	Q1-Q4
1	1.1.2	Engage with LCDCs to ensure relevant health and social care priorities are addressed	• Support engagement with the LCDCs in the development of the LCDC Local Economic and Community Plans.	Q1-Q4
1	1.1.3	Implement the Healthy Workplace Policy with supporting initiatives for staff to look after their own Health and Wellbeing	• In conjunction with HR and Health and Wellbeing establish a working group to advance and implement healthy workplace policy	Q1-Q4
1	1.2.1	Implement the revised child health programme	• Develop model for universal parenting support in collaboration with Children and Young Persons Services Committee (CYPSC). • Identify suitable parenting programme for rollout in CHO 1. • Further enhance partnership working with TUSLA. • Promote breastfeeding and increase breastfeeding rates and supports • Implement child and infant health and wellbeing programmes • Develop 2nd Tier Senior Medical Officer led Audiology Clinics and screening clinic for late developmental dysplasia of hip • Advocate for early referral to Speech and Language Therapy for children with delayed Speech and Language Development • Rolling out of ASQ 3 to PHN Service for all developmental checks.	Q1-Q4
1	1.2.1	Implement the revised child health programme	• Support Healthy Eating Active Living (HEAL) programme • Undertake initiatives to tackle obesity, • Undertake Diabetes prevention programmes • Deliver the Healthy families programme • Promote positive mental health	Q4
1	1.2.2	Implement the Nurture - Infant Health and Wellbeing programme in primary care settings	• Continue the roll out of Parenting Plus Programme across Donegal. • Continue the Mother's Together Group initiative which aims to maintain mental health and wellbeing of mother's in the post natal period in Inishowen	Q4
1	1.3.1	Improve influenza vaccination	• Endeavour to increase uptake rates for influenza vaccine among persons 65 years and over.	Q1-Q4

CG	DDOP No.	High Level Goals	Action	End Q
		uptake rates among persons aged 65 and over		
1	1.3.2	Improve influenza vaccine uptake rates among staff in front line settings	• Continue to promote uptake of influenza vaccine among staff in all front line settings	Q1-Q4
1	1.3.3	Implement recommendations of the review of models of delivery and governance for immunisation services.	• Implement recommendations of the review of models of delivery and governance for immunisation services as per National direction	Q1-Q4
1	1.3.4	Expand the current Primary Childhood Immunisation schedule to address agreed public health priorities	• Improve immunisation and primary childhood uptake rates by identifying areas where uptake is below national target and implement corrective actions • Increase the percentage of children who receive vaccines to the target percentages: - % of children 24 months of age who have received the MMR vaccine – target 95%. - % of children 12 months of age who have received the 6-in-1 vaccine – target 95%. - % of children 24 months of age who have received the third of Men C vaccine – target 95%. - % of first year girls who have received third dose of HPV vaccine – target 80%. - % uptake in flu vaccine > 65 years – target 75%.	Q1-Q4
1	1.4.1	Support the implementation of the Sexual Health Strategy	• Implement actions of the Sexual Health Strategy	Q1-Q4
1	1.4.2	Support brief intervention training for staff on smoking cessation	• Release a further 5% of front line Primary Care Division staff to attend brief intervention on smoking cessation	Q1-Q4
1		Implement calorie posting for all foodstuffs in Primary Care Settings	• Map all catering facilities in primary care settings with a view to implementing calorie posting for all food stuffs	Q1-Q4
1	1.5.1	Implement the HCAI / AMR clinical care training programmes	• Ensure staff undertake hand hygiene training & Infection Prevention & Control core skills training • Participate in National HALT study 2016 • Ensure quarterly Environmental Hygiene audits are carried out with associated Quality Improvement Plans 'actioned' in a timely manner to address gaps. • Ensure all Medical Devices / Equipment are compliant with maintenance and servicing requirements • Ensure no service will show evidence of the re-use of single-use medical devices / equipment • Undertake Legionnella Risk Assessment and submit to the Legionnella/Water Quality Committee • Implement Infection Prevention & Control PPPGs that are relevant to their areas • Improve prevention, control, and management of HCAI and improve antimicrobial stewardship, in conjunction with GPs and the Caredoc Clinical Governance Team. • Implement Quality Improvement Plan arising from self assessment against National Standards for SBHC • Complete workforce planning & develop Business case for Infection, Prevention and Control Nurse. • Participating in joint integrated steering /working group with the local Acute Hospital to implement Aseptic Non Touch Technique	Q1-Q4

CG	DDOP No.	High Level Goals	Action	End Q
			across settings	
1	1.6.1	Reimburse primary care contractors in line with health policy, regulations and within service level agreements governing administration of the health schemes	• Implement recommendations of the Deloitte Prospectus Review of Reimbursement Functions Report (July 2015).	Q4
Goal 2		**Provide fair, equitable and timely access to quality, safe health services that people need**		
2	2.1.1	Develop a programme to improve the quality and safety of addiction, homelessness and palliative care services	• Ensure a care and case management approach is implemented and working effectively in CHO 1 with particular focus on improving health outcomes for homeless, addiction and palliative care services. Implement a range of quality improvement initiatives. •Continue to Implement standardised PCC Addiction, Assessment & Care Plans. • Benchmark QuADS (Quality Alcohol Drug Standards) and identify gaps.	Q1-Q4
2	2.2.1	Support the Primary Care Teams (PCTs) participating in the Pressure Ulcer to Zero Collaborative	• Provide support to all Primary Care Teams participating in the Pressure Ulcer to Zero collaborative.	Q1-Q4
2	2.2.2	Provide awareness training to multi-disciplinary team members involved in the collaborative on the management and prevention of pressure ulcers within primary care	• Arrange training and awareness on the management and prevention of pressure ulcers within primary care and supporting PCTs participating in the Pressure Ulcer to Zero Collaborative.	Q1-Q4
2	2.3.3	Extend the 2015 minor surgery project	• Continue to support 1 GP Practice to participate on minor surgery project and identify further sites	Q1-Q4
2	2.3.4	Extend direct access for GPs to ultrasound and x-ray	• Continue the provision of GP Ultrasound Service at Markievicz House, Sligo and Letterkenny Primary Care Centre for GMS/GP visit patients • Review feasibility for roll out of GP Ultrasound Service in Cavan/Monaghan	Q1
2	2.3.5	Develop primary care psychology services	• Roll out service model agreed for the counselling of children 0-18 years • Strengthen Primary Care Psychology Services in Cavan/Monaghan and reduce waiting lists (through the submission of business cases for the provision of additional psychology posts) and roll out computerised CBT programmes	Q4
2	2.3.6.1	Implement the recommendations of the	• Following standardisation of school vision screening deliver school vision screening training to PHNs. • Support the National Clinical Pathways Programme in ophthalmology in Donegal	Q1

CG	DDOP No.	High Level Goals	Action	End Q
		Primary Care Eye Services Review Report	• Report on newly introduced Glaucoma Screening service • Scope the introduction of a waiting list initiative to refer children to Optometrists in the local community for refracting and visual tech on a cost per head / voucher basis • Submit business case for the appointment a Community Ophthalmic Nurse to enable ophthalmic services to be provided within the community thus allowing the acute service to concentrate on surgical ophthalmology	
2	2.3.6.2	Implement the recommendations of the Primary Care Eye Services Review Report	• Finalise model and implement an integrated eye service in Sligo/Leitrim • Release PHN staff to attend school vision training • Recruit Community Ophthalmic Nurse and Grade 1V to develop community ophthalmology services thus enabling Acute services to concentrate on surgical ophthalmology which will reduce waiting lists and facilitate earlier treatments	Q3
2	2.3.7.1	Advance Progressing Disability Services Programme for Children and Young People in collaboration with social care services	• Implement Progressing Disability Service Programme for Children and Young People in collaboration with Social Care Services	Q1-Q4
2	2.3.7.1	Advance Children and Adults - National guidelines on accessible health and social care services	• Implement the National Policy on Access to Services for Children with Disability or Developmental Delay - in collaboration with the Social Care Division.	Q1-Q4
2	2.3.7.1	Advance Adults - Comprehensive Employment Strategy for People with Disabilities	• Ensure primary care representation on a working group to oversee implementation - in collaboration with the Social Care Division.	Q1-Q4
2	2.3.8	Support the review of the model and provision of primary care speech and language therapy services, particularly for children.	• Participate in the review of the model and provision of primary care speech and language therapy services • Review the service model in the context of implementing Progressing Disability Services	Q4
2	2.3.9	Undertake waiting list initiatives to reduce waiting times for primary care speech and language therapy particularly for children	• Review existing waiting lists for speech and language therapy and undertake initiatives to reduce waiting times. • Consider system of prioritising for children on the waiting list • Deliver Parent/sibling Training programme	Q1
2	2.3.10	Advance the development of a Community Intervention Team Service (CIT) in the area	• Currently no CIT exists in this area. Business case submitted to primary Care and preparatory work for CIT service has commenced • Undertake feasibility study to explore the use of Outpatient Parenteral Antimicrobial Therapy (OPAT) with particular focus on hospital avoidance and earlier discharge.	Q1-Q4
2	2.3.11	Progress the implementation of the recommendations of the	• Implement recommendations of the GP Out of Hours Review and continue to improve, manage and monitor the use of GP OOH contacts through delivering on the following:	Q2

CG	DDOP No.	High Level Goals	Action	End Q
		GP Out of Hours Service Review using existing resources	• Progress the roll out of electronic messaging system (Healthlinks) to replace fax system of patient contact notifications to GPs. • Maintain RCGP/ICGP Accreditation • Facilitate service users' contacts through Centre Visits, Home Visits; Nurse telephone advice; GP telephone advice • Seek approval for continued investment in Estates, infrastructure and vehicles • Liaise with Dept of Health and Western Urgent Care (WUC) around the expansion of a cross-border project agreed for Pettigo and Blacklion. • Undertake ICT improvements, to incorporate Adastra Version 3, and enhanced ICT connectivity for Caredoc, subject to National/Regional funding	
2	2.3.12	Support the implementation of the recommendations from the Review of the Primary Care Island Services	• Implement the recommendations of the review of the Primary Care Island Services and seek approval for the replacement of the nursing post vacancy on Tory Island.	Q1-Q3
2	2.3.12	Support the development of National Lymphoedema services	• Support staff to avail of lymphoedema training and continue service across the County to ensure equity of service.	Q1-Q4
2	2.3.12	Facilitate the transfer of Complex Paediatric cases from acute to Primary Care	• Implement the recommendations of the review of Complex Paediatric Care in the Community and undertake a review of the respiratory Physiotherapy needs of complex paediatric cases in the community. • Develop Training Needs Analysis and deliver training to relevant staff • Develop Business Case for Health Care Assistants • Develop Business Case for the introduction of a Practice Development Co-ordinator (in collaboration with CNME) for operational role for children with Life Limiting Conditions in tandem with clinical governance brief	Q1-Q4
2	2.3.12	Support the national guidelines and protocols for community funded projects	• Implement when finalised the national protocols and guidelines for community funded projects (Demand Led Schemes)	Q1-Q4
2	2.3.12	Implement paediatric waiting list initiatives in Audiology	• Implement paediatric waiting list initiatives for audiology services across CHO 1	Q1-Q4
2	2.3.12	Support revised training programme for PHN's on the updated hearing screening protocol in collaboration with Health & Wellbeing	• Facilitate PHN's to attend training	Q1-Q4
2	2.3.12	Implement the recommendations of the Civil Registration Service Review when agreed	• Implement recommendations of the Civil Registration Service Review when agreed	Q1-Q4
2	2.5.1	Improve access to orthodontic treatment for children including	• Provide treatment to all children waiting over 4 years for orthodontic services and improve access to orthodontic treatment for children.	Q4

CG	DDOP No.	High Level Goals	Action	End Q
		those requiring orthognathic / oral surgery	• Work with the Orthodontics Departments on the delivery of assessment clinics and primary care advice and maintain Service Arrangement with CHO Area 8. • Provide conscious sedation for people with special needs through the upskilling of a senior dental lead • Continue to work with the acute sector to address access issues to general anaesthesia. • Continue to deliver Oral Health Education in CM & develop Business Case for Oral Health Educators in DL & SL • Provide specialist service for patients with cancer • Prepare for new Dental Council Guidelines being introduced in 2016 taking cognisance of staff training, infrastructure, equipment, etc • Examine and treat patients with special needs • Continue to see referrals from ED including OOH in DL & SL & examine how ED referrals are seen in other areas. • Report on the upgrade of the Dental Record & Info System (EXACT) to the new version (SOELHealth) &then migrate to national Database. • Continue the roll out of the Dental Safety Radiation Committee for CHO 1 & 2: develop QA schedules, update Radiology equipment inventory, identify equipment replacement needs & develop training programme.	
2	2.5.2	Commence the process of implementation of HIQA infection control standards.	• Implement HIQA pre-inspection audits and post inspection changes where necessary. • Explore the possibility of development a Centralised Area 1 Central Sterile Supply Departments (CSSD) in order to meet HIQA standards.	Q1-Q4
2	2.5.3	Provide advice and information and onward early referral for oral healthcare for high risk children by undertaking a 'smiles' pilot programme targeting children aged between 0–3 years in one site	• Await identification of pilot sites and support local initiatives	Q2-Q4
2	2.6.1	Provide an integrated response with acute services and social care services to relieve pressure in EDs, incorporating hospital admission avoidance and facilitating early discharge	• Develop the new GP out of hours Service in Sligo and North Leitrim • Continue to support 1 GP Practice to participate on minor surgery project and identify further sites • Improve Integrated care Pathway for the prevention and management of Chronic Disease. • Support minor surgery in 1 GP site in Donegal and identify further sites.	Q1-Q4
2	2.6.2	Support the implementation of the new model of practice for the management of children with non-complex needs	• Support the implementation of the new model of practice for the management of children with non-complex needs	Q1
2	2.6.3	Participate in the multi-divisional Respite Review Group (Carers Strategy) in collaboration with social care	• Participate in the Respite Review Group in collaboration with Social Care Services • Continue to deliver the Stroke Programme for Carers and Generic Carers Programme in Donegal	Q2

CG	DDOP No.	High Level Goals	Action	End Q
		services.		
2	2.6.4	Implement the Primary Care Education, Pathways and Research in Dementia (PREPARED) Programme	• Implement the Primary Care Education Pathways and Research in Dementia in CHO 1 sites identified in collaboration with Social Care.	Q1-Q4
2	2.7.1	Provide structured education programmes for patients with diabetes.	• Participate on National Diabetes Integrated Care & Regional DNS Groups to develop National Diabetes Management Guidelines • Provide a public awareness service in partnership with Diabetes Ireland • Develop guidelines for insulin management in the home for PHN / CRGNs. • Develop Integrated Insulin Passport for patients in the community • Provide ongoing structured education for medical students, GPs, practice nurses and student nurses and deliver the National foot care education programme. • Develop Business Case for Clinical Nurse Specialists, Podiatrists and Dietitians to roll out the Diabetes cycle of care • Support 22 GP Practices in structured diabetes care and aim to increase support to additional practices.	Q1-Q4
2	2.7.2	Implement the chronic disease demonstrator projects utilising the 2015 approved posts for respiratory, heart failure and diabetes	• Complete recruitment of Senior Physiotherapist and CNS and establish the Chronic Disease Demonstrator Project in Sligo/Leitrim in conjunction with SUH and other key services • Develop business case for 1.0 WTE Senior Paediatric Respiratory Physiotherapist post to be joint funded by LGH and Donegal PCCC. The role of the Paediatric Respiratory Physiotherapist will be to provide a service directly to children and work with families and home care staff to upskill them in meeting the child's respiratory needs.	Q1-Q4
2	2.7.3	Progress the implementation of the Diabetes Clinical Programme making best use of the existing Integrated Care Diabetes Clinical Nurse Specialists	• Continue to deliver DESMOND group education programme in Donegal/ Sligo/ Leitrim with a minimum of 1 DESMOND course per quarter in each primary care network area • Increase dietetic follow-up of all Type 2 diabetic patients. • Deliver training on Diabetes Management to all Primary Care Staff caring for patients with Diabetes. • Provide Diabetes Prevention programme targeting High risk groups identified by Primary Health Care staff. • Implement the Nurse Prescribing Service to patients with Diabetes Mellitus attending outpatient/nurse led clinics for patients under the care of the Consultant Endocrinologist / nurse prescribing mentor. • Increase Nurse Led Diabetic clinics on a monthly basis throughout all network areas depending on resources.	Q1-Q4
2	2.8.1	Develop and progress the priority work streams of the five integrated care programmes to improve integration, access and outcomes for patients in collaboration with Clinical Strategy and Programmes	• Further develop and refine the Long Term Conditions Programme in Donegal and plan roll for the roll out of the programme across the area • Support the work of the Integrated Care Programmes to improve access and outcomes for patients. Appoint Self Management Support Co-ordinator in Donegal to enable the implementation of the Self Management Support Framework.	Q1-Q4
2	2.9	Improve integrated care pathways in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease	• Implement the ICPs where relevant in the local area • Initiate the pilot telehealth project for newly diagnosed patients with type 2 diabetes. • Roll out quality initiatives with GPs and Primary Care Teams. • Develop a generic pathway for the major cardiovascular and respiratory diseases in conjunction with the clinical programmes. • Deliver pulmonary rehabilitation programme in Inishowen Northwest and South Donegal PC Networks,	Q1-Q4

CG	DDOP No.	High Level Goals	Action	End Q
			• Appoint COPD CNS and Senior Physiotherapist in Sligo and participate in National Demonstration COPD project. • Continue actions in relation of expanding the social prescribing initiative	
2	2.10.2	Ensure that adults deemed appropriate for treatment for substance abuse receive treatment within one calendar month (National Drug Strategy Action 32)	• Commence pilot of Hidden Harm • In partnership with Drug & Alcohol Task Force and depending on resources, undertake a needs assessment on family support services. • Continue to implement standardised PCC Addiction, Assessment & Care Plans. • Progress developments in relation to the Business Case submitted to National Social Inclusion Office to support the recruitment of HSE Addiction Coordinator for Cavan Monaghan and 2 HSE Addiction Counsellors. • Facilitate the transfer of the Task Force Drug Project from the former North Eastern Area into Cavan Monaghan • Deliver screening and assessment for substance misuse within primary care and mental health services and expand coverage to South Donegal following appointment of CNMH in Addiction Service • Subject to approval of additional staff deliver group therapy programmes. • Ensure service users have access to assessment for methadone programme and continue to promote within the local GP population, level 1 GP training in an effort to provide more accessible services locally	Q1-Q4
2	2.10.3	Ensure that children deemed appropriate for treatment for substance abuse receive treatment within one week	• Ensure children appropriate for substance misuse treatment receive treatment within one week	Q1-Q4
2	2.10.4	Ensure that addiction services operate within the person-centred care planning processes of the *Drugs Rehabilitation Framework*	• Through Service Agreement continue to support and fund White Oaks Rehabilitation Centre as a Tier 4 Treatment Service and provide training in relation to dual diagnosis • Through Grant Aid Agreement support Bill W Club to deliver an outreach, support and signposting service for people with addiction issues • Expand the availability, accessibility and coverage of effective and diversified drug treatment nationally to problem and dependent drug users including non-opioids users, so that all those who wish to enter drug/ alcohol treatment can do so, according to relevant needs. • Ensure adults appropriate for substance misuse treatment receive treatment within one calendar month Implement Acute Hospital Discharge Protocol. • Work in partnership with the Local Authority on the Homeless Action Team (HAT) to address the needs of Homelessness people • As part of the work of HAT, work with the SIMON community develop a small dwelling for homeless persons in Donegal • Participate on the Regional Homelessness Forum led out by Sligo County Council • Review current in-reach services and identify gaps and develop care pathways were appropriate.	Q1-Q4
2	2.10.5	Implement the recommendations of the Naloxone Demonstration project within available resources	• Implement the recommendations of the Naloxone Demonstration project within available resources	Q1-Q4
2	2.10.6	Support the work of the audit of drug services in line with the	• Review current in-reach services and identify gaps and develop care pathways where appropriate. • In partnership with Drug & Alcohol Task Force and depending on resources, undertake a needs assessment on family support	Q1-Q4

CG	DDOP No.	High Level Goals	Action	End Q
		Drugs Rehabilitation Framework on care planning, assessment, key working and referrals	services.	
2	2.10.7	Continue to ensure that those with dual diagnosis of Addiction & Mental Health are prioritised through multi-disciplinary working	• Continue to ensure that those with dual diagnosis of Addiction & Mental Health are prioritised through multi-disciplinary working	Q4
2	2.11.1	Support the implementation plan to reduce homelessness with particular focus on health related recommendations	• Work in partnership with the Local Authority on the Homeless Action Teams (HAT) to address the needs of Homelessness people in Donegal • Participate on the Regional Homelessness Forum led out by Sligo County Council • As part of the work of HAT, work with the SIMON community to develop a small dwelling for homeless persons in Donegal • Review current in-reach services and Identify gaps and develop care pathways were appropriate. • Continue to support Hostels for Homeless People through Service Agreements.	Q1-Q4
2	2.11.2	Ensure arrangements are in place and working effectively to ensure homeless persons have access to primary care services where required	Ensure appropriate care is delivered through our Primary Care Teams by: • Working in partnership with the Local Authorities on the homeless action team (HAT) to address the needs of the homeless. • Participate on the regional homeless forum led out by Sligo County Council.	Q1-Q4
2	2.11.3	Work towards ensuring that no patient is discharged into homelessness from an acute setting and ensure the provision of step-down care for homeless people with chronic and enduring needs in long-term supported accommodation in collaboration with mental health services	• Implement Acute Hospital Discharge Protocol.	Q1-Q4
2	2.11.4	Ensure the provision of in-reach services to emergency accommodation settings and long-term supported accommodation for people with high support needs	• Identify existing HSE Services and NGO's that offer in-reach service • Identify gaps and address same • Build on cross agency working group inclusive of representation from statutory and community	Q4
2	2.12.1.	Traveller and Roma health -	Implement and monitor health related recommendations of anticipated National Traveller and Roma Inclusion Strategy by	Q1-Q4

CG	DDOP No.	High Level Goals	Action	End Q
	1	Provide health information and education for travellers on diabetes and cardiovascular health.	undertaking the following: • On publication of the strategy; review current service provision in partnership with the Children & Families Agency • Develop implementation strategy in consultation with Traveller & Roma Organisations for the period of the strategy. • Continue to support NGOs through Service Arrangements to undertake a range of actions designed to raise awareness and give information to Travellers in relation to Type 2 diabetes, Cardiovascular health, assisting Traveller women to access National Screening Programmes such as Breast Check and Cervical Check etc. • Designated Public Health Nurse for Travellers will explore the initiation of a register of travellers with diabetes in order to ensure safe, timely client-focussed engagement with Health and Social Care Services. (Clinical governance would require this to be HSE lead).	
2	2.12.2.1	Implement the recommendations of the *Strategy on Domestic, Sexual and Gender-based Violence 2015–2020* with particular attention to vulnerable or at risk communities and support for staff in recognising and responding to victims of violence	• Implement health related elements of Domestic, Sexual and Gender based violence, with regard to cross Government strategies in particular by undertaking the following: • On publication of the strategy; review current service provision/access in partnership with Children & Families Agency • Identify gaps & blocks • Develop implementation strategy for the period of the strategy. • Identify existing HSE Services and NGO's that offer support to women in affected by conflict and Identify gaps and address same • Build on cross agency working group inclusive of representation from statutory and community to highlight the issue of human trafficking.	Q1-Q4
	2.12.2.1	Develop a Traveller and Roma Inclusion Strategy in collaboration with clinical programmes and mental health services	Develop a Traveller and Roma Inclusion Strategy in collaboration with clinical programmes and mental health services.	Q1-Q4
	2.12.2.2	Implement the recommendations of the *Strategy on Domestic, Sexual and Gender-based Violence 2015–2020* with particular attention to vulnerable or at risk communities and support for staff in recognising and responding to victims of violence	Implement health related elements of Domestic, Sexual and Gender based violence, with regard to cross Government strategies in particular by undertaking the following: • On publication of the strategy; review current service provision/access in partnership with Children & Families Agency • Identify gaps & blocks • Develop implementation strategy for the period of the strategy. • Identify existing HSE Services and NGO's that offer support to women in affected by conflict and Identify gaps and address same • Build on cross agency working group inclusive of representation from statutory and community to highlight the issue of human trafficking.	Q1-Q4
2	2.12.3	Develop structures and processes to provide health services under the Irish Refugee Protection	• Enhance current structures and processes to ensure a comprehensive response to the health and care needs of service users from diverse ethnic and cultural backgrounds by undertaking the following: • Promote HSE Staff to complete on line Intercultural training available via HseLand • Support the development of 2nd HSE National Intercultural Health Strategy	Q1-Q4

CG	DDOP No.	High Level Goals	Action	End Q
		programme with associated monitoring and reporting of outcomes	• Continue to cooperate with the Intercultural Multi-agency group established to resettle programme refugees. • Support work towards national Ethnic Identifier implementation • Continue to work with HSE Ethnic Minority working group, interagency Donegal Human Trafficking group, Intercultural Platform and other community groups and individuals in responding to health and care needs. • Plan for the implementation of the "Report on Health Screening, Infectious Disease Assessment for Migrants" in collaboration with Public Health • Undertake mapping exercise to identify Social Inclusion Services	
2	2.13.1	Provide translation facilities to assist patients not proficient in English or deaf to access and navigate health services effectively	• Map existing models of interpreting provision.	Q2
2	2.14.2	Extend the implementation of specialist palliative care eligibility criteria to include non-cancer patients	• Implement the Specialist Palliative Care eligibility criteria to include non cancer patients	Q2
2	2.15.1	Strengthen palliative care services through the implementation of the *National Standards for Safer Better Healthcare*	• Implement "Towards Excellence in Palliative Care" Self assessment tool • Implement the recommendations from the National Palliative Care Programme • Develop education programmes utilising the National PC Competency Framework. Dependant upon resources, increase capacity of CNS outreach in CM • Implement the Excellence in Palliative Care Workbook • Develop and implement local guidelines in line with national clinical guidelines • Increase the number of Clinical Audits in Palliative Care Services • Develop Palliative Care Social Work Service in North West Hospice subject to the appointment for Senior Social Work Practitioner.	Q1&Q4
2	2.15.2	Implement clinical guidelines on the management of cancer pain and the management of constipation.	• Implement clinical guidelines on the management of cancer pain and the management of constipation.	Q1&Q4
2	2.15.3	Implement when available, a suite of quality improvement measures for children's palliative care services	• Continue to work and develop existing services i.e. Outreach Nurses and shared care- link between paediatrics and acute hospitals • Work with the All Island Institute of Hospice & Palliative Care (AIIHPC) in developing awareness with regard to the palliative hub for children and young people • Collaborate with GP's, Primary Care Teams and Paediatric Services to implement a range of quality improvement measures. • Develop respite facilities for children and their families in collaboration with other divisions	Q4
2	2.18.2	Support the extension of the Primary Care Nursing oncology programme within Area 1.	• Support the extension of the Primary Care Nursing oncology programme within Area 1.	Q3

CG	DDOP No.	High Level Goals	Action	End Q
	Goal 3	**Foster a culture that is honest, compassionate, transparent and accountable**		
3	3.1.1	Continue service user involvement through existing patient experience and satisfaction questionnaires and examine feedback	• Continue service user involvement through existing patient experience and satisfaction questionnaires and examine feedback and implement quality improvement actions across all services • Act as National Project Lead for roll out of Patient Satisfaction Survey in Addiction Services	Q1-Q4
3	3.2.1	Work with the Quality Improvement Division to foster accountability for quality within primary care through quality initiatives, i.e. provide support, training and advice to the primary care quality and safety committees	• Implement National Standards for Safer Better Healthcare with particular focus on addiction and homeless services, Management Quality Indicators, Serious Incident Reporting & Quality and Safety indicators, NCEC Guidelines and Standards for Clinical Practice • Ensure work plans of PCCC Quality & Risk Group, PCCC Infection Control Group, & Health & Safety Committees are implemented across all services • Undertake hygiene audits across a number of sites including Primary Care faculties • Participate in Hand Hygiene Audits using 'SureWash Facility' in a number of our Primary Care Facilities. • Implement the Quality Improvement Plan (QIP) following the self assessment process. • Submit a business case for the recruitment of staff in support of the implementation of the National standards and development of management quality indicators and SRI reporting.	Q1-Q4
3	3.3.1	Work with the Quality Improvement Division to roll out the Open Disclosure Programme to all primary care services	• Ensure that all compliments and complaints are recorded on the CHO Consumer Affairs Register • Develop and implement a Clinical Audit Plan for 2016 • Implement the Open Disclosure policy and hold staff briefing sessions. • Complete two clinical audits in CHO 1 • Prioritise and implement the national primary care workload management tool	Q4
3	3.4.1	Monitor performance of health services against agreed indicators for quality and safety and the Primary Care Quality Dashboard.	• Utilise the Primary Care Dashboard to Quality and Patient Safety targets.	Q1-Q4
3	3.5.1	Ensure systems and structures are in place within primary care for reporting and monitoring serious reportable events (SREs) and other serious safety incidents	• Continue to participate in the Primary Care Quality & Safety Committee to ensure there are clear structures and processes in place to monitor, review, and learn from Incidents, Patient Experience, Risk Registers, Report Recommendations, Complaints, Audits	Q2-Q4
3	3.8.1	Support the roll out of the National Incident Management System (NIMS) in primary care	• Ensure all incidents are returns on National Incident Management System (NIMS) forms and roll out systems in conjunction with Quality Assurance and Verification and the State Claims Agency as per National direction to allow for the production of high level incident information data. Arrange for additional training as required.	Q4

CG	DDOP No.	High Level Goals	Action	End Q
		in conjunction with Quality Assurance and Verification and the State Claims Agency		
3	3.9.1	Undertake audits of quality and safety in primary care, with the support of the National Quality Assurance and Verification Division, to provide assurance that standards are in line with the *National Standards for Safer Better Health Care*	• Undertake audits of quality and safety in primary care, with the support of the National Quality Assurance and Verification Division, to provide assurance that standards are in line with the *National Standards for Safer Better Health Care*.	Q1-Q4
3	3.10.2	Work with the Quality Improvement Division to develop a quality profile in the primary care setting.	• Work with the Quality Improvement Division to develop a quality profile in the primary care setting.	Q1-Q4
3	3.12.1	Implement standard systems of reporting child protection and welfare concerns to TUSLA	• Implement standard systems of reporting child protection and welfare concerns to TUSLA. • Circulate names and contact details of DLP's • Submit child protection and welfare concerns to the DLPs. • DLP's forward weekly/monthly reports to Children First Office	Q3 Q1 Q1-Q4 Q1-Q4
3	3.15.1	Develop and implement Screening and Brief Intervention (SBI) Implementation plan	• Develop and implement Screening and Brief Intervention (SBI) Implementation plan. • Develop and distribute standardised problem alcohol and substance use screening and brief intervention toolkits to support Tier 1 and Tier 2 services implementing SBI. • Primary Care Addiction Counsellor to complete the SAOR "train the trainer" module with a view to rolling it out to PCT staff	Q2
3	3.16.1	Strengthen community development approaches in line with Healthy Ireland and other relevant initiatives	• Strengthen community development approaches in line with Healthy Ireland and other relevant initiatives by: • Establishing a Social Inclusion Working Group on Community Development, to ensure incorporate principles in respect of addressing Health Inequalities, Community Development, Community Participation, Social Prescribing etc with a focus on vulnerable communities). This working group will have representation from each CHO. • Support the implementation of joint health projects between PCTs and CHFs that will address health inequalities and special health concerns identified in Healthy Ireland around child health, physical activity, obesity, carer support, mental health and dementia • Continue to support CHF Networking Events • Support the implementation of the HSE Suicide Prevention Action Plan in the community • Convene the Community Participation Advisory Group to advance Community Participation in Primary Care	Q4
3	3.17.1	Collaborate with HIV Ireland and other stakeholders to further develop and enhance community approaches to addressing HIV / AIDS	• Collaborate with HIV Ireland and other stakeholders towards further development and enhancement of community approaches to addressing HIV/AIDS.	Q2

CG	DDOP No.	High Level Goals	Action	End Q
3	3.19.1	Develop an integrated whole system approach to person-centred care provision	• Continue to deliver palliative inpatient & home care services so that people receive the level of care they require in the setting of their choice.	Q1-Q4
3	3.19.2	Undertake a health system performance and evaluation study from a person-centred perspective	• Implement Theme 1 Person Centred Care and support within National Standards for Safer Better Healthcare with the support of the Primary Care Quality and Safety Office	Q4
3	3.19.3	Incorporate the experiences of service users and staff to evaluate and plan services	• Scope the establishment of a CHO Area 1 Service User Forum to ensure patient representation on Palliative Care working Groups	Q1-Q4
3	3.19.4	Support services to implement the *Patient Charter for Specialist Palliative Care*	• Support the implementation of Palliative Care Needs Assessment Guidance Document and Education Module	Q3
3	3.19.5	Commence collection of key performance indicators with a quality focus	• Commence collection of key performance indicators with a quality focus	Q2
3	3.19.6	Commence the collection of patient / family satisfaction feedback.	• Commence the collection of patient / family satisfaction feedback.	Q3
Goal 4		**Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them**		
4	4.2.1	Improve capacity in quality and safety within primary care by providing support to staff to develop clinical audit tools.	• Designated staff will undertake Systems Analysis Investigation training • Release staff to train in systems analysis investigation, incident management, risk assessment, open disclosure and clinical audit.	Q1-Q4
4	4.3.1	Promote the implementation of Children First	• Develop Children First Implementation Plan in the CHO area • Develop Local Child Protection and Welfare Policy for CHO 1 • Appoint DLP for CHO 1 • Participate in the system of reporting child protection and welfare concerns and circulate contact details for DLPs among staff	Q2 Q2 Q1 Q3
4	4.3.2	Ensure that each staff member is aware of their social, corporate and legal responsibilities under Children First	• Commence e-reporting of all child protection reports • Ensure all new Primary care staff receive information on the HSE Child Protection and Welfare Policy as part of their induction	Q3 Q1-Q4
4	4.7.1	Provide LGBT health training for health service staff if	• Participate in LCBT training for health staff if CHO 1 is selected	Q2

CG	DDOP No.	High Level Goals	Action	End Q
		selected		
4	4.7.2	Provide intercultural health training to enable staff to deliver services in a culturally competent manner if Area 1 is selected	• Provide LGBT & intercultural health training for health service staff to deliver services in a culturally competent manner subject to available funding • Deliver social inclusion training to a Primary Care Team and Community representatives.	Q2-Q4
4	4.7.3	Roll out of SAOR screening and brief intervention training if area 1 is a site	• Roll out of SAOR (Support, Ask and Assess, Offer Assistance and Refer) screening and brief intervention training for problem alcohol and substance use within Tier 1 and Tier 2 services.	Q4
4	4.8.1	Progress the implementation of the *Palliative Care Competence Framework*	• Implement the Palliative Care Competence Framework.	Q1
4	4.8.2	Provide training and support on the *Needs Assessment Guidance Document* and Education Module.	Advance Training & upskilling of staff by delivering on the following: • In collaboration with CNME, progress the implementation of the Palliative Care Competence Framework • Continue to deliver relevant training and education programmes to up-skill palliative care and associated healthcare staff, i.e. medical, allied health, HCAs etc. • Ensure all new specialist-nursing staff undertake Induction Training, have a PDP in place and identify training needs requirements • Ensure staff have adequate training for specialist posts. Continue to have CPD on staff meeting agenda. • Continue to deliver relevant training and education programmes to up-skill palliative care and associated healthcare staff, i.e. medical, allied health, HCAs etc. • Deliver training in Princess Alice, Irish Foundation Training (Final Journeys), What Matters to Me, Breaking Bad News	Q3
4	4.8.3	Implement the *Role Delineation Framework*	• In collaboration with CNME, implement the Role Delineation Framework. • The RDF applies to all Palliative Care providers (different settings & professional groups) including non-specialists. • Implementation requires engagement with Saolta hospital group & at CHO level in order to be all-inclusive.	Q4
4	4.8.4	Establish nurse prescribing within specialist palliative care	• Establish Nurse Prescribing	Q1
		**Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money**		
5	5.1.2	Policies, Procedures, Protocols and Guidelines (PPPG)	• Participate as required in the development of a HSE Policy Framework for PPG's including education , training and support	Q1
5	5.2.1	Roll out of primary care ICT systems to support safe and effective provision of services. (ICT)	• Implement ICT enabling projects where applicable to support improved efficiencies and effectiveness across services. • Prepare for the roll out of key ICT national systems for audiology and addiction	Q1-Q4

Social Care

Introduction

Name of Division	
2016 Budget €m	
€m	184.5
Full details of the 2016 budget are available in Table 1 page 7	

Social Care Services support the ongoing service requirements of older people and people with disabilities. People are supported to enable them to live at home or in their own community and to promote their independence and lifestyle choice in as far as possible.

The social care operational plan for Area 1 identifies the major developmental actions to be delivered in 2016 while taking into consideration the challenges faced around resourcing, particularly front line staff and support staff, compliance with the national standards for residential care and requirement to move from congregated settings within disability services.

The Area 1 population group is largely rural, bordered by Northern Ireland and encompasses two Hospital groups. Delivery of services for older people and people with disabilities will be constantly challenged given the large rural geographical spread, high level of deprivation and an ever increasing dependency among the people in both care groups.

A range of services are provided to older people including homecare, day care, respite and short and long-term residential services. People with disabilities receive supports to achieve the best possible independence and control over their lives and to pursue activities and living arrangements of their choice.

Quality and Patient Safety

Focus on improving the quality of services and supports for older people and people with disabilities and ensuring their safety is a fundamental priority in Area 1. There are a range of mechanisms in place for ensuring quality and patient safety which are overseen by the Quality and Patient Safety Governance Committees across the region. The local strategic priorities of this group and its sub-groups are contained within the QPS chapter overview. The progress in delivering on these priorities together with the National quality and patient safety KPIs (mechanisms for collection to be developed) will be supported and reviewed on an ongoing basis to ensure compliance and continuous development.

The National Quality Standards for Residential Services for Older People and People with Disabilities continue to be actioned across services through the implementation of quality improvement plans to meet regulatory requirements and to address areas for improvement identified in HIQA inspection reports.

Services for Older People

The ethos of service delivery for older people in Area 1 is to maintain the person in their own home for as long as possible thereby promoting their independence dignity, privacy and respect. This principal is supported by a Community Team comprising of Public Health Nursing, Home Support Services, Allied Health Professionals and a range of other community and voluntary sector supports. Services are accordingly organised to deliver health and social care supports to enable this.

Area 1 has the highest age dependency of all CHO areas at 36% compared to a National average of 33%. Just over 13% (51,284) of the population are aged 65 years and over with 1.6% of the population aged 85 years and over; higher than the National pattern of 11.6% for population aged over 65 years and 1.3% for those aged over 85 years.

The publication of a range of policy documents in recent years have been taken into consideration when planning service delivery and development, these include:-

- A Ten Year Strategy for Continence Care in Ireland (2007)
- The National Strategy to Prevent Falls and Fractures in Ireland's Ageing Population (2008)
- Nursing Homes Support Scheme, *A Fair Deal* (2009)
- HIQA National Quality Standards for Residential Care Setting for Older People (2009)
- The National Carer's Strategy (2012)
- Healthy Ireland (2013)
- Positive Ageing Strategy (2013)
- The National Dementia Strategy (2014)

A brief summary of services provided in Area 1 is included in the table below.

Residential Services	**Bed configurations**
Cavan/Monaghan	
Virginia Community Services	37 beds (31 NHSS, 6 Short Stay)
Ballyconnell	22 beds (22 NHSS, 0 Short Stay)
Sullivan Memorial	21 beds (16 NHSS, 5 Short Stay)
Lisdarn Unit	36 beds (22 NHSS, 14 Short Stay)
Oriel House	21 beds (0 NHSS, 21 Short Stay)
St. Mary's Hospital	70 beds (62 NHSS, 8 Short Stay)
Donegal	
Buncrana Community Nursing Unit	30 Beds (15 NHSS, 15 Short Stay)
Ramelton Community Nursing Unit	30 Beds (14 NHSS, 16 Short Stay)
Carndonagh Community Hospital	45 Beds (23 NHSS, 22 Short Stay)
Donegal Community Hospital	29 Beds (3 NHSS, 26 Short Stay)
Dungloe Community Hospital	35 Beds (16 NHSS, 19 Short Stay)
Falcarragh Community Hospital	38 Beds (10 NHSS, 28 Short Stay)
Killybegs Community Hospital	41 Beds (10 NHSS, 31 Short Stay)
Lifford Community Hospital	20 Beds (3 NHSS, 17 Short Stay)
Rock Community Nursing Unit	22 Beds (22 NHSS)
Shiel Community Hospital	33 Beds (17 NHSS, 16 Short Stay)
St. Josephs Community Hospital	78 Beds (29 NHSS, 49 Short Stay)
**2 beds, which were closed on a temporary basis in Carndonagh, re-opened in June 2015. 8 beds remain closed on a temporary basis in Killybegs. 11 beds currently not in use in St. Josephs (included in temporary closures above) – total capacity at St. Josephs is 78 beds.*	
Sligo/Leitrim	
St John's Community Hospital	139 Beds (100 NHSS & 39 Short Stay)
St. Patrick's Hospital	85 Beds (63 NHSS & 22 Short Stay)
Arus Breffni	25 Beds (NHSS)
Arus Carolan	37 Beds (31 NHSS & 6 Short Stay)
Our Lady's Hospital	35 Beds (Short Stay)
Day Centres	
Cavan/Monaghan	50 (4 HSE and 46 funded voluntary providers)
Donegal	23 (funded voluntary providers
Sligo/Leitrim	17 (5 HSE & 12 funded Voluntary Providers)

A range of additional services and teams support older people to remain independent and at home including primary care teams, home support services, continence care, aids and appliances etc. and the community and voluntary sector. Over the last number of years, a range of initiatives around discharge planning and supports have supported this ethos and allowed for persons to be discharged from hospital and avoidance of delays. It is hoped that there will be continued investment in this area.

Key Priorities and Actions to Deliver on Goals in 2016

Services for Older People

CG	DDOP No.	High Level Goals	Action	End Q
Goal 1		Promote health and wellbeing as part of everything we do so that people will be healthier		
1	1.2.1	Improve diabetes Care	Provide support to HSE and Private Nursing Homes for patients with diabetes through individual patient and staff education. Provide support to identified diabetes link nurses in place within unit.	4
1	1.2.1	Improve diabetes Care	Develop annual diabetes review for in-patients in community hospitals / CNUs.	4
1	1.2.1	Improve diabetes Care	Conduct audit of blood glucose monitoring practice and deliver training in 11 Community Hospitals	2
1	1.2.2	Positive ageing and improve physical activity levels	Continue to deliver Care Pals Programme across Community Hospitals	4
1	1.2.2	Positive ageing and improve physical activity levels	Submit business case for Diabetic Nurse Specialist post for community and acute sector	1
1	1.2.2	Provide dietetic service to all residential units in Co. Leitrim and delivery of training and education	Submit business cases for the provision of dedicated nutritional input and training of staff in St. Pat's, & Arus Breffini and delivery of training and education	1
1	1.2.2	Positive ageing and improve physical activity levels	Submit business case and explore the role of Diabetic Nurse specialist in providing additional service delivery in residential units	1
1	1.2.2	Positive ageing and improve physical activity levels	Work with Age & Opportunity, patients and residential staff to further develop physical activity for residential clients	4
1	1.2.2	Positive ageing and improve physical activity levels	Continue to work closely with Age Friendly Alliances across the 3 areas to implement the key strategy priorities relevant to the HSE	4
1	1.2.2	Implementation of the Carers Strategy	Continue to work with Local Authorities to promote the Age Friendly Cities and Communities Strategy and potential collaborative initiatives	
1	1.2.2	Positive ageing and improve physical activity levels	Further develop Age Friendly integrated Day Care Services through the Age Friendly Health Forum and the roll out of workshops in CHO Area 1	4
1	1.2.2	Staff in older persons services to receive training in Brief Intervention Smoking Cessation	Deliver Brief Intervention Smoking Cessation training to staff	4
1	1.2.2	Positive ageing and improve physical activity levels	Map funding provided to voluntary groups for activity to older people in the community	2
1	1.2.3	Dementia Strategy	Implement actions from the Dementia Strategy Implementation Programme in identified locations. Service Managers from the 3	4

CG	DDOP No.	High Level Goals	Action	End Q
		Implementation Programme	areas will map all services and to identify areas of good practice and establish where shared learning can take place across CHO 1.	
1	1.2.3		Appoint Dementia Lead Role across CHO Area 1 and 1 WTE CNS for Dementia where resources permit	2
1	1.2.3		Explore data collection methods in relation to dementia	2
1	1.2.3		Continue to work with Dementia Aware Donegal to deliver a range of initiatives and projects to raise awareness of dementia in Donegal	4
1	1.2.3		Support HSE staff to attend National Dementia Training	4
1	1.2.3		Roll out training in the Newcastle Model (non pharmalogical management of responsive behaviour in dementia) and PMAV Training (Professional Management of Aggression and Violence) to HSE Staff	4
1	1.2.3		Continue the delivery of clinics for family carers that include free health checks	4
1	1.2.3		Continue the delivery of carers clinics at Day Centres	4
1	1.2.3		Deliver dementia training to Carers	4
1	1.2.3		Continue to work with Good Morning Services to develop the Befriending Project across Donegal	4
1	1.2.3		Continue to work with Leitrim Development Company and Sligo Leader to develop the Befriending Project across Sligo and Leitrim	4
1	1.2.3		Continue to work with the Alzheimer's Society to deliver Day Care and Home Supports to persons with dementia	4
1	1.2.3		Continue to work with Alzheimer's Society Of Ireland to increase the number of Pop up Saturday Carers Respite Day Care Services from 1 to 4 across Sligo and Leitrim	4
1	1.2.3		Support Brindley Healthcare to deliver a dementia specific days at Brentwood Nursing Home	4
1	1.2.3		Continue the Genio Dementia Programme in County Leitrim and extend the project to South Leitrim	4
1	1.2.3		Support the provision of dementia specific respite beds at Aras Gaoth Dobhair Nursing Home.	4
1	1.2.5	Implement Older People Remaining at Home (OPRAH) in identified locations	Continue to work closely with Cavan Monaghan Age Friendly Alliance and explore the possibility of a position to support the OPRAH project on a pilot basis in one Network.	4
1	1.2.5	Respite Care	Maximise usage of respite beds and monitor same	4
1	1.2.5	Day Centre Provision	Work closely with colleagues in the Voluntary Sector to maximise the provision of day care for older people	4
1	1.2.5	Day Hospital Provision	Continue to provide day hospitals services	
1	1.2.5	Community Supports	Work closely with colleagues in the Voluntary Sector to deliver laundry, meals and chiropody services in the community	
1	1.2.5	Continence Care	Continue to provide ongoing continence clinics across Community Hospitals and PCCC	
1	1.2.5		Continue the delivery of 'Healthy Bladder and Bowel Clinics'	
	1.2.5		Explore funding options for the provision of continence services in SL, CM	
1	1.2.6	Falls Prevention and Bone Health	Submit business case in support of the appointment of falls Co-ordinators.	1
1	1.2.6		Continue to roll out Forever Autumn Falls Programme for Falls Prevention in residential Units	4
1	1.2.6		Extend the Forever Autumn Falls Programme for Falls Prevention to Day Hospitals	4
1	1.2.6		Extend the Genio Falls Project to Glenview Ward OLMH, St John's	4
1	1.2.7	Tobacco free houses/units	Continue the work of the tobacco free campus policy	4
1	1.2.7	Implement appropriate	Continue to implement appropriate medication management policies across residential settings	4

CG	DDOP No.	High Level Goals	Action	End Q
		medication management policy across residential settings		
1	1.2.11	Day Centre Staff to receive training in Person Centred Care	Work with Age & Opportunity to deliver Age Wise / Person Centred workshops to Day Centre staff in both HSE Managed and Voluntary run centres on behalf of the HSE.	4
1	1.2.8	HCAI improvement	Participate in the workforce planning exercise for Infection Prevention Control and antimicrobial stewardship Support maximum participation of disability residential services in the National HALT Study 2016	4
Goal 2		**Provide fair, equitable and timely access to quality, safe health services that people need**		
2	2.5.1	Establish implementation group if required to progress home care service improvement plan	Establish implementation group if required to progress home care service improvement plan	1
2	2.5.1	Implement the national standard approach to management of resources	Implement the national standard approach to management of resources	1
2	2.5.1	Ensure a quality & safe services for all service users	Participate in monthly meetings of Quality & Safety Committees in respective areas. Ensure risk registers are completed as appropriate. Ensure infection, prevention and control work plan is implemented. Co-operate with registered provider visit on an bi-annual basis.	4
2	2.5.1	Improve HIQA Compliance	Submit a business case (aligned to the National SC capital works register) for the refurbishment programme within SL & DL	1
2	2.5.2		Work with Estates to achieve HIQA compliance in residential facilities	4
2	2.5.2		Continue to utilise CO monitoring template to monitor compliance and status of remedial actions against HIQA reports	4
2	2.5.2	Plan for existing and projected population based demand for services	Submit business case in support of the progression of capital works for the Area based on projected and immediate population needs	4
2	2.5.2	Ensure a quality & safe services for all service users	Submit business case and progress arrangements for the opening of the extension of Virginia and the upgrading of oriel house.	1
2	2.5.1	Ensure continuation of the improvements in waiting time for NHSS (Fair Deal) applications seen in 2015	Support clients under NHSS within allocated resources.	4
2	2.5.4	Address the current waiting list for home care packages (HCPs) and to continue to provide intensive home care packages when required to support people to stay at home	Seek additional funding to continue to provide intensive home care packages when required to support people to stay at home for as long as possible and to expedite discharges from acute hospitals	4
2	2.5.4	Support Home Care	Continue to work with agencies who provide home care to ensure recruitment of appropriately trained staff for isolated areas	4

CG	DDOP No.	High Level Goals	Action	End Q
2	2.5.4		Conduct a review of Home Support Services in Donegal	4
2	2.5.4		Submit Business Case for the recruitment of 1 WTE Home Support Co-ordinator due to caseload and Grade 5 to deliver a brokerage service across the county	1
2	2.5.4		Collaborate with appropriate services to provide induction and ongoing training for new Home Helps for care provision	4
2	2.5.4	Up skilling of Home Support Staff	Complete evaluation of FETAC L5 SKILL training delivered in 2015.	2
2	2.5.4		Develop Business Case for the continued delivery of FETAC Level 5 training to new Home Helps with mentorship and support provided by PHNs and Opts	1
2	2.5.4	HCPs to alleviate delayed discharges in acute hospitals.	Maximise the provision of home support and home care packages to older people with a focus on hospital avoidance and minimise delayed discharges within acute hospital setting	4
2	2.5.4	Avoidance of Delayed Discharges	Continue to work with colleagues in acute hospitals to minimise delayed discharges and ensure that older people are transitioned from the acute hospital setting to an appropriate facility or home.	4
2	2.5.4		Work with colleagues in primary care to progress business case for the appointment of a Community Geriatrician.	4
2	2.5.4		Explore the opportunities for approval and appointment of a Community Discharge Co-ordinator	1
2	2.5.4		Continue to explore the provision of additional Step Down/Transitional beds within facilities in both counties to assist with the issue of delayed discharges with the acute hospital	4
2	2.5.4		Progress roll out of the Admissions and Discharges planning objectives on a phased basis	4
2	2.5.4		Develop an ICT based communication mechanism with SRH in relation to pending discharges	2
2	2.5.4	Cross Sectoral Working	Develop Business Case for the development an ANP in Tissue Viability to advance partnership working between Public Health Nursing, Older Persons Services, Acute Services LGH and NMPDU.	1
2	2.5.5	Roll over of additional funding received in April 2015 to continue to provide transitional care beds for rehabilitation, step down or convalescence services to ensure reductions in delayed discharges in 2015 are sustained	Report on the number of clients availing of national transitional bed funding	4
2	2.5.5	Continue to provide transitional care beds for rehabilitation, step down or convalescence services to ensure reductions in delayed discharges in 2015 are sustained	Seek transitional bed funding as need arises to enable timely discharges from acute services. Report on the number of clients availing of national transitional bed funding	4
2	2.5.5	Co-operate with the development of a central 'money follows the patient' model of funding for Community Short Stay Beds in public residential Units	Continue to participate on National working Group	4
2	2.5.5	Provide short stay beds to older	Provide short stay beds within approved bed numbers, staffing allocation and allocated funding. Report on the bed uptake	4

CG	DDOP No.	High Level Goals	Action	End Q
		persons through palliative care, respite care, rehab care beds, convalescent beds and assessment beds in line with national budgetary reduction directions and subject to staffing levels	monthly	
2	2.5.5	Review alternative models of care	Continue to support subvention beds and contract beds in Private Nursing Homes, on a named patient basis	4
2	2.5.5		Continue to operate Boarding Out Services	4
2	SC 2.2	Co-operate with the development of a central 'money follows the patient' model of funding for Community Short Stay Beds in public residential Units (similar to current NHSS Funding Model)	Continue to work with colleagues in acute hospitals to progress the Frail Elderly Programme.	4
2	2.5.5	Review alternative models of care	Support SVdP Ozanam House through Service Agreement in accommodating 20 people	4
2	2.5.5		Continue to support Clonmany High Support Unit in the provision of 10 beds for patients with high support non-nursing needs	4
2	2.5.6	Recruit 6 WTE MDT in conjunction with Sligo Univ hospital to support enhanced care pathways for older persons	Recruit 6 WTE MDT in conjunction with Sligo Univ hospital to support enhanced care pathways for older persons	4
Goal 3		**Foster a culture that is honest, compassionate, transparent and accountable**		
3	3.3.1	Establishment of Quality and Safety Structures	Monitor the establishment of Quality and Safety Structures in each CHO through the introduction of a Social Care Quality and Safety Dashboard. Report on the current operational governance structures in place: · CHO Quality and Safety Committee · Social Care Quality and Safety Committee · HCAI / Infection Control Committee per CHO · Drugs and Therapeutics Committee per CHO	1
3	3.3.1	Governance & Communication in relation to Quality & Safety	Commence monitoring of a range of Quality and Safety metrics in CHO Area 1 under the Themes of Person-centred Care, Effective Care, and Safe Care	1
3	3.3.1	Governance & Communication	Provide training and education to CHOs for: · Systems Analysis · NIMS (National Incident Management System) Phase 2 · NIRF (National Incident Report Form) training	4

CG	DDOP No.	High Level Goals	Action	End Q
3	3.3.1	Continue to support Medication Management & Prescribing	Support all HSE and HSE-funded Social Care Residential Providers to participate in the HALT Survey of Healthcare Associated Infections (HCAI) and antimicrobial use	2
3	3.3.1	Support Communication & Engagement	Implement the Social Care Communication and Engagement Plan once developed	2
3	3.3.1	Support the Volunteer Advocacy Programme	Work closely with national Volunteer Advocacy Programme and SAGE to ensure that the voice and views of older people is represented at all levels within the organisation	4
3	3.3.3	Support Advocacy Service	Continue to ensure all Service Users living in Residential settings have been supported to access the Advocacy Service as is evidenced by HIQA reporting.	4
3	3.3.1	Support the Confidential recipient	Provide information to residential and their families in relation to Confidential recipient	1
3	3.3.1	Progress Residents Councils	Progress the implementation of Residents Councils for older persons residential care services Monitor the implementation and effectiveness of Residents Councils for older persons residential care services as part of the quarterly process with Chief Officers	4
3	3.3.3	Implement National quality standards for residential settings.	· Implement National quality standards for residential settings and recommendations arising from inspections where possible · Support the work of the quality improvement enablement programme / Quality Improvement team	4
3	3.3.3	Operate Focus Groups	All residential units to continue to operate focus groups with residents or consumer panels involving representation from the patients, public and carers.	4
3	3.3.4	Implementation of HSE Safeguarding Vulnerable Adults Policy 2014	Work closely with the National Safeguarding Implementation Group (Limerick) to:- o Assist and develop ICT system to be used o Create and roll out standardised Business Processes o Participate on Train the Trainer training to assist the National Implementation Body in providing training at a local regarding the Safeguarding Vulnerable Persons at Risk of Abuse National Policy 2014 o Assess resource implications of implementation of the policy	4
3	3.3.4		o Complete mapping exercise of existing service provision re. adult safeguarding o Develop CHO implementation plan using existing structures and resources o Endeavour to establish a simplified ICT system at local level to allow the capture and collation of statistics of notifications and referrals o Support Service Managers to replace existing staff who have transferred to Safeguarding Service and identify gaps in service provision particularly in relation to complex and challenging cases that may require a social work input, i.e. prevention, welfare and support.	4
3	3.3.4		Ensure Designated Officers and staff avail of training	4
3	3.3.4		Submit business case to enhance the current social work provision to Older persons by appointment of 5 additional wte Social Workers (1 Leitrim, 1 Sligo, 2 Cavan / Monaghan, 1 Donegal)	1
3	3.3.4	Implement Open Disclosure	Provide training and awareness in Open Disclosure with support from the National Team where training the trainer courses are provided in CM and SL.	4

CG	DDOP No.	High Level Goals	Action	End Q
		Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them		
4	4.1	Develop and support leaders to provide direction and purpose, and connect with all staff and teams through open and ongoing communication and engagement as a core leadership activity	Promote the availability of coaching and mentoring services	1
4	4.1		Release staff to participate on the Leadership Development Programme	2
4	4.1		Continue to deliver Achieving Excellence for Clinical Nurse Managers and Directors of Nursing in Donegal and explore the delivery in other areas subject to available resources	4
4	4.1	Develop leaders' capacity to engage effectively with service users, work with other relevant health service divisions and connect with local communities to enhance patient pathways and patient experiences	Older Persons Management Team to continue to meet on a monthly basis to provide communication and sharing opportunity	4
4	4.1		Provide communication and sharing opportunity at the Older Persons monthly management team meeting	4
4	4.1	Increase visibility and connection between the leadership and the workforce placing particular emphasis on improved communication, feedback and responsiveness	Service Managers to continue to meet on a quarterly basis. Continue regular meetings at various staffing levels across the service	4
4	4.1		Service Managers to continue to meet on a quarterly basis. Continue regular meetings of various staffing levels across the service	4
4	4.2		Social Care Division, in partnership with CHO's and Systems Reform Group, will arrange for staff engagement through ongoing consultation and workshops on the CHO reform programme	4
4	4.2	Support the work of the National reform programme	Participate with social care division and SRG in workshops and consultations as they are formulated	4
4	4.3	Commit to a culture of staff engagement in service design and delivery	Service Managers will meet with staff reps and unions on a bi-annual basis	4
4	4.4	Put in place Personal Development Plans and enable	Unit Managers will work with the HR department in having Personal Development Plans in place for staff in their area and enable staff to exercise personal and professional responsibility for the quality and safety of services provided.	4

CG	DDOP No.	High Level Goals	Action	End Q
		staff exercise personal and professional responsibility for the quality and safety of services provided		
4	4.4	Work with professional bodies and staff representative associations to develop Continuous Professional Development responses that support improved performance	Older Persons Practice Development Committee in partnership with NMPDU will meet monthly and progress training	4
4	4.4	Deliver training in Trust in Care and Interview Training	Deliver training in Trust in Care and Interview Training In partnership with HR and Learning & Development	4
4	4.5	Implement SMART action plan once developed	Implement SMART action plan to implement agreement reached at the WRC regarding skill mix	4
		**Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money**		
5	5.1	Oversee service arrangements	Ensure Part 2 SLAs in respect of S38 & S39 agencies are completed within timeframe	1
5	5.1	Utilise the IORN Tool	Continue to use IORN Tool as a management tool	4
5	5.1		Explore the implementation of the IORN Tool as a management tool	2
5	5.1	Utilise Management Tools	Continue to use Dependency and Ratio Tools as a management tool	4
5	5.1	Utilise Nursing Metrics	Implement Nursing Metric in each residential unit	3
5	5.2	Implement SAT following early adopter completion	Commence phased implementation of SAT in due course.	4
5	5.1	Adopt Open Disclosure	Adopt the open disclosure policy and provide open disclosure briefing sessions	4
5	5.1.2	Record, review and learn from complaints and compliments	Ensure all compliments and complaints are registered on the Area 1 register. Review and learn from compliments and complaints	4
5	5.4	Support Practice Development	Continue to support Practice Development Nurse on National Policy Development Group	4
5	5.4		Continue to seek funding for Practice Development Nurse through NMPDU funding	1

Disability Services

The focus in Area 1 is to support people with disabilities to achieve their full potential including living as independently as possible and to ensure that people with disabilities are heard and involved at all stages of the process to plan and improve services.

Services are provided to service users, their families and carers either directly by the HSE or by other agencies working in partnership with the HSE. Services are also provided through statutory and voluntary groups and also locally based community groups with the aim of achieving the best quality of life for each individual. In keeping with national disability policy development, services are predominantly community orientated and as close as possible to the person's own home.

Disability services have developed strong working relationships with the voluntary/statutory sector supported through service agreement funding. These organisations provide a range of services on behalf of the HSE including general health services, health promotion activities, assessment, residential services, rehabilitative training programmes, sheltered programmes and day activity programmes.

Services are staffed by highly qualified disability services staff supported by other community based professionals. All services adopt a case management approach to care which is person centered and supported by the multi-disciplinary team. Specialist services are delivered in the community by the residential, respite or day service facilities together with training services, the local primary health care and community services.

Area 1 had 2,083 people registered on the NPSDD and 2,573 people registered on the NIDD in December 2014.

The publication of a range of policy documents in recent years have been taken into consideration when planning service delivery and development, these include:-

- A Time to Move on from Congregated Settings (2011)
- Report of Disability Policy Review (2011)
- Future Health A Strategic Framework for Reform of the Health Service 2012 - 2015, (2012)
- National Housing Strategy for People with Disability 2011 -2016 (2012)
- National Carers' Strategy (2012)
- New Directions: HSE Day Services Implementation Plan (2012)
- Review of Autism Services (2012)
- Value for Money and Policy Review (2012)
- The National Disabilities Strategy Implementation Plan 2013 – 2015
- National Policy and Strategy for the Provision of Neuro-rehabilitation Services in Ireland 2011-2015"
- National Standards for Residential Centres for Children and Adults with a Disability (HIQA) (2013)

Residential Services	
Donegal:	
Bundoran Residential Unit	ID Service
JCM Hospital	ID Service
Sean O'Hare Unit	ID Service
Sligo/Leitrim:	
Cloonamahon Residential Unit	ID Service (43 Residents)
HSE Cregg Services Residential Unit	ID Service (108 Residents)

Community Residential Settings:	
Cavan/Monaghan	11 HSE Adult Intellectual Disability Residential Centres: Donagh House, Ros na Ri, Lisdarragh, Tonniscoffey, Fernview, Cluain Mhuire, The Arches, Tonnyglasson, Millbrook, Corlorgan, Manderely Lodge, Millbrook. 1 HSE Physical & Sensory Disability Residential Centre (St. Christopher's)
Donegal	27 (24 HSE & 3 voluntary) 1 semi-independent living (ID)
Sligo/Leitrim	49 (40 HSE & 9 Voluntary)
Acquired Brain Injury Ireland	P&S
Cheshire	P&S
Respite Services	
Sligo Leitrim (Solas & Tullaghan)	1 Unit P&S (13 Beds)
Cavan Monaghan	1 HSE Respite Centre (Annalee View) - 5 Beds 2 Respite Beds provided in Physical & Sensory Disability Centre (St. Christophers)
Donegal	4 designated units, 6 CGH's provide limited respite 17 (ID) Units provide respite, Cheshire (P&S), P&S Respite Services (P&S)
Day Services	
Cavan/Monaghan	5 HSE Adult ID Day Services: DAU Monaghan, DAU Cavan, DAU Virginia, MISE, Horticultural Service Monaghan. 1 HSE Physical & Sensory Adult Day Service Facility (Crannog)
Donegal	17 Units (ID). IWA (P&S), ABII (P&S).
Sligo/Leitrim	19 HSE (11 HSE & 8 Voluntary Providers)
Work / Work like activity:	
Cavan/Monaghan	222 people in receipt of work/work like activities in 2014
Donegal	268 people in receipt of work/work like activities in 2014
Sligo/Leitrim	344 people in receipt of work/work like activities in 2014

In addition to the above day and residential service provision, disability services also deliver community based health and social services through community based teams including Adult Community Teams, early intervention teams, school aged teams, neuro-rehabilitation team etc.

Key Priorities and Actions to Deliver on Goals in 2016

Services for Disability

CG	DDOP No.	High Level Goals	Area Action	End Q
		**Promote health and wellbeing as part of everything we do so that people will be healthier**		
1	1.1	Implement of Time to Move On from Congregated Settings	CHO to identify a named lead person to have oversight of the implementation of *Time to Move on from Congregated Settings* actions across CHO and link with the local service providers and national working group	1
1	1.1		**In relation to 17 individuals planned to transition from Cregg House :** · CHO to work with Approved Housing Bodies, Housing Authorities, HSE Estates to develop and progress the plan for meeting the housing requirement for people transitioning from congregated settings. · CHO to ensure that a Community Living Transition Plan is in place to identify how each person will be supported to transition into the community, which has been developed with meaningful involvement of the person, their family and /or advocates. · CHO to develop and implement a time-framed plan identifying how the care supports will be reconfigured/developed to support individuals living in the community. · CHO to ensure the national communication strategy developed to support individual's transitioning into the community is fully implemented. · CHO to ensure that the pre-transition assessment being developed by the Transforming Lives Working Group 1 is administered for all individuals being supported to move in 2016.	4
1	1.1		Facilitate the relocation of service users from congregated settings in JCM, Carndonagh and Sean O'Hare Unit, Stranorlar. Engage with external agencies, housing - voluntary and statutory to identify appropriate alternative accommodation types to facilitate this move.	4
1	1.1		Develop 2 Community Group Homes in Castlefinn in partnership with Habinteg (8 places) to accommodate the move of service users from congregated settings at Ard Greine Court, Stranorlar and provide new residential places	4
1 & 2	1.1		Develop accommodation in Stranorlar for 4 service users in partnership with Donegal Co-Co, APEX Housing Association	4
1	1.1		Submit business case for the appointment/assignment of Project Officer to lead out on the relocation process.	1
1	1.1		Support and develop education and training in our workforce in the operational policies and procedures and the model of service delivery within the Interdisciplinary team. A training package will be agreed with the Local Implementation Group for Progressing disabilities	4
1	1.1		Develop upon the Community Connectedness Project in partnership with Sligo Leader to support communities to facilitate the smooth transition for persons in congregated settings	4
1	1.1		Continue engagement process through established working group meetings between P&S Disability Service & Cheshire (Local & Regional Managers & Cheshire CEO to facilitate decongregation. Meet with Cheshire & HSE P&S Disability Team to progress decongregation	4
1	1.1		Establish a Communication Group to provide clear communication and updates on developments.	2

CG	DDOP No.	High Level Goals	Area Action	End Q
			Set up meetings with key stakeholders i.e. service users & families	
1	1.1		Continue engagement with the Local Housing Authority through the established Local Disability & Housing Steering Group	4
1	1.1		Continue to work with Donegal County Council to reconfigure Milltown House to respite accommodation and enable the transition of 3 service users to move to appropriate accommodation at Riverwalk House, Carndonagh	4
1	1.1		In partnership with Estates redesign / reconfigure Inbhear na Mara, Bundoran internally into 3 living compartments providing accommodation for 4 / 5 service users in each. Submit staffing proposal for completion of staff to support the implementation of 3	4
1	1.2	Service Reform Fund	Review service provision with a view to developing programmes as part of the *Transforming Lives* agenda to facilitate individuals to transition into the community	2
1	1.3.1	Health & Wellbeing within Disability Services	♦ Ensure that all new residential houses are compliant with the HSE Tobacco Free Campus Policy. ♦ Continue to work towards 25% of existing buildings becoming tobacco free	4
1	1.3.2	Implementation of Healthy Ireland in the Health Services 2015-2017	Continue to engage with the consultation process on the National Health Behaviour Change Framework and support the training of frontline staff in Brief Intervention Training when finalised in 2016.	4
1	1.3.3		Staff to make every service user interaction count by routinely assessing levels of physical activity of service users and to promote as much physical activity as is possible for the individual.	4
1	1.3.3		Continue to roll out the Special Olympics Health Promotion Initiative focusing on all aspects of good health to all registered athletes to all clubs, schools and centres.	4
1	1.3.3		Deliver appropriate health and fitness programmes for service users and ensure integration into local sports clubs for people with disabilities	4
1	1.3.3		Engage with Sport & Recreation Groups (e.g. Sligo Sports Partnership) to promote positive ageing and improve physical activity levels	4
1	1.3.8	Influenza Vaccination Uptake Rates	In partnership with Health & Wellbeing continue to promote influenza uptake rates amongst staff and service users	4
1	1.3.10	Medication Management Policy	As per National direction, establish a Medication Management Subgroup as part of the Quality Enablement Programme to address Medication Management in Disability Residential units	3
1	1.3.11	Improve HCAI	Participate in the workforce planning exercise for Infection Prevention Control and antimicrobial stewardship Support maximum participation of disability residential services in the National HALT Study 2016	4
1	1.3.12	Annual Health Checks	Facilitate access to annual health checks for residential service users including access to national screening programmes	4
1	1.3.12	Health Screening	Continue with initiatives to ensure that the health needs and screening needs of all service users are addressed	4
1	1.3.12	Dementia	Submit business case for Dementia Strategy Coordinator for ID Dementia Service users to support the working group. The Group will continue with the rollout of local dementia initiatives in accordance with National Dementia Strategy, including use of screening.	4
1	1.3.12	Healthy Ireland & National Dementia Strategy	Establish a generic Social Care Consortium	4
1	1.3.12		Provide stakeholder "ageing in place awareness" training across the services	4
1	1.3.12	Healthy Living Groups	Continue to deliver "Healthy Living Groups' for those living alone with disabilities and link with befriending	4

CG	DDOP No.	High Level Goals	Area Action	End Q
1	1.3.12		Submit Business Case for 10 Social Work Assistants to work with Intellectual Disability service users living alone	1
1	1.3.12	Relationship & Sexuality Education	Continue the delivery of Relationship & Sexuality Education for Adults with intellectual disabilities and their Carers	4
1	1.3.12		Develop a responsive service strategy to meet the needs of persons with Down Syndrome who are a recognised as an at risk population	4
1	1.3.12		Engage with local active retirement groups to establish practical opportunities for persons with an ID to integrate into the community	4
1	1.3.12		Engage with Health Promotion Department in relation to prevention and early detection of health problems such as the implementation of health screening programmes.	4
Goal 2		**Provide fair, equitable and timely access to quality, safe health services that people need**		
2	2.1.1	Progressing Disability Services for Children & Young People	**Actions to Implement Progressing Disability Services – 0-18s Programme** Cavan/Monaghan · C/M will reconfigure its school age services into 2 School Age Teams (SATs) · Cavan Monaghan will have IFSPs (Individual Family Service Plans) for 100% children attending EITs & SAT	 1 4
2	2.1.1		**Actions to Implement Progressing Disability Services – 0-18s Programme** **Donegal** · Donegal will reconfigure its school age services into 4 SATs · Donegal will have IFSPs for 100% of children attending EITs & SATs	 1 4
2	2.1.1		**Actions to Implement Progressing Disability Services – 0-18s Programme** **Sligo Leitrim** · Sligo Leitrim will reconfigure its school age services into 2 SATs · Sligo Leitrim will have IFSPs for 100% children attending EITs & SATs	 1 4
2	2.1.1		Review all current working groups established locally under the National Programme focusing on clinical governance and performance management of the teams. The EIT is funded through a Service Arrangement with Enable Ireland and the national programme. I	1
2	2.1.1		Facilitate training for staff in the reconfigured School Age Teams to achieve integrated multidisciplinary working	2
2	2.1.1		Establish a Parenting Advisory Panel	4
2	2.1.1		Continue the work of 4 EITs providing therapeutic input for children aged 0-6 years with complex disabilities to enable them to reach their full potential.	4
2	2.1.1		Submit Business Case to address the need for increased staff supports to EITs given the increase in caseload size by 100%. A requirement for administrative support of 0.8 WTE; provision of adequate training for staff working with children with complex disability	1
2	2.1.1		Develop Business Case for clerical support for EITS (0.5 wte) and SATs (2 wte) in Donegal and Grade 3 to support Network School Age Team post reconfiguration in Cavan Monaghan	2
2	2.1.1		Progress multi-disciplinary working within teams and inter-agency working with the Education Sector by the establishment of structures and groups to facilitate interagency and multi-disciplinary working.	4
2	2.1.1		Progress an interface framework by which Autism services will support the Children's Disability Network Teams in meeting the needs of Children with Autism	1

CG	DDOP No.	High Level Goals	Area Action	End Q
2	2.1.1		Establish a communication process with families, service managers and staff by way of Information campaign, letters to parents, information leaflets and welcome packs for SAT	1
2	2.1.1		Training for Teams Q1 & Q2 2016 In house – interdisciplinary model, key worker model. Pathways, Standard Operating Procedure, PPPGs, Operational Plan for SAT's	2
2	2.1.1		The Local Implementation Group for Progressing Children's Disability Services in Sligo/Leitrim will establish a multi-agency Governance Group in Q2 2016 to provide appropriate governance over service planning and the delivery of services to children	2
2	2.1.1		* IFSP for 6-18 age group in Sligo / Leitrim Consider a memorandum of understanding for Department of Education IEP and HSE Care Plan to form IFSP.	4
2	2.1.1	Progressing Disability Services for Children & Young People - Autism Services	Submit Business Case for the approval for allocation and appointment of Autism Service Manager (Grade VII)	4
2	2.1.1		Submit Business Case for the approval for allocation and appointment of 3 WTE Autism Therapists (0.5wte to be aligned to EIT) due to the increased numbers of children 6-18yrs presenting with severe and complex needs.	1
2	2.1.1	Progressing Disability Services for Children & Young People - Paediatric Dysphagia Service	Submit Business to develop a SALT Service for paediatric dysphagia across acute and community settings	4
2	2.1.1	Progressing Disability Services for Children & Young People - Legislative Requirements	Endeavour to meet legislative obligations with regard to the Disability Act – Assessment of Need	4
2	2.1.1	Progressing Disability Services for Children & Young People - Pre-School Services (ID)	Review the Inclusion Model of pre-school services for children with ID and or Autism in South Donegal in line with budgetary changes	3
2	2.1.1	Progressing Disability Services for Children & Young People - Pre-School Services (Mainstream)	Continue financial support towards special needs assistants in support of children with disabilities to attend mainstream pre-schools	4
2	2.1.1	Progressing Disability Services for Children & Young People - ECCE Scheme	Work in partnership with the Inter Departmental Group to implement Supporting Access to the Early Child Care Education Programme for children with a disability	4

CG	DDOP No.	High Level Goals	Area Action	End Q
2	2.2.2	New Directions - reconfiguring day services including school leavers and rehabilitative training.	Continue to review existing demonstration sites / models of good practice to translate learning and inform implementation against 2014 National Implementation Plan	4
2	2.2.2		Continue review of baseline service provision within disability day services in preparation for the reconfiguration of day services in line with New Directions. Complete Guidance document currently under development.	2
2	2.2.2		Complete screening exercise to identify individual service related obstacles and impediments. Continue to provide Individual support to the unit managers to develop and implement strategies which may overcome these difficulties.	4
2	2.2.2		Continue to re-align day service configuration with 'New Directions' to facilitate individual service users to successfully access job bridge programmes, work experience programmes and supported employment placements throughout 2016	4
2	2.2.2		Continue to work within the new CHO structures to ensure a standardised approach across the area and agree a process to implement and monitor the new standards.	4
2	2.2.2		Decommission use of Clogher house in its current format. Place the Special Care unit in a separate central location and develop smaller community based hubs in line with New Directions. This has been identified as a priority for 2016.	2
2	2.2.2	New Directions - Interim Standards	Support a continuous quality improvement approach to the implementation of the Interim Standards for day services. Linked actions: · Develop a Communications Strategy to launch the Interim Standards. · Develop an Easy to Read Interim Standards document. .	4
2	2.2.2		Establish a working group between Donegal Persons Support & Training Services and Ballytivnan Personal Support & Training Services, Sligo and potentially expand to include all of Area 1 to work towards the implementation of the draft interim standards for	4
2	2.2.2	New Directions - Implementation of Monitoring Standards	Implement monitoring process for New Directions Standards across Day Services, as per National direction	4
2	2.2.2	New Directions - Programme Development	Deliver day services and develop new programmes for people with disabilities at HSE Centres and in partnership with voluntary providers.	4
2	2.2.2	New Directions - South Donegal Day Services	In partnership with Parents & Friends progress the re-location of current Cleary Day Services	3
2	2.2.2	New Directions - Establish operational management team	Establish operational management team to enable Donegal Personal Support & Training Services Community Inclusion Hub to become fully operational early 2016 Recruitment / reassignment of staff to fill the staff profile required to operationalise the CIHUB	1
2	2.2.2	New Directions - Develop new programmes	The pilot project for clients with Autism / ID using a specific research based approach will become fully operational in 2016. Develop a self-contained autism space within the Centre.	1
2	2.2.2	New Directions - Develop age	Develop an age appropriate service for clients aged 55 and over.	4

CG	DDOP No.	High Level Goals	Area Action	End Q
		appropriate new programmes		
2	2.2.2	New Directions - Develop Speech & Language service for adults with ID/ASD	Develop SALT service for adults with ID/ASD in line with New Directions to enhance service user quality of life	3
2	2.2.2	New Directions - Increase capacity in West Donegal Day Services	Secure accommodation for the purpose of increased capacity in day service provision in the Dungloe area for clients with ID	3
2	2.2.2	New Directions - Review and expand day service provision in line with New Directions.	Continue the standardised process to: - Identify all individuals that will require a day service in 2015 by Q1 (approx 138 for CHO Area 1) - Identify the capacity available from within current resources to meet the needs of those leaving school	Ongoing
2	2.2.2		Scope details in regard to those people that have a requirement for day service supports by CHO (excluding 2016 school leavers and those exiting RT)	4
2	2.2.2	New Directions - School Levers/Rehabilitative Training	Actively participate in the working group established to review and report on the application of current good practice to support the implementation of New Directions.	4
2	2.2.2	New Directions - Donegal School Leavers Co-ordination Team,	Establish Donegal School Leavers Co-ordination Team, on a pilot basis for 2016, to streamline the referral pathway for school leavers	1
2	2.2.2	New Directions - National co-ordination	Continue to participate on National School Leavers Project Group and co-ordinate the standardised school leaver process for CHO Area 1	4
2	2.2.2	New Directions - Donegal School Leavers Co-ordination Team	Secure additional accommodation to meet the increased demands on Day Services arising from School Leaver referrals in 2016. (High Complex needs & Capacity Challenges)	2
2	2.2.2	New Directions - P&S School Leavers group	Develop a specific programme for P&S School Leavers group which is mainstream and specific to their needs which is not currently available in Donegal, based on Bridging the Gap	2
2	2.2.2	New Directions - identify and develop day opportunities for those with intensive complex support needs and autism specific Day Opportunities in the	*Review and expand day service provision in line with New Directions. *Place a minimum of 29 school leavers and RT exits in appropriate day programmes. *Develop innovative and alternate day service supports for 6 young people who require an Autism Specific services	4

CG	DDOP No.	High Level Goals	Area Action	End Q
		Community		
2	2.2.2	New Directions - Reconfigure and relocate existing high support day services located in congregated settings into an appropriate community based service.	Review and expand day service provision in line with New Directions. Develop innovative and alternate day service supports for 6 young people who require an Autism Specific service in consultation with their families and service providers in the area.	4
2	2.2.2	New Directions - Rehabilitative Training Programme and Day Services Programme	Manage the contracts for the Rehabilitative Training Programme and Day Services Programme (formerly known as sheltered work) to people throughout Donegal, Sligo & Leitrim. This includes SLA's with third party providers and programme delivery agreements	4
2	2.3.1	Facilitate reconfiguration of existing team required to implement the Neuro Rehabilitation Strategy	Review resources available to provide rehabilitation services at a network level including PC. Submit business Case for 1.0 WTE Neuropsychologist post and 1 WTE Senior Social Work post to provide specific supports to accommodate the needs of clients presenting	4
2	2.3.1		♦Conduct a review of service provision / evaluation of the existing neuro-rehabilitation teams based on the draft implementation plan. ♦ Map existing deficits in relation to the plan. ♦ Prepare for implementation of the strategy	1
2	2.3.1		Develop Business Case to recruit 0.5 WTE senior physiotherapist and 2 WTE Rehabilitation Assistants to maintain all community therapeutic referrals, enable early hospital discharge, minimise re-entry into the system due to lack of mobility and implement recommendations	1
2	2.3.1		Complete business case to propose the development of a dedicated high support unit or facility within Brentwood for adults with complex needs directed by the CNRT (independent of the current care model employed at Brendwood).	2
2	2.3.1	Develop Residential Services	Develop an options appraisal/business case around residential services for adults with complex needs secondary to neurological injury(<65 years) in 2 high support units (8 places) to relocate clients inappropriately placed in community hospitals / nursing	4
2	2.3.1	Community Neuro Rehab Team	Ascertain the requirements required in the establishment of a "Community Neuro Rehab Team" to accommodate the needs of clients presenting with neurological conditions	1
2	2.3.1		Complete mapping exercise of existing neurological services	1
2	2.3.1		Establish a PPPG Sub group to complete the required actions in establishing the Community Neuro Team.	2
2	2.3.1		Establish Accommodation Sub Group to source appropriate building that will meet the needs of the team and service users and work with Property Manager to identify a suitable property	4
2	2.4.1	Demographic and Changing Need	Continue to review all Service User need to support planning for the emerging need in areas of complex home support packages, residential and respite services to address increased demand and increasing complexity of needs of some individuals.	4
2	2.4.1		Provide equity of access for Older People within Disability Services accessing NHSS (Fair Deal) for long term nursing home placements where possible and appropriate to their need.	4

CG	DDOP No.	High Level Goals	Area Action	End Q
2	2.4.1		Advocate for 2 Community Group Homes (8 places) in South Donegal in partnership with Oaklee Housing and Donegal Co-Co.	1
2	2.4.1		Submit business case to develop three 4 Bedded Residential units (12 places) in the Dungloe area in partnership with Parents & Friends	4
2	2.4.1		Submit business case to re-develop HSE accommodation at Listillion, Letterkenny (5 places ID Children's Services)	2
2	2.4.1		Work in partnership with Parents & Friends and the Housing Association in Inishowen and make submissions for funding to progress a further 2 Community Group Homes to meet the residential needs of this catchment area	4
2	2.4.3		Continue the delivery of centre based and other models of respite	4
2	2.4.3		Reconfigure existing respite accommodations in South Donegal, Dungloe and Inishowen Area, subject to the completion of accommodation works	4
2	2.4.3		Complete mapping exercise of respite services currently available for c.l.l.c. in Donegal and based on finding reconfigure or develop service based on need.	4
2	2.4.3		Identify and submit business case to source additional staffing to enable the continued provision of respite services in ID	4
2	2.4.3	Alternative Models of Respite	Progress alternative models of respite Care to include advancing the Host Family Support Model & Shared Lives Model in Inishowen and After-school programmes, evening and weekend day respite in Clara House (staffing)	4
2	2.4.3	Seek approval for capital and revenue to support provision of suitable accommodation for respite.	Seek approval for capital and revenue to support provision of suitable accommodation for respite.	4
2	2.4.3	Alternative Models of Respite	Continue to identify appropriate residential accommodation options for those currently living in inappropriate accommodation, both in their home and in HSE funded services	4
2	2.4.3		Seek approval to further develop Intellectual Disability Services in Co Leitrim. To include: - Determination of the viability of SOLAS as a respite facility - Provision of 2 bungalows to accommodate 8 persons - Provision of 1 bungalow to provide respite	4
2	2.4.3	Provide transitional short term respite facility for clients with complex & progressive needs transitioning from acute setting to home/suitable long term accommodation.	Continue to engage with Cheshire re the utilisation of their current residential/respite facility to enable the continuation of a transitions/step down service for clients going forward.	4
2	2.4.3	Continue to respond to service user transport needs/requirements as per local Transport criteria	Continue to engage with Local Link transport Provider & Voluntary organisations to meet clients needs	4
2	2.4.3	Transfer of services	Engage with the Older Persons Service Manager to transfer clients to OP Services while giving consideration where possible that clients	4

CG	DDOP No.	High Level Goals	Area Action	End Q
		provided to clients aged 66 and over to Older People Services.	in receipt of PA/HS service remain with current voluntary provider thus ensuring continuity & consistency of care	
2	2.4.3	Demographic and Changing Need	Develop a comprehensive proposal for the development of a Children's only Respite Facility as the Annalee Respite Centre, Cootehill is limited in its provision of respite to Children with Complex Needs as it provides respite to adults also (on a 2 in 4 we	1
2	2.4.3	Children with Life Limiting Conditions	Develop a business case for Case Manager / Key Worker for operational role in accordance with 'Integrated Model for Community Care for Children' in collaboration with multi disciplinary team as per Draft national S.O.P in relation to multidisciplinary man	1
2	2.4.3		Develop a business case for Co ordination of training / up skilling for members of Multi disciplinary team supporting C.L.L.C in community. This will include training needs analysis of all disciplines supporting children and family members.	1
2	2.4.4	Provide Personal Assistant (PA)/Home Support t	Provide Personal Assistant (PA)/Home Support Services to people with P&S disabilities, ID/Autism in the community.	4
2	2.4.4		Identify areas where additional PA/Home Support funding is required for day activation for clients with P&S disabilities	4
2	2.4.3	Transfer of services provided to clients aged 66 and over to Older People Services.	Hold review meeting with the OPS Manager to advise of client numbers, diagnosis, care and identified support needs as per current care plan.	4
2	2.4.3		Liaise with PHN service regarding referral to PHN Service for the completion of CSAR's Assessment to determine client need at a point in time.	4
2	2.4.4	Ensure staff availability & consistency to provide Home Support/PA for service users	Continue discussions with Voluntary & Private Organisations and through the SA process in an attempt to resolve lack of resources	4
2	2.4.4	Key Workers	Continue to case manage the growing number of persons with P&S disabilities who meet criteria for the service	4
2	2.4.4		Submit Business Case for 1WTE Children's Key Worker and 1 WTE Grade 3 Clerical Officer to support key workers	1
2	2.4.4	Develop therapy services through the recruitment of additional therapy staff with increased skill mix, experience, etc. for adult disability services.	Develop business Case for the development of therapy services.	1
2	2.4.4	Service Improvement	Develop Business Case to for a Director of Nursing post in the Letterkenny area due to the increase in population and change in service provision in recent years	1
2	2.4.4		Develop Business Case for the appointment of Grade 3 Clerical Officers to assist Directors of Nursing in 5 areas and link to new Primary Care Network Areas	1
2	2.4.4		Submit Business Case for 5 CNM2 nursing posts to support intellectual disability community services as a real alternative to hospital	1

CG	DDOP No.	High Level Goals	Area Action	End Q
			admission	
2	2.4.4		Address the need to fill the Project Officer vacancy that arose in 2008 to implement service developments including congregated settings, HIQA action plan, minor capital requirements, implementation of day services review , progression of school leavers i	1
2	2.4.4		Develop Business Case for CNM3/Project Officer to ensure appropriate residential services for young people are in place, respite care for children is developed, after school respite services is developed and pre-school inclusion model in line with South D	1
2	2.4.4		Develop Business Cases for 3 Grade VIIs to support Service Managers in an operational and management role (2 x Donegal, 1 x Cavan/Monaghan)	1
2	2.4.4		Backfill 2 WTE Specified Purpose Contracts in Adult Social Work to cover sick leave	1
2	2.4.4		Ensure 2 upcoming retirement posts are filled in Central Sector and the West	1
2	2.4.4		Submit Business Case for 2 WTE Grade 3 Clerical Officers to support the Social Work Team	1
2	2.4.4	Respond to emergency placement requests as they arise	Establish a local emergency residential protocol in line with HSE Safeguarding Vulnerable Persons at Risk of Abuse that will meet the needs of HIQA Standards in respect of residential compliance	4
2	2.4.6	Reduce numbers residing in Acute hospitals by responding to emergency needs as they arise	Provide high level support packages of care for any P&S clients residing in Acute settings by seeking funding through the "Business Case" process to GM for consideration.	4
2	2.4.6	Quality & Patient Safety	Participate in regular meetings of Quality & Safety Committees in respective areas. Ensure risk registers are completed as appropriate and closely monitor the management of serious incidents.. Co-operate with registered provider visit on an bi-annual bas	4
2	2.4.6	Quality & Safety	Ensure the Safety Agenda is also reflected in Disability Service's approach to all Section 39 funded agencies whereby every Service User placement is reviewed from both a clinical perspective and an Organisational Governance perspective.	4
2	2.4.6	Quality & Patient Safety (vehicles)	Assess patient safety and the financial sustainability of all the ID service transport fleet (Older Vehicles) Develop a business case to seek Capital funding / Investment to upgrade vehicles identified as potentially hazardous to patient safety and / or p	1
2	2.4.6	Infection, Prevention & Control	§ Ensure all staff undertake mandatory hand hygiene training and Infection Prevention & Control core skills training § Report on KPIs in a timely manner § Ensure quarterly Environmental Hygiene audits are carried out with associated Quality Improvement P	4
Goal 3		Foster a culture that is honest, compassionate, transparent and accountable		
3	3.1	Governance & Communication in relation to Quality & Safety	Commence monitoring of a range of Quality and Safety metrics in CHO Area 1 under the Themes of Person-centred Care, Effective Care, and Safe Care	1
3	3.1	Governance &	Monitor the establishment of Quality and Safety Structures in each CHO through the introduction of a Social Care Quality and Safety	1

CG	DDOP No.	High Level Goals	Area Action	End Q
		Communication	Dashboard. Report on the current operational governance structures in place: · CHO Quality and Safety Committee · Social Care Quality and Safety Committee · HCAI / Infection Control Committee per CHO · Drugs and Therapeutics Committee per CHO	
3	3.1		Provide training and education to CHOs for: · Systems Analysis · NIMS (National Incident Management System) Phase 2 · NIRF (National Incident Report Form) training	4
3	3.1		Maintain accurate and timely progress reports on the management of serious incidents (SIs) including serious reportable events (SREs) using the incident information management system (IMMS)	4
3	3.1		Commence monitoring of the CHO Social Care Risk Registers through the Quality and Safety Dashboard	1
3	3.1		Utilise the National Independent Review Panel for complex investigations	3
3	3.1		Monitor the analysis of complaints in Social Care in CHOs through the Quality and Safety Dashboard	3
3	3.1		Support the revision of the HSE Complaints Management Policy	4
3	3.1	Medication Management & Prescribing	Support all HSE and HSE-funded Social Care Residential Providers to participate in the HALT Survey of Healthcare Associated Infections (HCAI) and antimicrobial use	2
3	3.1	Communication & Engagement	Implement the Social Care Communication and Engagement Plan once developed	4
3	3.2	Service User & Family Engagement - Volunteer Advocacy Programme	Expand the national Volunteer Advocacy Programme in adult disability residential settings in conjunction with families and services users.	3
3	3.2		Support each Service User to be fully informed of their named advocate and how to make contact with them directly.	1
3	3.2		Rollout of advocacy framework developed in partnership with Inclusion Ireland and HSE Cregg Services.	3
3	3.2	Improved Service User Engagement	Continue to consult with residents about every aspect of their daily life informally on a continuous basis. Hold formal discussions through regular house meetings and review meetings. Encourage residents encouraged to participate in all aspects relating to the running of the designated centre including shopping, menus, and choosing activities.	4
3	3.2	Service User & Family Engagement	Work in partnership with Disability Network and Sligo Leader Partnership in delivering facilitation support to people with Intellectual Disability and set up of service user forums.	3
3	3.2		Establish a Cregg Services parents and guardians group to advance the communication, co-operation, planning and execution of quality services for residents	1
3	3.2		Continue to strengthen Service User Engagement by using the learning from 'Our Home, Our Say' in 2016.	4
3	3.2		Audit on an ongoing basis services to drive quality service improvement.	3
3	3.2		Continue to improve service user engagement through the following groups / mechanisms:- o EIT/SAT – Parent Advisory Forum	4

CG	DDOP No.	High Level Goals	Area Action	End Q
			o Advocacy Groups across Donegal Training Services o Weekly/Monthly meetings in ID Residential Group Homes o Person Centred Planning o Donegal Disability Consultative Committee o Annual residential service user satisfaction questionnaires in ID & EIT o Progress model of consumer representation in P&S Home Support o 'Your Service Your Say'	
3	3.2		Engage in developing effective communication mechanisms with Service Users, Families and staff across the wider ID Service area; *Continue training in advocacy awareness	4
3	3.2	Continue to complete client reviews	Complete of client reviews/evaluation of service on an annual basis.	4
3	3.2	Improved Service User Engagement	Develop survey to ascertain client satisfaction with service provision	3
3	3.2	Adopt Open Disclosure	Adopt the open disclosure policy and provide open disclosure briefing sessions	4
3	3.2	Confidential Recipient	Ensure that the poster for the Confidential Recipient is distributed to all Disability Services for display	1
3	3.2		Continue to operate the Confidential Recipient in Donegal & Cavan/Monaghan. Progress model of consumer representation in P&S Home Support	4
3	3.2	Provide volunteer support to enable access to social opportunities as per the Social Outings Assistant role	Continue to engage with the local Sligo Volunteer Programme to engage volunteers to provide supports to our client group.	4
3	3.2	Adopt a positive communication process across the ID Community Establish meaningful links with local community groups to inspire them to support persons with an ID	Set up an open forum in local areas where people with an ID live and invite community members to greet and meet with the purpose of establishing local disability platforms to promote citizenship in local hubs	4
3	3.2	Seek access to funding opportunities in partnership with voluntary and community agencies to assist community	Develop a Business Case proposal for submission to Dormant Accounts to assist with community connectiveness	2

CG	DDOP No.	High Level Goals	Area Action	End Q
		connectedness		
3	3.2	Governance & Communication in relation to Quality & Safety	Implement action plans/quality improvement plans to meet regulatory requirements and to address areas for improvement identified in HIQA inspection reports	4
3	3.2		Ensure all HIQA inspection outcomes and actions are registered on the CHO 1 register and update status as it occurs	4
3	3.2		Ensure all compliments and complaints are registered on the Area 1 register. Review and learn from compliments and complaints	4
3	3.2		Continue to respond and submit proposals as necessary in relation to immediate, medium and longer term actions required from HIQA recommendations, including the overall plan to implement a sustainable model of person- centred community based service	4
3	3.2		Submit Business Case for 1 WTE social work to strengthen implementation.	2
3	3.2		Fully engage with HIQA Inspector re the inspection of Bayview Respite House	4
3	3.2		Strive to provide services in line with standards & regulations	4
3	3.2		Complete a structured evaluation of the quality systems in place and include as a set agenda item at the monthly team meetings	4
3	3.2	Improve Compliance with National Standards for Disability Residential Centres	Engage and support the establishment of a process with the Chief Officers to monitor the percentage of recommendations implemented which have arisen from HIQA Inspection Reports. Support the work of the quality improvement enablement programme / Quality Improvement team	4
3	3.3	Safeguarding Vulnerable Adults - Continuing the Implementation Process	**Actions to Continue the Implementation Process of the Safeguarding Vulnerable Adults Policy** - Safeguarding and Protection Committees to be in place in CHO Area 1 - Complete training rollout of Safeguarding and Protection Team Members - Complete training of Designated Officers - Front line staff – awareness briefings - Recruit additional administrative staff to support the CHO teams - Complete final compilation of Funded Agencies audit checklists to ensure policy alignment Q2 - National database of safeguarding concerns to be maintained by NSO with information supplied by each CHO - Distribute practice handbook	4
1	3.5		The Principal Social Worker for Adult Safeguarding will work closely with the National Safeguarding Implementation Group (Limerick) to:- o Assist and develop ICT system to be used National o Create and roll out standardised Business Processes o Participate on Train the Trainer training to assist the National Implementation Body to provide training at a local level in CHO Area 1 with regard to the Safeguarding Vulnerable Persons at Risk of Abuse National Policy 2014 o Assess resource implications of implementation of the policy	4
1	3.5		Service Managers at a local level will work with the Principal Social Worker to:- o Complete mapping exercise of existing service provision re. adult safeguarding o Develop CHO implementation plan using existing structures and resources o Endeavour to establish a simplified ICT system at local level to allow the capture and collation of statistics of notifications and referrals o Support Service Managers in identifying gaps in service provision particularly in relation to complex and challenging cases that may require a social work input, i.e. prevention, welfare and support where staff migrated to Safeguarding Service	4

CG	DDOP No.	High Level Goals	Area Action	End Q
1	3.5		Release designated officers to participate on relevant training. Provide training to all Disability Services staff. Prioritise training as necessary to target groups of staff including designated staff in Section 39 agencies locally.	4
1	3.5		Senior management team member will act as a designated officer in line with the national policy. Active implementation of the national policy is evidenced by receipt of referrals, the conducting of preliminary screening assessments, and the development of safeguarding plans.	4
1	3.5		Provide ongoing support to all unit managers and PIC's regarding the development and review of all Safeguarding plans.	4
3	3.5		Monitor compliance of all Section 39 agencies and For Profit /Out of State agencies regarding their commitment to, and compliance with, their requirements under the national Safeguarding policy and include as quality assurance process in the Service Arrangement process.	4
3	3.5		Continue to build capacity to support the preliminary screening and the investigation process and continue to strengthen and enhance existing structures to ensure that a robust process remains in place to respond as required.	4
3	3.5		Establish Safeguarding Team to ensure all vulnerable adults with a physical and/or sensory disability are protected.	4
3	3.5	HSE Safeguarding Vulnerable Persons at Risk of Abuse Policy	Submit business case for the provision of 1 WTE Social Work for Donegal to progress the Safeguarding Vulnerable Persons at Risk of Abuse Policy within the voluntary sector and manage the complex cases which require social work input.	1
Goal 4		**Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them**		
4	4.1	Leadership	Promote the availability of coaching and mentoring services	1
4	4.1		Release staff to participate on the Leadership Development Programme	2
4	4.1	Leadership Presence	Continue to develop and support leaders to provide direction and purpose, and connect with all staff and teams through open and ongoing communication and engagement as a core leadership activity . Each Manager will meet minimum bimonthly with their teams/direct reports to ensure maximum engagement and communication with the different service areas.	4
4	4.1		Continue to commit management time to engage effectively with service users, work with other relevant health service divisions and connect with local communities to enhance patient pathways and patient experiences. This work will be further strengthened Q1 – Q4 through the Implementation of New Directions, Progressing Disability Services for Children and Young People, Value for Money programme, HIQA registration, Your Service Your Say, and national Safeguarding Processes. Service Managers have been identified to take a lead role in each of these areas.	4
4	4.1		Continue to have a visible presence in all areas of the service through 'walking' the floor in all Residential Settings and Day Services. Commencing in 2015 Disability Services have developed a process whereby all Day Services provided through Section 39 agencies are being benchmarked against the Draft New directions Standards and feedback is being provided to the Service Managers. This initial phase of work will be completed in Q1 2016 and quality improvement action plans reviewed in Q2.	2
4	4.1		Ensure that all Service Areas will have formalized communication processes wherein the Service Managers will facilitate communication from frontline staff up to the Disability Services Management Team and to ensure that all Organisational information is cascaded down to the frontline. This will ensure increased visibility and connection between the leadership and the workforce.	4
4	4.1	Implementation of the Neuro Rehab Strategy through the established	Identify & set targets for achievement as outlined under Neuro Rehab Strategy	4

CG	DDOP No.	High Level Goals	Area Action	End Q
		LIG & links with relevant Acute & Community Services.		
4	4.1	Provide opportunities for each member of the P&S Clinical Team to discuss current case loads/complex cases	Clinical team caseloads & complex cases will be on the agenda for discussion at Monthly Clinical Meeting	4
4	4.1	Leadership Presence	Actions to Deliver Person In Charge Training - PIM (HIQA) training - HIQA Compliance training - Social Role Valorisation Training - Audit Training	4
4	4.1		Develop upon the Walk About/Round framework across all residential services; to promote leadership awareness and governance accountability within the management team	4
4	4.1		QSRM Lead to attend QSRM Monthly Meetings and update the P&S Team at local QSRM monthly meetings	4
4	4.2	Quality Improvement through Staff Engagement	Social Care Division, in partnership with CHO's and Systems Reform Group, will arrange for staff engagement through ongoing consultation and workshops on the CHO reform programme	4
4	4.3	Employee Engagement	Respond to requests from the Social Care Division for updates on local initiatives to support employee engagement to provide constructive feedback on service delivery. The Social Care Division will provide this through the continuation of the national disability summits	4
4	4.3		Update P&S Team & relevant Voluntary organisations on all relevant material/documentation & immunisation campaigns through Staff Meetings & e-mail correspondence	4
4	4.3		Provide effective feedback by all Service Managers from team meetings through the Disability Services Management Team meetings.	4
4	4.3		Listening to front line workers & their feedback, respond appropriately and initiate service improvements This is formalized through the process of Service Managers meeting with the frontline staff .	4
4	4.3		Include all local & National policy developments/QSRM etc. as an item on the agenda at all team meetings	4
4	4.3		Engage all staff in the 2016 Service Planning process to facilitate a culture of staff engagement in service design and delivery.	4
4	4.3		Identify, use and share learning from staff engagement initiatives in partnership with HR and the Quality Improvement Division	3
4	4.4	Learning & Development Approach	MDT Reviews organised as and when required to meet the needs of the individual client and staff.	4
4	4.4		Continue the work with performance and development in developing and enabling and empowering skill set for staff	4
4	4.4		Schedule joint Staff Forum meetings for 2016 to build upon the governance framework rolled out in 2015	4
4	4.4		Provide training in effective decision making for persons with an ID [PCP key working strategies] to assure their role as an effective advocate for this population	4
4	4.4		Include policy developments etc. as an item on the agenda at every physical & sensory staff meeting	4
4	4.4		The Disability Services Management Team will demonstrate their commitment to staff Motivation through the Monthly Management Team	4

CG	DDOP No.	High Level Goals	Area Action	End Q
			meetings.	
4	4.4		Revisit value clarification within team structures; Encourage staff champions in Person Centred Planning and Risk Management Establish areas of weaknesses across services to focus training priorities for staff groups;	4
4	4.4		Acknowledge, communicate and disseminate areas of good practices in designated centres to support shared learning	4
4	4.4		Implement Open door Policy for staff to discuss matters of concern	4
4	4.4		Organise a Team building day for P&S, Assistive Technology and Database Team with identified training/development opportunities for the team	2
4	4.4		Organise clinical supervision sessions for the Team through an identified Psycho/Social Therapist quarterly.	4
4	4.4		Team to avail of 1:1 supervision & PDP session bi-annually with Service Manager to include review of training requirements organised bi-annually	4
4	4.4		Ensure that *Personal Development Plans* are in place for staff and enable staff to exercise personal and professional responsibility for the quality and safety of services provided.	2
4	4.4		Ensure that personal development planning and staff supervision are core management practices focused on the competencies, knowledge and behaviours required of the workforce.	4
4	4.4		Ensure established working with professional bodies and staff representative associations to develop Continuous Professional Development responses that support improved performance.	4
4	4.4		All relevant staff to achieve professional registration, credentialing etc (CORU etc.) within Disability Services. Disability Services Management will work with local HR and Clinical Heads of Discipline to ensure that all staff are on the appropriate live registers and are demonstrating their continued commitment to CPD.	4
4	4.4		Ensure that *Personal Development Plans* are in place for staff and enable staff to exercise personal and professional responsibility for the quality and safety of services provided.	4
4	4.4		Roll out the training module agreed with Performance and Development Services across the wider LDS area	3
4	4.4		Undertake an analysis of training requirements and arrange training as identified through the local community sector i.e. CNME/St. Angela's	4
4	4.4		In partnership with HR and Learning & Development deliver training in Trust in Care and Interview Training	4
4	4.4		In collaborating with Learning & Development and the Education Centre complete a staff training needs assessment and develop a standardised training programme for Social Work staff	3
4	4.4		Enhance and support managers in performance reviews with their respective team members	4
4	4.4		Evaluate competency levels within teams for the purpose of additional training requirements	4
4	4.4		Ensure that all members of the P&S Team are fully engaged and up to date in national policy and related local initiatives.	4
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		
5	5.1	Pay bill Management Framework	Maintain compliance with the Pay bill Management Framework	1

CG	DDOP No.	High Level Goals	Area Action	End Q
5	5.2	VFM and Policy Review of Disability Services	Participate on Working Group 5 (WG5 - Management and Information Systems) if required when a lead area is agreed	4
5	5.2		Participate in the establishment and work of the CHO Area 1 New Directions Implementation Groups	4
5	5.2		Continue to participate and support the work of the National sub-groups for: § Rehabilitative Training Review Committee § Independent Guidance Service § Information Management Systems	4
5	5.2		Through the SLA Review/Meetings engage with Voluntary/Community/Private Organisations on VFM initiatives & updates re National/Local Policy developments	2
5	5.3	People with Disability and Community Involvement	Update members of the Consultative Fora with all relevant Information at the Quarterly Meetings	4
5	5.3	Quality & Standards - Infection Prevention & Control	§ Ensure all staff undertake mandatory hand hygiene training and Infection Prevention & Control core skills training § Report on KPIs in a timely manner § Ensure quarterly Environmental Hygiene audits are carried out with associated Quality Improvement Plans to be 'actioned' in a timely manner to address deficiencies. § Each large residential facility will carry out twice yearly 'Deep Cleans' across all divisions, and each small residential facility and health centre/ primary care centre/ admin block to have one 'Deep Clean' per year § Participate in HALT 2016 § Care Bundles to be formally introduced and implemented § Comply with the Infection Prevention & Control PPPGs relevant to that area	4
5	5.7	Governance and Service Arrangement	Endeavour to ensure that Part 2 of the SLAs in respect of S38 & S39 disability agencies are completed by 29.02.16	1
5	5.8	Quality Improvement	Continue to actively support national Service Improvement Team in relation to the review of School Leavers and Day Services and any other supports	4
5	5.9	European Working Time Directive	Work with the National Social Care Division to ensure compliance with the European Working Time Directive	4

Mental Health

Introduction

Name of Division	
2016 Budget €m	
€m	66.9
Full details of the 2016 budget are available in Table 1 page 7	

The health concerns in CHO Area 1 mirror those of the national population (circulatory and respiratory diseases, cancer, lifestyle behaviours of smoking and alcohol and mental health related diseases. These major health concerns are strongly correlated with lifestyle behaviours and socio-economic factors, levels of education, employment and housing (Healthy Ireland, 2012). Planning and delivery of mental health services in Area 1 must take account of these given that the area rates extremely poorly on each of these important influencing variables.

Health planning in Area 1 must take account of:

- Population of 389,048
- Rural, low density (35 per km^2, Ireland 67 per km^2), peripheral counties
- Highest dependency ratio of all CHOs (36 compared to 67 nationally).
- Highest levels of unemployment of all CHOs at 9.6% (national average of 8.5%)
- High levels of GMS/GP visit card
- Lowest levels of educational status (14% not educated beyond primary – 10% nationally)
- Highest levels of deprivation (31.6% classified as deprived – 23.3% nationally)
- Higher proportions of older people (13% compared to 11.6% national average)
- Higher proportions of oldest old - >85 years (1.6% compared with national average of 1.3%

Mental Health

Mental Health and the impact therein of socio-economic status is one of the key national health priorities identified within *Healthy Ireland*, (2013). The plan for mental health service delivery into 2016 will concentrate not only on responding to mental ill-health presentations but will actively promote a life-course approach, through mental ill-health prevention, treatment where necessary whilst maintaining a recovery focus in all service delivery aspects.

Services will be orientated and delivered within a recovery based model of care in partnership with the service user, their advocates / carers. This will be underpinned by a systematic ethos of recovery across all teams and specialties. Integrated care and evidence of integrated care planning is a core requirement for Area 1 Mental health services for the forthcoming year.

Key achievements in recent years

There have been considerable advancements and achievements in mental health services across Area 1 over the last number of years, despite resource constraints. It is hoped that the area will continue to grow and expand in meeting both the health promotion and mental health protective aspects of service delivery as well as providing a quality service to those affected by mental health into the future.

Quality and Service User Safety

Quality, Safety & Risk Management (QSRM) remains central to delivery of services within CHO Area 1. During 2016 robust structures and processes will be further established and developed to provide assurances around the quality and safety of the service provision to Area 1 and national Governance and accountability structures and to the Mental Health Commission. The **Quality Framework for Mental Health Services in Ireland (Mental Health Commission)** sets out a clear framework for Mental Health Services and this will support services in meeting their regulatory and legislative requirements.

The core objectives for 2016 include:

- Promotion of service user involvement and engagement within the service to include the implementation of advocacy programmes.
- Collaborative working with the Mental Health Commission to improve reporting and sharing of quality information.
- Monitoring and reporting on patient safety and quality improvement through key performance indicators
- Managing Serious incidents and Serious Reportable Events in line with HSE Policy
- Ensuring there is an active Risk register in place
- Reporting on implementation of recommendations arising from Investigations of Serious Incident and complaints
- Supporting & implementing programmes which will promote better health and wellbeing
- Reporting on Implementation of actions arising from Regulatory Mental Health Commission inspections
- Promotion of staff engagement strategies in the workplace to achieve quality and safety objectives

Key Priorities and Actions to Deliver on Goals in 2016

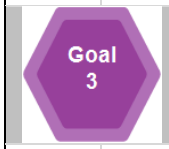
Mental Health

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
	**Promote health and wellbeing as part of everything we do so that people will be healthier**				
1	1.1.1	Provide training to staff, service users and carers in Wellness Recover Action Plan (WRAP)	Deliver training by WRAP facilitators within the service	2	Cavan Monaghan
1	1.1.1	Become self sufficient with WRAP facilitators	Train a service user and staff member as Advanced Level WRAP facilitators	1	Cavan Monaghan
1	1.1.1	Implementation of ImROC	Recruit a Recovery Coordinator for the implementation of ImROC (Genio funding). Train all staff in the principles of Recovery. Arrange co delivered recovery workshops.	2	Cavan Monaghan
1	1.1.1	Deliver Recovery Oriented Services	Prioritise the establishment of a Recovery Forum with staff from across the service committed to creating the "Culture of Recovery",	4	Donegal
1	1.1.1		Support the participation of staff, service user and carer in the DCU Leadership programme	4	Donegal
1	1.1.1		Support the participation of staff, service user and carer in the DCU Leadership programme	4	Sligo Leitrim
1	1.1.1		Explore the Mayo Institute model ARI and the possibility of creating a Sligo Recovery School in collaboration with the Sligo Institute	4	Sligo Leitrim
1	1.1.1		Generate support for the delivery of LOCUS Training and WRAP training to staff in partnership with Action Recovery Ireland as part of the Recovery Model	4	Donegal
1	1.1.2	Wellbeing of staff working in MHSs	Deliver Stress Control Programmes	4	Donegal
1	1.1.2	Deliver health promotion and improvement programmes aimed at supporting the wellbeing of staff working in MHS.	With support from the Smoking Cessation Office & through the Smoking Cessation Working Group continue the roll out of Tobacco Free Campus Policy to community residences	3	Sligo Leitrim
1	1.1.2		Deliver Stress Control Programmes and make available to staff	4	Sligo Leitrim
1	1.1.2		Implement and roll out the "5-a-day" programme on site to all staff	4	Sligo Leitrim
1	1.1.3	Promote Positive	Develop trainers in STORM for MH staff aimed at enhancing identification of suicidality and self harm behaviours.	3	Cavan

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
		Mental Health & Improve Suicide Prevention	Train staff and the voluntary agencies in suicide awareness through roll out of ASIST and SAFE TALK.		Monaghan
1	1.1.3	Develop Implementation plan in line with National Connecting for Life strategy for CMMHS	Develop Implementation plan in line with National Connecting for Life strategy for CMMHS. Ensure that health promoting approaches are integrated into existing practices in line with CMMHS Strategic Plan 2015-2020	3	Cavan Monaghan
1	2.1.3	Progress the Development of a JIGSAW project within the service.	Formulate Development Programme for introduction of Jigsaw to the CMMHS	4	Cavan Monaghan
1	2.2.2	Introduce the Individual placement and support (IPS) program for service users with first episode psychosis	Recruit and fill posts that have been approved in the National MHS 2015 service plan following request from the National Clinical programme Office.	1	Cavan Monaghan
1	1.1.3	Connecting for Life - Suicide Prevention Strategy	Deliver SafeTALK, ASIST, STORM and Understanding Self Harm training programmes	4	Donegal
1	1.1.3		Establish an implementation structure to oversee, support and ensure the implementation of Connecting For Life Donegal	1	Donegal
1	1.1.3		Implement and integrate national communications campaigns e.g. Little Things at a local level	3	Donegal
1	1.1.3		Organise community wide events to promote mental health and wellbeing with a focus on providing information on help seeking and services	4	Donegal
1	1.1.3		Provide information on mental health support services	4	Donegal
1	1.1.3		Implement the Stress Control Programme and strengthen links with GPs and MHS to signpost people presenting with anxiety and depression.	4	Donegal
1	1.1.3		Provide support to Primary Schools in mental health promotion	4	Donegal
1	1.1.3		Establish networks of ASIST trained individuals	3	Donegal
1	1.1.3		Provide support to families affected by suicide and deliver enhanced bereavement support	4	Donegal
1	1.1.3		Deliver enhanced bereavement support services to families and communities affected by suicide including those people known to MHS	4	Donegal
1	1.1.3 & 2.3.1		Implement recommendations of the NSRF Study	4	Donegal
1	1.1.3		Continue to implement and further develop the SCAN service to all GPs in the county	4	Donegal
1	1.1.3		Develop and deliver a uniform procedure to respond to suicidal behaviour across MHS	4	Donegal

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
1	1.1.3		Develop and commence implementation of an Action Plan for Co Sligo and Co. Leitrim	1	Sligo Leitrim
1	1.2.1	Social Prescribing	Continue to develop & support the Social Prescribing Programme	4	Donegal
1	1.2.1	Continue to develop integrated Day Care facilities within communities	Develop an integrated Day Care facility in Ballymote with in-reach support from CMHT	2	Sligo Leitrim
1	1.2.2	Cross Sectoral Working - Progress the work of the sub-group of the 'Think Family Strategy' between TUSLA, Adult MHS & CAMHS	Progress the work of the sub-group in addressing integrated care that involves info sharing and sharing of risk with specific reference to Children First.	4	Donegal
1	1.2.2 & 3.1.5	Jigsaw	Endeavour to extend the Jigsaw services (based on resources)	4	Donegal
1	1.2.3	Improve access to CBT & CIPC	Implementation of the Review of Psycho-Counselling Services	4	Sligo Leitrim
1	1.2.4	Implement national programmes to reduce HCAI as part of our work to deliver quality services	Implementation and audit of all HSE policies, Legionalla, Hand Hygiene, Infection Control	4	Sligo Leitrim
	**Provide fair, equitable and timely access to quality, safe health services that people need**				
2	2.1.1	Review service user needs of those residing in SRU Carndonagh with a view to progressing to more appropriate purpose built accommodation and private settings as appropriate	Produce overall plan for accommodation	3	Donegal
2	2.1.1	Expand and develop services to meet needs	Develop and submit business cases for the expansion and development of CA, OAP, GA, ID teams, liaison psychiatry and clinical programmes	3	Donegal
2	2.1.2	Reduction of Acute Unit bed occupancy,	Consult with the wider CHO and complete needs assessment for a Specialist Unit/Service for Difficult to Manage Behaviour clients	4	Sligo Leitrim

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
		incidents of violence & aggression & overtime and improved patient outcomes			
1	2.1.3	Progress the Development of a JIGSAW project within the service.	Formulate Development Programme for introduction of Youth MH initiative / Jigsaw to the SLMHS	4	Sligo Leitrim
2	2.1.3	Establish HBTT in Cavan Monaghan CAMHS	Progress the Implementation of a Home Based treatment Team for CAMHS.	4	Cavan Monaghan
2	2.1.3	Improve access to MHS and reduce wait times	Increase access to CAMHS Community Mental Health Team through the provision of a CAMHs Day Hospital where resourcing permits	4	Sligo Leitrim
2	2.1.3	Improve access to MHS and reduce wait times	Introduce CAPA (Choice and Partnership approach) to CAMHS	4	Sligo Leitrim
2	2.3.1, 2.3.3, 2.3.4	Develop programmes to improve the quality and safety of MHS for adults, children and adolescents	Review all Complaints, Trust in Care, Serious Incidents on a monthly basis circulating learning to AMHMT	4	Sligo Leitrim
2	2.1.5	High Observation Units	Develop a High Dependency Facility within the Department of Psychiatry to replace services currently provided in Sligo which will cease early 2017	4	Donegal
2	2.2.2	Clinical Programmes: Self-Harm in EDs, Eating Disorders and Early Intervention in Psychosis	Subject to the availability of Consultants establish Steering Group for First Time Psychosis and Eating Disorders	2	Donegal
2	2.2.3	Build capacity and capability to address MH, alcohol and other drug issues	Upskill front line mental health practitioner staff to address through participation on Screening & Brief Intervention (SBI) Training	4	Donegal
2	2.2.4	Enhance CMHT response	Prepare and submit business cases to develop teams and services	4	Cavan Monaghan
2	2.3.1	Implement the Choice and Partnership Approach (CAPA) in CM CAMHS	Appoint Coordinators to both CAMHS teams	1	Cavan Monaghan
3	3.1.1	Record, review and	Ensure all compliments and complaints are registered on the Area 1 register. Review and learn from compliments and	4	Area 1

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
		learn from complaints and compliments	complaints		
2	2.3.2	Formulate Development Programme for introduction	Provide structured clinical supervision to all clinical staff in CMMHS	2	Cavan Monaghan
2	2.3.2	Provide access to training in line with statutory requirements.	Provide access to training in line with statutory requirements.	3	Cavan Monaghan
2	2.3.2	Legislative Requirements - MHC, HACCP, IPC.	Develop a programme of works to address MHC inspection recommendations, Infection Control & HACCP guidelines in Acute Unit Dept of Psychiatry Letterkenny General Hospital and residential units	4	Donegal
2	2.3.2	Legislative Requirements	Recruit Team Co-ordinator Posts in Central Sector and CAMHS as required under NSP funding rules	1	Donegal
		**Foster a culture that is honest, compassionate, transparent and accountable**			
3	4.1.1	Adopt Open Disclosure	Adopt the open disclosure policy and provide open disclosure briefing sessions	4	Area 1
3	4.1.1	Embed the role of service user, family member and carer.	Provide consumer panel training. Engage with the wider community to increase opportunities for building a life 'beyond illness' including developing co-production of mental health recovery programmes for roll out in the service aimed at establishing a recovery college through the CAWT project.	3	Cavan Monaghan
3	4.1.1	Embed the role of service user, family member and carer.	Increase the participation of service users and carers at business meetings of all teams within CMMHS	4	Cavan Monaghan
3	4.1.1	Embed the role of service user, family member and carer	Continue to promote advocacy through MH advocacy group.	4	Donegal
3	4.1.1	Embed the role of service user, family member and carer	Introduce a Service User representative on to the AMHMT & on CMHTs through close liaison with the Office of Service User Engagement	2	Sligo Leitrim
3	4.1.4	Enhance the service user and carer engagement structures at national and CHO level in the planning and development of MHS	Introduce Mental Health Advocacy in service development and planning	2	Sligo Leitrim

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
3	4.1.4	Enhance the service user and carer engagement structures at national and CHO level in the planning and development of MHS	Publish the Service User Study undertaken in collaboration with St Angela's College	1	Sligo Leitrim
3	4.1.4	Enhance the service user and carer engagement structures at national and CHO level in the planning and development of MHS	Continue to use Patient Opinion website for feedback on services	4	Sligo Leitrim
3	4.1.4	Enhance the service user and carer engagement structures at national and CHO level in the planning and development of MHS	Ensure patient feedback is an Agenda item for the Quality and Risk Management Group	4	Sligo Leitrim
3	4.1.5	Work with partner organisations to reduce stigma	Work with alternative services to reduce the stigma of mental health including Family Matters; Parents Plus and Family Resource Centres	4	Donegal
3	4.1.5		Support post-primary schools to continue implementation of the Wellbeing Guidelines on mental health promotion and suicide prevention.	4	Donegal
3	4.1.5		Deliver Self Harm Awareness Programme	4	Donegal
3	4.1.5		Support local community action on suicide prevention, e.g. Finn Valley Together – youth mental health initiative	4	Donegal
3	4.2.2	Strengthen accountability with funded voluntary agencies including accountability for clinical services	Quarterly reviews of all Service Level Agreements	4	Sligo Leitrim
Goal 4		Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them			

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
4	5.1 & 6.4	Refurbishment of existing Approved Centres to comply with Mental Health Commission standards and to introduce anti-ligature measures in all settings.	Continue the process to replace Blackwater House Approved Centre	4	Cavan Monaghan
4	5.1.1	Implement the Peer Support Worker role funded in 2015 within the MHS	Establish Peer Support Models for all mental health units in Donegal	4	Donegal
4	5.1.2	Develop staff training and development programmes.	Develop team development plan for all teams in CMMHS. Prioritise staff engagement and communication to promote the desired culture and connectivity across services and Continue to prioritise multi-disciplinary team development and capacity building	2	Cavan Monaghan
4	5.1.3	Foster a culture of reflective practice and learning, & prioritise training and development	Train additional staff in evidence based therapies for people with dementia, EUPD, Eating Disorders and those who self harm. Put in place appropriate support services for staff including clinical supervision along with addressing equipment and assessment tool requirements	3	Cavan Monaghan
4	5.1.3	Develop performance management processes	Provide up to date test materials and resources. Identify non pay resource. Develop performance management processes to assure that our services are delivered to a high standard making the best use of resources available	2	Cavan Monaghan
4	5.1.4	Stress Control within the HSE	Support the delivery of Stress Control within the HSE and the community sector to approx. 300 participants	4	Donegal
4	5.1.4	Networking	Develop CHO Area 1 Forum within Mental Health	1	Donegal
	**Manage resources in a way that delivers best health outcomes, improves people's experience and demonstrates value for money**				
5	6.3	Enhance process to provide resources on an equitable basis aligned to population and deprivation	Commission a review of existing premises to establish critical analysis of accommodation provided vis a vis need of clients	4	Sligo Leitrim
5	6.3		Strengthen Psychiatry of Old Age through additional medical and nursing resources where resourcing permits	4	Sligo Leitrim
5	6.3		Endeavour to appoint Team Co-ordinator to Mental Health ID Team	4	Sligo Leitrim

CG	DDOP No.	High Level Goals	Action	End Q	ISA Area
5	6.3		Develop Advanced Nurse Practitioner posts in line with CCPs x 3 - Eating Disorder, Liaison Psychiatry, CBT, ANP, site approved by NIMB depending on resources	4	Sligo Leitrim
5	6.5	Develop new programmes by utilising the capability of digital technology and implement ICT Framework	Review of ICT infrastructure and use of technology in service delivery	3	Sligo Leitrim
5	6.1.1	Refurbish or replace current unfit for purpose acute inpatient units (subject to capital funding)	Work with Estates to identify mental health service needs re. infrastructural deficits	4	Donegal
5	6.1.2	Partner with Estates in the provision of appropriate buildings so that they are fit for purpose for the MHS	Continue to progress new Acute Inpatient Unit Project to revised schedule through continued integrated working with Sligo Regional Hospital and Estates Management	4	Sligo Leitrim

Appendices

Appendix 1: Financial Tables

	Closing budget 2015	Full year Cost 2015 / 2016 Developments	Pay Adjustments - Lansdowne Road	Once-off / Deficit funding	VFM / Efficiency measures	Opening budget 2016
	€000s	€000s	€000s	€000s	€000s	€000s
Primary Care	76,602	529	154	703	-428	77,560
Social Inclusion	2,244				-3	2,241
Palliative Care	5,783		7		-11	5,779
Demand Led Schemes	20,149			865		21,014
Total Primary Care	**104,778**	**529**	**161**	**1,568**	**-442**	**106,594**
Disability	105,441	1,405	245	1,977	-127	108,941
Older Person	72,985	92	401	2,612	-528	75,562
Total Social Care	**178,426**	**1,497**	**646**	**4,589**	**-655**	**184,503**
Mental Health	**64,927**	**1,938**	**130**	**7**	**-137**	**66,865**
TOTAL CHO 1	**348,131**	**3,435**	**937**	**6,693**	**-1,234**	**357,962**

Notes:
Social Care budget excludes funding for contract, subvention and S39 Fair Deal beds of €2.6m in 2016.

Appendix 2: HR Information

Table 1 - Staffing position by Community Health Area / Integrated Service Area

Community Healthcare Organisation Area 1							
Integrated Service	**Medical Dental**	**Nursing**	**HSCP**	**Clerical/ Admin**	**General Support Staff**	**Other Patient & Client Care**	**Total by WTE**
Primary Care & Social Incl.	78	285	276	306	47	79	**1,072**
Health & Wellbeing	-	-	-	-	-	-	
Social Care	23	851	94	172	218	1286	**2,644**
Mental Health	67	487	106	95	97	78	**930**
Total by grade	**168**	**1623**	**476**	**573**	**362**	**1443**	**4646**

Note 1: Dental for Cavan Monaghan are not recorded as they appear on Regional Dental WTE Census Data.
Note 2: Figures extracted from divisional plans

Appendix 3: Performance Indicator Suite

1. Primary Care

Balance Scorecard - Quality and Access Indicators of Performance

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Primary Care	
Service User Experience	*System-wide*
• Complaints	
• % of PCTs by CHO that can evidence service user involvement.	100%
Safe Care	
• Serious Reportable Events	*System-wide*
• Safety Incident Reporting	
Healthcare Associated Infections: Medication Management	
• Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	< 21.7
***Health Amendment Act*: Services to persons with state acquired Hepatitis C**	
• Number of patients who were reviewed	50
Primary Care Reimbursement Service	
Effective Care	
Medical Cards	
• % of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	90%
• % of Medical Card / GP Visit Card applications which are accurately processed by national medical card unit staff	95%
Social Inclusion	
Effective Care	
Traveller Health	
• No. of people who received health information on type 2 diabetes and cardiovascular health	245
Homeless Services	
• % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	85%
Palliative Care	
Effective Care	90%
• % of patients triaged within 1 working day of referral	
• % of patients with a multi-disciplinary care plan documented within 5 working days of initial review	90%

Access	Expected Activity / Target 2016
Primary Care	
GP Activity	
• No. of contacts with GP Out of Hours service	194,386*
Nursing	
• No. of new patients accepted on the caseload and waiting to be seen over 12 weeks	0
Speech and Language Therapy	
• % on waiting list for assessment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 52 weeks	100%
Physiotherapy and Occupational Therapy	
• % of new patients seen for assessment within 12 weeks	70%
• % on waiting list for assessment ≤ 52 weeks	100%
Podiatry, Ophthalmology, Audiology, Dietetics and Psychology	
Podiatry	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	75%
Ophthalmology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Audiology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Dietetics	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	70%
Psychology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Oral Health	
• % of new patients who commenced treatment within 3 months of assessment	80%
Orthodontics	
• % of referrals seen for assessment within 6 months	75%
• Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	< 5%
Social Inclusion	
Substance Misuse	
• % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	100%
• % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	100%
• No. of clients in receipt of opioid substitution treatment (outside prisons)	85
• Average waiting time from referral to assessment for opioid substitution treatment	14 days
• Average waiting time from opioid substitution assessment to exit from waiting list or treatment	28 days

Access	Expected Activity / Target 2016
commenced **Needle Exchange** • No. of unique individuals attending pharmacy needle exchange	
Palliative Care • Access to specialist inpatient bed within 7 days • Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital) • No. of patients in receipt of specialist palliative care in the community • No. of children in the care of the children's outreach nursing team / specialist palliative care team	 98% 95% 413 31

*OOH contacts based on 2016 Target for Donegal extrapolated to Area 1 population of 389K. Will increase due to Sligo/Leitrim OOH commencement.

Appendix 3 – Performance Indicator Suite

Primary Care – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

KPI/Metric	NSP/DOP	KPI Type	Report Frequency	Level of Reporting	CHO 1 2016 Targets
Community Intervention Teams (number of referrals)					0
Admission Avoidance (includes OPAT)	NSP	Quality	M	CHO	0
Hospital Avoidance	NSP	Quality	M	CHO	0
Early discharge (includes OPAT)	NSP	Quality	M	CHO	0
Unscheduled referrals from community sources	NSP	Quality	M	CHO	0
Outpatient parenteral Antimicrobial Therapy OPAT Re-admission rate %	DOP	Access /Activity	MQ2	HG	
Community Intervention Teams Activity (by referral source)				CHO	0
ED / Hospital wards / Units	DOP	Access /Activity	M	CHO	0
GP Referral	DOP	Access /Activity	M	CHO	0
Community Referral	DOP	Access /Activity	M	CHO	0
OPAT Referral	DOP	Access /Activity	M	CHO	0
GP Out of Hours					
No. of contacts with GP Out of Hours Service	NSP	Access /Activity	M	National	
Tobacco Control					
% of primary care staff to undertake brief intervention training for smoking cessation	DOP	Quality	Q	CHO	5%
Physiotherapy					
No of patient referrals	DOP	Activity	M	CHO	25,157
No of patients seen for a first time assessment	DOP	Activity	M	CHO	21,228
No of patients treated in the reporting month (monthly target)	DOP	Activity	M	CHO	4,721
No of face to face contacts/visits	DOP	Activity	M	CHO	116,183
Total No. of physiotherapy patients on the assessment waiting list at the end of the reporting period *	DOP	Access	M	CHO	3,313
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	DOP	Access	M	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	CHO	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	CHO	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	CHO	90%
Occupational Therapy					
No of patient referrals	DOP	Activity	M	CHO	11,698
No of new patients seen for a first assessment	DOP	Activity	M	CHO	10,306
No of patients treated (direct and indirect) monthly target	DOP	Activity	M	CHO	2,706
Total No. of occupational therapy patients on the assessment waiting list at the end of the reporting period **	DOP	Access	M	CHO	1,161
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	CHO	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	DOP	Access	M	CHO	No target

KPI/Metric	NSP/DOP	KPI Type	Report Frequency	Level of Reporting	CHO 1 2016 Targets
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	CHO	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	CHO	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	CHO	80%
Orthodontics					
No. of patients receiving active treatment at the end of the reporting period	DOP	Access	Q	National/ former region	
% of referrals seen for assessment within 6 months	NSP	Access	Q	National/ former region	
% on waiting list for assessment ≤ 12 months	DOP	Access	Q	National/ former region	
% of patients on the treatment waiting list less than 2 years	DOP	Access	Q	National/ former region	
% of patients on treatment waiting list less than 4 years (grade 4 and 5)	DOP	Access	Q	National/ former region	
No. of patients on the assessment waiting list at the end of the reporting period	DOP	Access	Q	National/ former region	
No. of patients on the treatment waiting list – grade 4 –at the end of the reporting period	DOP	Access /Activity	Q	National/ former region	
No. of patients on the treatment waiting list – grade 5 –at the end of the reporting period	DOP	Access /Activity	Q	National/ former region	
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	NSP	Access	Q	National/ former region	
Oral Health (Primary Dental Care and Orthodontics)					
No. of new patients attending for Scheduled Assessment	DOP	Access /Activity	M	CHO	7,500 (data gaps)
No. of new patients attending for Unscheduled Assessment	DOP	Access /Activity	M	CHO	4,071 (data gaps)
% of new patients who commenced treatment within 3 months of assessment	NSP	Access	M	CHO	80%
Healthcare Associated Infections: Medication Management				CHO	
Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	NSP	Quality		National	
Primary Care – Psychology					
No. of patient referrals	DOP	Activity	M	CHO	1,443
Existing patients seen in the month	DOP	Activity	M	CHO	630
New patients seen	DOP	Activity	M	CHO	1,449
Total No. of psychology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	CHO	882
No. of psychology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	DOP	Access	M	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	CHO	100%

KPI/Metric	NSP/DOP	KPI Type	Report Frequency	Level of Reporting	CHO 1 2016 Targets
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	CHO	60%
Primary Care – Podiatry					
No. of patient referrals	DOP	Activity	M	CHO	2,407
Existing patients seen in the month	DOP	Activity	M	CHO	1,456
New patients seen	DOP	Activity	M	CHO	1,987
Total No. of podiatry patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	CHO	819
No. of podiatry patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	CHO	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	CHO	90%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	CHO	75%
No of patients with Diabetic Active Foot Disease treated in the reporting month	DOP	Quality	M Q3	CHO	32
No. of treatments for Diabetic Active Foot Disease in the reporting month	DOP	Access /Activity	M Q3	CHO	128
Primary Care – Ophthalmology					
No. of patient referrals	DOP	Activity	M	CHO	6,147
Existing patients seen in the month	DOP	Activity	M	CHO	1,770
New patients seen	DOP	Activity	M	CHO	4,620
Total No. of ophthalmology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	CHO	2,478
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	CHO	60%
Primary Care – Audiology					
No. of patient referrals	DOP	Activity	M	CHO	1,951
Existing patients seen in the month	DOP	Activity	M	CHO	499
New patients seen	DOP	Activity	M	CHO	1,629
Total No. of audiology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	CHO	1,894
No. of audiology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target

KPI/Metric	NSP/DOP	KPI Type	Report Frequency	Level of Reporting	CHO 1 2016 Targets
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	CHO	60%
Primary Care – Dietetics					
No. of patient referrals	DOP	Activity	M	CHO	3,624
Existing patients seen in the month	DOP	Activity	M	CHO	589
New patients seen	DOP	Activity	M	CHO	3,335
Total No. of dietetics patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	CHO	1,061
No. of dietetics patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	CHO	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	CHO	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	CHO	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	CHO	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	CHO	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	CHO	85%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	CHO	70%
Primary Care – Nursing					
No. of patient referrals	DOP	Activity	M	CHO	8,351 (Data gap)
Existing patients seen in the month	DOP	Activity	M	CHO	3,857 (Data gap)
New patients seen	DOP	Activity	M	CHO	10,960 (Data gap)
Number of new patients accepted on the caseload and waiting to be seen over 12 weeks	NSP	Access	M	CHO	0
Primary Care – Speech and Language Therapy* **					
No. of patient referrals	DOP	Activity	M	CHO	6,140
Existing patients seen in the month	DOP	Activity	M Q2	CHO	New PI 2016
New patients seen for initial assessment	DOP	Activity	M	CHO	4,569
Total No. of speech and language patients waiting initial assessment at end of the reporting period ****	DOP	Access	M	CHO	963
Total No. of speech and language patients waiting initial therapy at end of the reporting period ****	DOP	Access	M	CHO	61
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	CHO	100%
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	CHO	100%
Health Amendment Act - Services to persons with state acquired Hepatitis C					
No. of patient who were reviewed.	NSP	Quality	Q	National	50

Note: All waiting list targets reflect end of year target.
***Monthly average based on April – Oct 2015 submitted data.**
**** Monthly average based on July – Oct 2015 submitted data.**
***** Speech and Language Therapy Data includes all non – acute activity across the care groups.**
****** SLT Monthly average based on Jan – Oct. 2015 submitted data**

Quality and Patient Safety – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Quality and Patient Safety	NSP/ DOP	Quality/Access	Report Frequency	Level of Reporting	CHO 1
Service User Experience					
% ratio of compliments to complaints by CHO	DOP	Quality	Q	CHO	New PI 2016
% of complaints investigated within 30 working days of being acknowledged by the complaints officer (mandatory)	NSP	Quality	M	CHO	75%
Service User Involvement					
% of PCTs by CHO, that can evidence service user involvement as required by Action 19 of the Primary Care Strategy – A New Direction (2001)	NSP	Quality	Q Q3	CHO	100%
Serious Reportable Events					
% of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer (mandatory) and entered on the National Incident Management System (NIMS)*	NSP	Quality	M	CHO	99%
% of investigations completed within 120 days of event occurrence)	NSP	Quality	M	CHO	90%
Safety Incidence Reporting					
% of **Safety** Incidents being entered on the National Incident Management System (NIMS) within 30 days of occurrence	NSP	Quality	Q	CHO	90%
% of claims received by State Claims Agency that were not reported previously as an incident	NSP	Quality	A	CHO	New PI 2016

*** All incidents including SREs are to be reported on NIMS. Until IIMS has been formally stood down, all SREs must also be reported onto the Incident Information Management System (IIMS)**

Social Inclusion – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

KPI Title	NSP/DOP	KPI Type	Reporting level	CHO 1
Total no. of clients in receipt of opioid substitution treatment (outside prisons)	NSP	Access	CHO	85
No. of clients in opioid substitution treatment in Clinics	DOP	Access	CHO	0
No. of clients in opioid substitution treatment with level 2 GP's	DOP	Access	CHO	50
No. of clients in opioid substitution treatment with level 1 GP's	DOP	Access	CHO	35
No. of clients transferred from clinics to level 1 GP's	DOP	Access	CHO	0
No. of clients transferred from level 2 GP's	DOP	Access	CHO	0
No. of clients transferred from level 2 to level 1 GPs)	DOP	Access	CHO	10
Total no. of new clients in receipt of opioid substitution treatment (outside prisons)	DOP	Access	CHO	20
Total no. of new clients in receipt of opioid substitution treatment (clinics)	DOP	Access	CHO	0
Total no. of new clients in receipt of opioid substitution treatment (level 2 GP)	DOP	Access	CHO	20
Average waiting time from referral to assessment for Opioid Substitution Treatment (days)	NSP	Access	CHO	14 days
Average waiting time from Opioid Substitution assessment to exit from waiting list or treatment commenced	NSP	Access	CHO	28 days
Number of Pharmacies providing of opioid substitution treatment	DOP	Access	CHO	34
Number of people obtaining opioid substitution treatment from Pharmacies	DOP	Access	CHO	97
No. of substance misusers who present for treatment	DOP	Access	CHO	724
No. of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	CHO	368
% of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	CHO	100%
No. of substance misusers (over 18 years) for whom treatment has commenced following assessment	DOP	Quality	CHO	584
No. of substance misusers (over 18) for whom treatment has commenced within one calendar month following assessment	DOP	Quality	CHO	580
% of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	NSP	Access	CHO	100%
No. of substance misusers (under 18 years) for whom treatment has commenced following assessment	DOP	Access	CHO	36
No. of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	CHO	32
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	NSP	Access	CHO	100%
% of substance misusers (over 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	CHO	100%
% of substance misusers (over 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	CHO	100%
No. of substance misusers (under 18 years) for whom treatment has commenced	DOP	Access	CHO	36
% of substance misusers (under 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	CHO	100%
% of substance misusers (under 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	CHO	100%
No. of problem alcohol users who present for treatment	DOP	Access	CHO	548
No. of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	CHO	272
% of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	CHO	100%
No. of problem alcohol users (over 18 years) for whom treatment has commenced following assessment	DOP	Access	CHO	464
No. of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	DOP	Access	CHO	28
% of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	DOP	Access	CHO	100%
No. of problem alcohol users (under 18 years) for whom treatment has commenced following assessment	DOP	Access	CHO	8
No. of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	CHO	8
% of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	CHO	100%

KPI Title	NSP/DOP	KPI Type	Reporting level	CHO 1
% of problem alcohol users (over 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	CHO	100%
% of problem alcohol users (over 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	CHO	100%
% of problem alcohol users (under 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	CHO	100%
% of problem alcohol users (under 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	CHO	100%
No. of tier 1 and tier 2 staff trained in SAOR Screening and Brief Intervention for problem alcohol and substance use	DOP	Quality	CHO	30
No. of pharmacies recruited to provide Needle Exchange Programme	DOP	Quality	CHO	12
No. of unique individuals attending pharmacy needle exchange	NSP	Access	CHO	28
No. of pharmacy needle exchange packs provided	DOP	Access	CHO	124
Average No. of needle / syringe packs per person	DOP	Quality	CHO	16
No. and % of needle / syringe packs returned	DOP	Quality	CHO	38 (30%)
No. and % of individual service users admitted to homeless emergency accommodation hostels/ who have medical cards	DOP	Quality	CHO	68 (75%)
No and % of service users admitted during the quarter who did not have a valid medical card on admission and who were assisted by Hostel staff to acquire a medical card during the quarter.	DOP	Quality	CHO	7 (70%)
% of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	NSP	Quality	CHO	85%
% of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed and are being supported to manage their physical / general health, mental health and addiction issues as part of their care/support plan	DOP	Quality	CHO	80%
Number of people who received health information on type 2 diabetes and cardiovascular health	NSP	Quality	CHO	245
Number of people who received awareness and participated in positive mental health initiatives	DOP	Quality	CHO	245

Palliative Care – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

KPI/Metric Title	NSP/DOP	KPI Type	Reporting Level	CHO 1
Inpatient Palliative Care Services				
Access to specialist inpatient bed within 7 days (during the reporting month)	NSP	Access	CHO	98%
Access to specialist palliative care inpatient bed from 8 to14 days (during the reporting month)	DOP	Access	CHO	2%
Total number of referrals for specialist inpatient Palliative care services received	DOP	Access /Activity	CHO	New metric
Total number of referrals deemed appropriate for admission - cancer	DOP	Access /Activity	CHO	New metric
Total number of referrals deemed appropriate for admission - non cancer	DOP	Access /Activity	CHO	New metric
No. of patients in receipt of treatment in specialist palliative care inpatient units (during the reporting month)	DOP	Access /Activity	CHO	41
No. of new patients seen or admitted to the specialist palliative care service (monthly cumulative)	DOP	Access /Activity	CHO	270
No. of admissions to specialist palliative care inpatient units (monthly cumulative)	DOP	Access /Activity	CHO	311

Community Palliative Care Services				
Access to specialist palliative care services in the community provided within 7 days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	NSP	Access	CHO	95%
Access to specialist palliative care services in the community provided to patients in their place of residence 8 to 14 days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	DOP	Access	CHO	3%
Access to specialist palliative care services in the community provided to patients in their place of residence 15+ days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	DOP	Access	CHO	2%
Total number of referrals received for specialist Palliative care services in the normal place of residence	DOP	Access /Activity	CHO	New metric
Total number of referrals deemed appropriate for services - cancer	DOP	Access /Activity	CHO	New metric
Total number of referrals deemed appropriate for services - non cancer	DOP	Access /Activity	CHO	New metric
No. of patients in receipt of specialist palliative care in the community (monthly cumulative)	NSP	Access /Activity	CHO	413
No. of new patients seen or admitted to specialist palliative care services in the community	DOP	Access /Activity	CHO	577
No. of patients in receipt of specialist palliative day care services (during the reporting month)	DOP	Access /Activity	CHO	14
No. of new patients in receipt of specialist palliative day care services (monthly cumulative)	DOP	Access	CHO	48
No. of patients in receipt of care in designated palliative care support beds (during the reporting month)	DOP	Access /Activity	CHO	16
Children's Palliative Care Services				
No. of children in the care of the children's outreach nursing team / specialist palliative care team	NSP	Access	CHO	31
No. of children in the care of the children's outreach nursing team / specialist palliative care team (Acute setting)	DOP	Access /Activity	CHO	0
No. of children in the care of the children's outreach nursing team / specialist palliative care team (community)	DOP	Access /Activity	CHO	31
No. of new children in the care of the children's outreach nursing team / specialist palliative care team	DOP	Access /Activity	CHO	18
No. of new children in the care of the children's outreach nursing team / specialist palliative care team (Acute settings)	DOP	Access /Activity	CHO	0
No. of new children in the care of the children's outreach nursing team / specialist palliative care team (Community)	DOP	Access /Activity	CHO	18
Total number of new referrals for inpatient services seen by the specialist palliative care team	DOP	Access /Activity	CHO	Baseline to be determined
Specialist palliative care services provided in the acute setting for new patients and re referral within 2 days	DOP	Quality	CHO	Baseline to be determined
Bereavement Services				
Total number of family units who received bereavement services	DOP	Access /Activity	CHO	New metric
% patients triaged within 1 working day of referral (acute service)	NSP	Quality	CHO	90%
% patients with a multidisciplinary care plan documented within 5 working days of initial review	NSP	Quality	CHO	90%

PC Appendix ii: Financial Tables

2016 CHO Net Expenditure Allocations

CHO	Pay	Non Pay	Gross Budget	Income	Net Budget
	€m	€m	€m	€m	€m
Area 1					
Primary Care	59.9	19.2	79.1	-1.6	77.5
Social Inclusion	.3	1.9	2.2	.0	2.2
Palliative Care	4.7	1.6	6.3	-.5	5.8
Core Services	**64.9**	**22.7**	**87.6**	**-2.1**	**85.6**
Local DLS	.0	21.0	21.0	.0	21.0
Total	**64.9**	**43.7**	**108.6**	**-2.1**	**106.6**

PC Appendix iii: HR Information

Primary Care Division – Staff Numbers by CHO (WTEs)

Primary Care	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care	Total	Projected Outturn Dec 2015
CHO 1	78	285	276	306	47	79	**1,072**	1,079

2. Social Care Key performance indicators

Disability KPI Title	CHO 1
No. of requests for assessments received	302
% of assessments commenced within the timelines as provided for in the regulations	100%
% of assessments completed within the timelines as provided for in the regulations	100%
% of service statements completed within the timelines as provided for in the regulations	100%
Proportion of Local Implementation Groups which have Local Implementation Plans for progressing disability services for children and young people	100%
Proportion of established Children's Disability Network Teams having current individualised plans for each child	100%
Number of Children's Disability Network Teams established	100% (16/16)
No. of work / work-like activity WTE 30 hour places provided for people with a disability (ID/Autism and Physical and Sensory Disability)	191
No. of people with a disability in receipt of work / work-like activity services(ID/Autism and Physical and Sensory Disability)	346
No. of people with a disability in receipt of Other Day Services (excl. RT and work/like-work activities) - Adult (Q2 & Q4 only) (ID/Autism and Physical and Sensory Disability)	1,301
No. of Rehabilitative Training places provided (all disabilities)	272
No. of people (all disabilities) in receipt of Rehabilitative Training (RT)	292
% of school leavers and RT graduates who have received a placement which meets their needs	100%
No. of people with a disability in receipt of residential services (ID/Autism and Physical and Sensory Disability)	746
No. of new referrals accepted for people with a disability for respite services (ID/Autism and Physical and Sensory Disability)	109
No. of new people with a disability who commenced respite services (ID/Autism and Physical and Sensory Disability)	78
No. of existing people with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	558
No. of people with a disability formally discharged from respite services (ID/Autism and Physical and Sensory Disability)	39
No. People with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	505
No. of overnights (with or without day respite) accessed by people with a disability (ID/Autism and Physical and Sensory Disability)	11,711
No. of day only respite sessions accessed by people with a disability (ID/Autism and Physical and Sensory Disability)	5,001
No. of people with a disability who are in receipt of more than 30 overnights continuous respite (ID/Autism and Physical and Sensory Disability)	6
No. of new referrals accepted for adults with a physical and / or sensory disability for a PA service	25
No. of new adults with a physical and / or sensory disability who commenced a PA service	24
No. of existing adults with a physical and / or sensory disability in receipt of a PA service	230
No. of adults with a physical or sensory disability formally discharged from a PA service	18
No. of adults with a physical and /or sensory disability in receipt of a PA service	217
Number of PA Service hours delivered to adults with a physical and / or sensory disability	123,011
No. of adults with a physical and / or sensory disability in receipt of 1 - 5 PA Hours per week	95
No. of adults with a physical and / or sensory disability in receipt of 6 - 10 PA hours per week	50
No. of adults with a physical and / or sensory disability in receipt of 11 - 20 PA hours per week	44

Disability KPI Title	CHO 1
No. of adults with a physical and / or sensory disability in receipt of 21 - 40 PA hours per week	28
No. of adults with a physical and / or sensory disability in receipt of 41 - 60 PA hours per week	9
No. of adults with a physical and / or sensory disability in receipt of 60+ PA hours per week	2
No. of new referrals accepted for people with a disability for home support services (ID/Autism and Physical and Sensory Disability)	94
No. of new people with a disability who commenced a home support service (ID/Autism and Physical and Sensory Disability)	153
No. of existing people with a disability in receipt of home support services (ID/Autism and Physical and Sensory Disability)	759
No. of people with a disability formally discharged from home support services (ID/Autism and Physical and Sensory Disability)	61
No of people with a disability in receipt of Home Support Services (ID/Autism and Physical and Sensory Disability)	856
No of Home Support Hours delivered to persons with a disability (ID/Autism and Physical and Sensory Disability)	336,605
No. of people with a disability in receipt of 1 - 5 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	301
No. of people with a disability in receipt of 6 – 10 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	94
No. of people with a disability in receipt of 11 – 20 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	46
No. of people with a disability in receipt of 21- 40 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	32
No. of people with a disability in receipt of 41 – 60 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	7
No. of people with a disability in receipt of 60 +Home Support hours per week (ID/Autism and Physical and Sensory Disability)	20
Facilitate the movement of people from congregated to community settings	
In respect of agencies in receipt of €3m or more in public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL or CARF	100%
% of compliance with outcomes of Disability Units following HIQA inspections by CHO	75%

Older people KPIs

Older People KPI Title	CHO 1
Total no. of persons in receipt of a HCP/DDI HCP(Monthly target)	1235
No. of new HCP clients, annually	525
Intensive HCPs number of persons in receipt of an Intensive HCP at a point in time (Capacity)	
No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	1,375,000
No. of people in receipt of home help hours (excluding provision of hours from HCPs) (Monthly target)	4,900
No. of persons funded under NHSS in long term residential care during reporting month	
% of clients with NHSS who are in receipt of Ancillary State Support	10%
% of clients who have CSARs processed within 6 weeks	90%
No. in receipt of subvention	13
No. of NHSS Beds in Public Long Stay Units.	534
No. of Short Stay Beds in Public Long Stay Units	395
Average length of Stay for NHSS clients in Public, Private and Saver Long Stay Units	3.2
% of population over 65 years in NHSS funded Beds (based on 2011 Census figures)	4%
Service Improvement Team Process Deliver on Service Improvement priorities.	
Percentage of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Older Persons Services.	
Safeguarding: % of Preliminary Screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan.	
% of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy Reporting to begin by Quarter 2 2016	
% of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy Reporting to begin by Quarter 2 2016	
Total no. of preliminary screenings for adults under 65 years	
Total no. of preliminary screenings for adults aged 65 and over	
No. of staff trained in safeguarding policy	

Appendix Balanced Score Cards

Disability

Progressing Disability Services for Children and Young People (0-18s) Programme	**100%**
• No. of Children's Disability Network Teams established	**(16/16)**
Service User Experience	
• % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Disability Services	**100%**
Congregated Settings	
• Facilitate the movement of people from congregated to community settings	**17**
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)	**99%**
• % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	**90%**
Safety Incident Reporting	
• % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	**90%**
Complaints	
• % of complaints investigated within 30 working days of being acknowledged by the complaints officer	**75%**
Safeguarding	
• % of preliminary screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan	**100%**
• % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy	**100%**
• % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy	**100%**
• % compliance with inspected outcomes following HIQA inspection of Disability Residential Units	**75%**
Service Improvement Team Process	
• Deliver on Service Improvement priorities	**100%**
Transforming Lives - VfM Policy Review	
• Deliver on VfM Implementation priorities	**100%**
Quality	

Disability Act Compliance	
• % of assessments completed within the timelines as provided for in the regulations	**100%**
Day Services	
• % of school leavers and RT graduates who have been provided with a placement	**100%**
Respite*	
• No. of day only respite sessions accessed by people with a disability	**5,001**
• No. of overnights (with or without day respite0 access by people with a disability	
Personal Assistance (PA)	**123,011**
• No. of PA service hours delivered to adults with a disability	
Home Support Service	**336,605**
• No. of Home Support Hours delivered to persons with a disability	

Finance		Human Resources	
Budget Management including savings		**Absence**	
Net Expenditure variance from plan (budget)		• % of absence rates by staff category	**≤ 3.5%**
• Pay - Direct / Agency / Overtime	**≤ .33%**		
• Non-pay	**≤ .33%**	**Staffing Levels and Costs**	
• Income	**≤ .33%**	• % variation from funded staffing thresholds	**≤ 0.5%**
Service Arrangements/ Annual Compliance Statement	**100%**	**Compliance with European Working Time Directive (EWTD)**	
• % of number of Service Arrangement signed	**100%**	• < 48 hour working week	**95%**
• % of the monetary value of Service Arrangements signed	**100%**		
• % of Annual Compliance Statements signed	**100%**		
Capital			
• Capital expenditure versus expenditure profile			
•			

Services for Older People

Quality and Safety

Service User Experience	
• % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Disability Services	100%
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)	99%
• % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	90%
Safety Incident Reporting	
• % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	90%
Complaints	
• % of complaints investigated within 30 working days of being acknowledged by the complaints officer	75%
Safeguarding	
• % of preliminary screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan	100%
• % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy	100%
• % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy	100%
Service Improvement Team Process	
• Deliver on Service Improvement priorities	100%
Governance for Quality and Safety	
• Quality and Safety committees across all Divisions at Divisional, Hospital Group and Community Healthcare Organisation	100%

Access

Home Care Packages	
• Total no. of persons in receipt of a HCP including delayed discharge initiative HCPs	1235
• Intensive HCPs: Total no. of persons in receipt of an intensive HCP	
Home Help	
• No. of home help hours provided for all care groups (excluding provision of hours from HCPs) (annual)	1.375m
• No. of people in receipt of home help hours (excluding provision from HCPs) (monthly)	4900
NHSS	
• No. of persons funded under NHSS in long term residential care	?
• No. of NHSS beds in Public Long Stay Units	534
• No. of short stay beds in Public Long Stay Units	395

Finance

Budget Management including savings	
Net Expenditure variance from plan (budget)	
• Pay - Direct / Agency / Overtime	≤0.33%
• Non-pay	≤0.33%
• Income	≤0.33%
Service Arrangements/ Annual Compliance Statement	
• % of number of Service Arrangement signed	100%
• % of the monetary value of Service Arrangements signed	100%
• % of Annual Compliance Statements signed	100%
Capital	
• Capital expenditure versus expenditure profile	100%

Human Resources

Absence	
• % of absence rates by staff category	≤ 3.5%
Staffing Levels and Costs	
• % variation from funded staffing thresholds	≤ 0.5%
Compliance with European Working Time Directive (EWTD)	
• < 48 hour working week	95%

•

Social Care Appendix ii: HR Information

Table 1 - Staffing position by Community Health Area / Integrated Service Area as at 31.12.2015

Community Healthcare Organisation Area 1							
Integrated Service	**Medical Dental**	**Nursing**	**HSCP**	**Clerical/ Admin**	**General Support Staff**	**Other Patient & Client Care**	**Total by WTE**
Social Care	23	851	94	172	218	1286	**2,644**

Appendix iii: Older persons Home Care Expected Activity

Home Care Targets/Expected Activity 2016				
CHO Area	**LHO**	**HCP Proposed 2016 Target**	**HH Hours Proposed 2016 Target**	**HH Clients 2016 Expected Activity**
1	LHO Cavan Monaghan	550	320,000	
	LHO Donegal	340	630,000	
	LHO Sligo/Leitrim	345	425,000	
Area 1		**1,235**	**1,375,000**	4,900

3. Mental Health Key performance indicators

Mental Health Balanced Scorecard

Quality and Access Indicators of Performance for Mental Health

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

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

Finance Indicators of Performance

Finance	Expected Activity / Target 2016
Budget Management including savings	
Net Expenditure variance from plan (within budget)	
• Pay – Direct / Agency / Overtime	0.33%
• Non-pay	0.33%
• Income	0.33%
• Acute Hospitals private charges – Debtor Days – Consultant Sign-off	90% @ 15 days by 31/12/16
• Acute Hospitals private income receipts variance from Actual v Plan	≤ 5%
Service Arrangements / Annual Compliance Statement	
• % of number of Service Arrangements signed	100%
• % of the monetary value of Service Arrangements signed	100%
• % of Annual Compliance Statements signed	100%
Capital	
• Capital expenditure versus expenditure profile	100%
Audit	
• % of internal audit recommendations implemented by due date	75%
• % of internal audit recommendations implemented, against total number of recommendations, within 12 months of report being received	95%

HR Indicators of Performance

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

MH KPI				CHO 1
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by General Adult Community Mental Health Team	NSP	Quality	M	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Team	NSP	Quality	M	75%
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	NSP	Access /Activity	M	18%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	NSP	Quality	M	98%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	NSP	Quality	M	95%
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	NSP	Access /Activity	M	3%
Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total number of admissions of children to mental health acute inpatient units.	NSP	Quality	M	N/A
Percentage of Bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of Bed days used by children in mental health acute inpatient units	NSP	Quality	M	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	NSP	Quality	M	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	NSP	Quality	M	72%
%. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	NSP	Access /Activity	M	10%
Total No. to be seen for a first appointment at the end of each month.	NSP	Access /Activity	M	394
Total No. to be seen 0-3 months	NSP	Access /Activity	M	145
Total No. on waiting list for a first appointment waiting > 3 months	NSP	Access /Activity	M	249
Total No. on waiting list for a first appointment waiting > 12 months	NSP	Access /Activity	M	0
No. of admissions to adult acute inpatient units	DOP	Access /Activity	Q in arrears	1,212
Median length of stay	DOP	Access /Activity	Q in arrears	10
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	DOP	Access /Activity	Q in arrears	72.7
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	DOP	Access /Activity	Q in arrears	18.9
Acute re-admissions as % of admissions	DOP	Access /Activity	Q in arrears	74%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area	DOP	Access /Activity	Q in arrears	53.8

MH KPI				CHO 1
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	DOP	Access /Activity	Q in arrears	23.2
No. of adult involuntary admissions	DOP	Access /Activity	Q in arrears	192
Rate of adult involuntary admissions per 100,000 population in mental health catchment area	DOP	Access /Activity	Q in arrears	12.4
% of General Adult Community Mental Health Teams serving a population of circa 50,000 (range of 45,000 to 60,000) as recommended in Vision	DOP		Q	N/A
Number of General Adult Community Mental Health Teams	DOP	Access	M	9
Number of referrals (including re-referred)received by General Adult Community Mental Health Teams	DOP	Access /Activity	M	3,766
Number of Referrals (including re-referred) accepted by General Adult Community Mental Health Teams	DOP	Access /Activity	M	3,578
No. of new (including re-referred) General Adult Community Mental Health Team cases offered first appointment for the current month (seen and DNA below)	DOP	Access /Activity	M	4,177
No. of new (including re-referred) General Adult Community Mental Health Team cases seen in the current month	DOP	Access /Activity	M	3,539
No. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	DOP	Access /Activity	M	638
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	DOP	Access /Activity	M	18%
Number of cases closed/discharged by General Adult Community Mental Health Teams	DOP	Access /Activity	M	2,860
Number of Psychiatry of Old Age Community Mental Health Teams	DOP	Access	M	3
Number of referrals (including re-referred)received by Psychiatry of Old Age Mental Health Teams	DOP	Access /Activity	M	1,789
Number of Referrals (including re-referred) accepted by Psychiatry of Old Age Community Mental Health Teams	DOP	Access /Activity	M	1,701
No. of new (including re-referred) Old Age Psychiatry Team cases offered first appointment for the current month (seen and DNA below)	DOP	Access /Activity	M	1,466
No. of new (including re-referred) Old Age Psychiatry Team cases seen in the current month	DOP	Access /Activity	M	1,424
No. of new (including re-referred) Old Age Psychiatry cases offered appointment and DNA in the current month	DOP	Access /Activity	M	42
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	DOP	Access /Activity	M	3%
Number of cases closed/discharged by Old Age Psychiatry Community Mental Health Teams	DOP	Access /Activity	M	1,360
No. of child and adolescent Community Mental Health Teams	DOP	Access	M	6
No. of child and adolescent Day Hospital Teams	DOP	Access	M	0
No. of Paediatric Liaison Teams	DOP	Access	M	0
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	DOP	Access /Activity	M	0
No. of children / adolescents admitted to adult HSE mental health inpatient units	DOP	Access /Activity	M	N/A
i). <16 years	DOP	Access /Activity	M	N/A

MH KPI				CHO 1
ii). <17 years	DOP	Access /Activity	M	N/A
iii). <18 years	DOP	Access /Activity	M	N/A
No. and % of involuntary admissions of children and adolescents	DOP	Access /Activity	Annual	N/A
No. of child / adolescent referrals (including re-referred) received by mental health services	DOP	Access /Activity	M	1,406
No. of child / adolescent referrals (including re-referred) accepted by mental health services	DOP	Access /Activity	M	1,124
No. of new (including re-referred) CAMHs Team cases offered first appointment for the current month (seen and DNA below)	DOP	Access /Activity	M	1,054
No. of new (including re-referred) child/adolescent referrals seen in the current month	DOP	Access /Activity	M	957
No. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	DOP	Access /Activity	M	96
%. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	DOP	Access /Activity	M	10%
No. of cases closed / discharged by CAMHS service	DOP	Access /Activity	M	900
Total No. to be seen for a first appointment by expected wait time at the end of each month.	DOP	Access /Activity	M	394
i) 0-3 months	DOP	Access /Activity	M	145
ii). 3-6 months	DOP	Access /Activity	M	93
iii). 6-9 months	DOP	Access /Activity	M	98
iv). 9-12 months	DOP	Access /Activity	M	58
v). > 12 months	DOP	Access /Activity	M	0

Health & Wellbeing Balanced Scorecard

Quality	Expected Activity / Target 2016	Access	Expected Activity / Target 2016
Service User Experience • % of complaints investigated within 30 working days of being acknowledged by the complaints officer	75%	**National Screening Service** • BreastCheck: % BreastCheck screening uptake rate	> 70%
Safe Care • % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	99%	• CervicalCheck: % eligible women with at least one satisfactory CervicalCheck screening in a 5 year period	> 80%
• % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	90%	• BowelScreen: % of client uptake rate in the BowelScreen programme	> 45%
National Screening Service • BreastCheck: % women offered hospital admission for treatment within 3 weeks of diagnosis of breast cancer	> 90%	• Diabetic RetinaScreen: % Diabetic RetinaScreen uptake rate	> 56%
• CervicalCheck: % urgent cases offered a Colposcopy appointment within 2 weeks of receipt of letter in the clinic	> 90%	**Health Promotion and Improvement – Tobacco** • No. of smokers who received intensive cessation support from a cessation counsellor	11,500
Public Health – Immunisation • % of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (acute hospitals and long term care facilities in the community)	40%	**Environmental Health Service – Food Safety** • No. of official food control planned, and planned surveillance inspections of food businesses	33,000
• % children aged 24 months who have received 3 doses of the 6 in1 vaccine	95%		
• % children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	95%		
Effective Care **Health Promotion and Improvement** • Tobacco: % of smokers on cessation programmes who were quit at one month	45%		
Public Health • Child Health: % of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age	95%		
• Immunisation: % uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	75%		
• Child Health: % of newborn babies visited by a PHN within 72 hours of discharge from maternity services	97%		
Finance	**Expected Activity / Target 2016**	**HR**	**Expected Activity / Target 2016**
Budget Management including savings **Net Expenditure variance from plan (within budget)** • Pay – Direct / Agency / Overtime	0.33%	**Absence** • % of absence rates by staff category	≤3.5%
• Non-pay	0.33%	**Staffing Levels and Costs** • % variance from funded staffing thresholds	≤ 0.5%
• Income	0.33%	**Health and Safety** • No. of calls that were received by the National Health and Safety Helpdesk during the quarter	15% increase
Service Arrangements / Annual Compliance Statement • % of number of Service Arrangements signed	100%		
• % of the monetary value of Service Arrangements signed	100%		
• % of Annual Compliance Statements signed	100%		
Capital • Capital expenditure versus expenditure profile	100%		
Key Result Areas – Governance and Compliance (Development focus in 2015) **Audit**			

• % of internal audit recommendations implemented by due date	75%		
• % of internal audit recommendations implemented, against total number of recommendations, within 12 months of report being received	95%		

Health & Wellbeing KPIs

Indicator	Expected Activity / Target 2016
Tobacco No. of smokers who received intensive cessation support from a cessation counsellor	
No. of frontline staff trained in brief intervention smoking cessation	
% of smokers on cessation programmes who were quit at one month	45%
Healthy Eating Active Living No. of 5k Parkruns completed by the general public in community settings	6,569
No. of frontline healthcare staff who have completed the physical activity e-learning module	49
No. of people who have completed a structured patient education programme for diabetes	395
% of PHNs trained by dietician's in the Nutrition Reference Pack for Infants 0-12 months	50%
No. of people attending a structured community based healthy cooking programme	250
% of preschools participating in Smart Start	15%
% of primary schools trained to participate in the after schools activity programme - Be Active	20%
Child Health % of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age	95%
% of newborn babies visited by a PHN within 72 hours of discharge from maternity services	97%
% of babies breastfed (exclusively and not exclusively) at first PHN visit	56%
% of babies breastfed (exclusively and not exclusively) at 3 month PHN visit	38%
% of total number of maternity hospitals with Baby Friendly Hospital designation	58%
Immunisations and Vaccines % children aged 12 months who have received 3 doses Diphtheria (D3), Pertussis (P3), Tetanus (T3) vaccine Haemophilus influenza type b (Hib3) Polio (Polio3) hepatitis B (HepB3) (6 in 1)	95%
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV2)	95%
% children at 12 months of age who have received 1 dose of the Meningococcal group C vaccine (MenC2)	95%
% children aged 24 months who have received 3 doses Diphtheria (D3), Pertussis (P3), Tetanus (T3) vaccine, Haemophilus influenza type b (Hib3), Polio (Polio3), hepatitis B (HepB3) (6 in 1)	95%

Indicator	Expected Activity / Target 2016
% children aged 24 months who have received 3 doses Meningococcal C (MenC3) vaccine	95%
% children aged 24 months who have received 1 dose Haemophilus influenza type B (Hib) vaccine	95%
% children aged 24 months who have received 3 doses Pneumococcal Conjugate (PCV3) vaccine	95%
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	95%
% children in junior infants who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)	95%
% children in junior infants who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine	95%
% first year students who have received 1 dose Tetanus, low dose Diphtheria, Acellular Pertussis (Tdap) vaccine	95%
% of first year girls who have received two doses of HPV vaccine	85%
% of first year students who have received one dose meningococcal C (MenC) vaccine	95%
% of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (acute hospitals)	40%
% of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (long term care facilities in the community)	40%
% uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	75%

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
Derrybeg/Bunbeg, Co. Donegal	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Virginia Healthcare Unit, Co. Cavan	Refurbishment and upgrade (to achieve HIQA compliance).	Q2 2015	Q1 2016	0	50	0.08	3.74	0	0.00
St. Mary's Hospital, Castleblaney, Co. Monaghan	Refurbishment and upgrade (to achieve HIQA compliance).	Q4 2015	Q1 2016	0	71	0.20	5.86	0	0.00
Ballinamore Community Nursing Unit (CNU), Co. Leitrim	Refurbishment and upgrade (to achieve HIQA compliance).	Q3 2014	Q4 2015/Q1 2016	0	21	0.20	6.00	0	0.00
Community Mental Health Unit, Donegal	Refurbishment of Rowanfield House to provide a community mental health unit for the area.	Q1 2015	Q1 2016	0	0	0.00	1.98	0	0.00

Appendix 5

PROFILE OF CHO 1
(COUNTIES DONEGAL, SLIGO, LEITRIM, CAVAN AND MONAGHAN)
(Produced by Public Health Department, Donegal)

This profile gives facts on health in Community Healthcare Organisation Area 1 (CHO 1). It is intended to inform health professionals and enable them to improve health services and reduce health inequalities.

GEOGRAPHY

CHO 1 is made up 5 Counties, 12 PCNs, 37 PCTs and 459 EDs; (Donegal - 149, Sligo - 79, Leitrim - 73, Cavan – 86/89 (3 EDs are in Area 8), Monaghan -70, Louth - 1, Meath – 1).

POPULATION

- CHO 1 has a total population of 389,048 which composes just less than 9% of the National population.
- The Population of CHO 1 has increased by almost 10% between 2006 and 2011 compared to national population increase of 8%.
- 7.9% (30,569) of the population of CHO 1 are aged 0-4 years (pre-schoolers) compared to 7.8% nationally.
- 14.5% (53,314) of the population of CHO 1 are aged 5-14 years compared to 13.6% nationally.
- Just over 13% (51,284) in CHO 1 are aged 65 years and over with 1.6% of the population aged 85 years and over ; higher than the National pattern of 11.6% for population aged over 65 years and 1.3% for those aged over 85 years.
- CHO 1 has the highest age dependent population nationally at 36%. There has been an increase of 13% (15,948 persons) in the age dependent population in CHO 1 between 2006 and 2011 compared to a 13.9% increase in the age dependent population nationally.
- CHO 1 has the highest number of persons aged 15 and over who are unemployed at 9.6% (8.5% nationally)
- 5.2% (20,373) of the population of CHO 1 are professional workers in comparison to over 7% for Ireland.
- Semi and unskilled workers make up a larger percentage of the population in CHO 1 at almost 17% (65,023) compared to 14% nationally.
- CHO 1 has the highest number or adults whose level of education is primary or lower nationally
- Between 2006 and 2011, the population with no formal or primary education only has declined dramatically in Ireland and similarly in CHO 1. Almost 14% (54,142) have no formal or primary education only, in CHO 1, much higher than the 10% for Ireland.
- CHO 1 has the lowest number of adults whose level of education is at 3rd level at 12%
- Over 16% of Ireland's population had a 3rd level education in 2011, compared to 12% (47,830 persons) in CHO 1.

- BIRTH AND NEONATAL STATISTICS

- There were 4,979 births in CHO 1 in 2014 representing 7.3% of the births in Ireland.
- The birth rate in CHO 1 was 12.7 per 1,000 population which was lower than the national birth rate of 14.7 per 1,000 population.
- 92% of all births registered in CHO 1 in 2014 were to mothers aged 20 to 39 years; 2% to teenage mothers and 6% were to mothers aged 40 years and over, this is similar to the trend seen for Ireland.

- Neonatal deaths are deaths of infants under 4 weeks of age. There were 184 neonatal deaths registered in 2014 in Ireland, giving a neonatal mortality rate of 2.7 deaths per 1,000 live births. The neonatal death rate of 3 deaths per 1,000 live births for CHO 1 is comparatively higher than the National rate in 2014.
- In additional, the infant mortality rate of 3.8 deaths per 1,000 live births was slightly higher in CHO 1 than in Ireland in 2014. Nationally 249 infant deaths were registered giving an infant mortality rate of 3.7 per 1,000 live births.

1. BREASTFEEDING

- During 2013 Breastfeeding rates in CHO 1 were lower than the national rates;
    - Breast only; CHO 1 - 39.5%, Ireland - 47.0%,
    - Breast & Combined; CHO 1- 46.3%, Ireland - 55.7%,

2. DEPRIVATION LEVEL – HP INDEX

- The 2011 All-Ireland HP Deprivation Index combines dimensions of the demographic profile, social class composition and labour market situation.
    - The combined deprivation scores illustrate that more people in CHO 1 - 31.6% (123,048) are classified as deprived - compared to 23.3%of the population nationally.
    - In addition there are less people in CHO 1 – 12.4% (48, 272) classified as affluent compared to 24.4% nationally.

3. HEALTH INDICATORS SELF-REPORTED

- 1.6% (6,101) of the population of CHO 1 report their health is bad or very bad (1.5% Nationally)
- 13.3% (52,081) of CHO 1 have a disability (13% Nationally) of these;
- 44.4% (23,142) have condition that limits basic physical activities (41.1% Nationally)
- 16.4% (8,555) are deaf or a have serious hearing impairment (15.5% Nationally)
- 9.6% (4,984) have an intellectual disability (9.7% Nationally)

4. VULNERABLE GROUPS

- 2,097 members of the travelling community reside in CHO 1 representing 0.5% of the population compared to 0.6% nationally.
- 8,800 vulnerable migrants residing in CHO 1 representing 2.3% of the population compared to 3.4% nationally. The number of vulnerable migrants living in CHO 1 has increased by 66.6% (+3,519) compared to a national increase of 30.2% between 2006 and 2011.

5. DEATHS

- There were 2,743 deaths registered in 2014 in CHO 1 giving a rate of 7.1 deaths per 1,000 population slightly higher that the national death rate of 6.3 per 1,000 population of these
    - 28.1% were due to Cancer (30.5% nationally)
    - 32.9% were from Heart Disease & Stroke (30.6% nationally)
    - 12.8% were from Respiratory Disease (11.6% nationally)
    - 5.3% were from injuries & poisonings (5.4% nationally)
- There were 29,095 deaths registered in 2014, a decrease of 3.1% (or 923 deaths) from 2013. This equates to a death rate of 6.3 per 1,000 population, a fall in rate of 0.2 in comparison with 2013

Notes:

i) The data for indicators 12-19, 28, 31, 42-52 and 55-60 were calculated for the total population of counties Donegal, Sligo, Leitrim, Cavan & Monaghan as the data was not available at CHO 1 level. Please note the difference in population between CHO 1 and the total population of counties Donegal, Sligo, Leitrim, Cavan & Monaghan is 2,945 persons.

ii) Infant mortality rates: Deaths of infants under one year per 1,000 live births, classified by area of residence of other.

iii) Neonatal mortality rates: Deaths of infants under 28 days per 1,000 live births, classified by area of residence of mother.

iv) Infant and neonatal mortality rates in some areas, based on small numbers are subject to considerable fluctuation and caution should be exercised in their interpretation.

Sources

(1-11) Population Data taken from the Census of Ireland 2011. www.cso.ie
(12-17) Births & Neonatal Statistics - Vital Statistics yearly summary for 2014 - www.cso.ie
(18-19) Breast feeding - Perinatal Statistics Report 2013
(20-27) Deprivation Level HP Index - Area Profiler – Health Atlas Ireland
(28) Percentage of lone parent households over the total number of households. Census of Ireland 2011. www.cso.ie
(29) Percentage of persons in labour force who are semi, unskilled or agricultural workers. Census of Ireland 2011. www.cso.ie
(30) Percentage of persons aged 15-64 available in the labour force who are unemployed including first time job seekers Census of Ireland 2011. www.cso.ie
(31) Percentage of households which are local authority rented over the total number of households. Census of Ireland 2011. www.cso.ie
(32-38) Percentage of persons by nationality. Census of Ireland 2011. www.cso.ie
(39) Percentage of persons who state they are a carer. - Census of Ireland 2011. www.cso.ie
(40) Percentage of persons in this area who reported that their health is either bad of very bad. - Census of Ireland 2011. www.cso.ie
(40) Percentage of persons in this area who state they have a disability - Census of Ireland 2011. www.cso.ie
(42-52) Percentage of persons with this type of disability out of all disabilities - Census of Ireland 2011. www.cso.ie
(53-54) Travellers & Vulnerable Migrants - Area Profiler – Health Atlas Ireland
(55-60) Deaths for various causes, by 1,000 population classified by area of residence. Data extracted from Vital Statistics yearly summary for 2014 - www.cso.ie

Facts & Health Summary

INDICATOR	CHO 1				Ireland			
	2011		Change since 2006		2011		Change since 2006	
POPULATION	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
1 Population Number and % of National	389,048	8.5	354,853	9.6%	4,588,252		4,232,597	8.4%
2 5 Year population change 2006 - 2011	34195	9.6	-	-	355655	8.4	-	-
3 Persons aged 0-4 years old	30,569	7.9	+ 5,100	+20%	356,329	7.8	+54,512	+18.1%
4 Persons aged 5 - 14 years old	53314	14.5	+4,948	+9.6%	623261	13.6	+ 62,030	+11.1%
5 Persons 65 years and older	51284	13.2	+ 5,900	+13%	535393	11.7	+68,000	+14.5%
6 Persons aged 85 years and older	6,295	1.6	+ 1,011	19.1%	58,416	1.3	+ 10,411	+21.7%
7 Age Dependency	138,167	35.5	+ 15,948	13%	1,514,983	33	+ 184,542	+13.9%
8 Classes - professional workers	20,373	5.2	n/a	n/a	336,620	7.3	n/a	n/a
9 Classes - semi & unskilled workers	65,023	16.7	n/a	n/a	657,463	14.3	n/a	n/a
10 Persons with no formal or primary education only	54,142	13.9	-6,046	-10%	456,896	10	-56,585	-11%
11 Persons with 3rd level education	47,830	12.3	n/a	n/a	739,992	16.1	n/a	n/a

	CHO 1		Ireland	
BIRTHS AND NEONATAL STATISTICS	**Number**	**Rate**	**Number**	**Rate**
12 Total number of live births to females all ages	4979	12.7 per 1000 population	67462	14.7 per 1000 population
13 Live births to females aged under 20, 2014	102	20.5 per 1000 live births	1253	18.6 per 1000 live births
14 Live births to females aged 20-39 years, 2014	4592	922 per 1000 live births	62129	920 per 1000 live births
15 Live births to females aged over 40 years, 2014	285	57.2per 1000 live births	4077	60.4 per 1000 live births
16 Neonatal mortality by area of residence of mother 2014	15	3.01 per 1,000 live births	184	2.7 per 1,000 live births
17 Infant mortality by area of residence of mother 2014	19	3.8 per 1,000 live births	249	3.7 per 1,000 live births

BREASTFEEDING	**Number**	**%**	**Number**	**%**
18 Breast Feeding Rates at Discharge 2013 (Breast Only)	2062	39.2%	31883	46.3%
19 Breast Feeding Rates at Discharge 2013 (Breast & Combined)	2469	47.0%	38372	55.7%

	CHO 1		Ireland	
DEPRIVATION LEVEL - HP INDEX	**Number**	**%**	**Number**	**%**
20 Extremely affluent	1,210	0.3%	79,725	1.7%
21 Very affluent	8,670	2.2%	289,032	6.3%
22 Affluent	38,392	9.9%	752,423	16.4%
23 Marginally above average	94,225	24.2%	1,209,013	26.4%
24 Marginally below average	123,504	31.7%	1,186,058	25.8%
25 Disadvantaged	85,196	21.9%	719,940	15.7%
26 Very disadvantaged	31,142	8%	277,331	6%
27 Extremely disadvantaged	6,710	1.7%	74,731	1.6%
28 Lone parent households	15309	10.8%	179761	10.9%
29 Semi, unskilled and agricultural workers	65,023	16.7%	657,463	14.3%
30 Unemployment - aged 15+	37,466	9.6%	390,677	8.5%
31 Households local authority rented	10876	7.7%	129033	7.8%

	CHO 1				Ireland			
	2011		**Change since 2006**		**2011**		**Change since 2006**	
NATIONALITY	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
32 Irish	342,519	88%	24,759	7.8%	3,927,143	85.6%	227,148	6.1%
33 UK	13,704	3.5	712	5.5	112,259	2.4	-167	-0.1
34 Polish	7,164	1.8	3,924	121.1	122,585	2.7	59,390	94
35 Lithuanian	4,469	1.1	1,564	53.8	36,683	0.8	12,080	49.1
36 Elsewhere in EU	5,531	1.4	1,816	48.9	115,237	2.5	39,986	53.1
37 Elsewhere in world	6,894	1.8	747	12.2	157,593	3.4	13,763	9.6
38 Not stated	3,613	0.9	833	30	53,781	1.2	8,262	18.2

	CHO 1		Ireland	
HEALTH INDICATORS SELF-REPORTED	**Number**	**%**	**Number**	**%**
39 Carers	17,563	4.5%	187,112	4.1%
40 Persons whose health is bad or very bad	6101	1.6%	69661	1.5%
41 Total persons with a disability (PD)	52081	13.3%	595335	13.0%
42 PD with blindness or a serious vision impairment	4644	8.9%	51718	8.7%
43 PD with deafness or a serious hearing impairment	8555	16.4%	92060	15.5%
44 PD with a condition that limits basic physical activities	23142	44.4%	244739	41.1%
45 PD with an intellectual disability	4984	9.6%	57709	9.7%
46 PD with a difficulty in learning, remembering or concentrating	12105	23.2%	137070	23.0%
47 PD with psychological or emotional condition	7589	14.6%	96004	16.1%
48 PD with other disability including chronic illness	23516	45.2%	274762	46.2%
49 PD with a difficulty in dressing/bathing/getting around the home	12459	23.9%	125450	21.1%
50 PD with a difficulty in working or attending school/college	17969	34.5%	194398	32.7%
51 PD with a difficulty in going outside home alone	16060	30.8%	165681	27.8%
52 PD with a difficulty in participating in other activities	19364	37.2%	207455	34.8%

	2011		Change since 2006		2011		Change since 2006	
VULNERABLE GROUPS	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
53 Travellers	2,097	0.5	+808	+62.7	29,495	0.6	+7,202	+32.3
54 Vulnerable Migrants	8,800	2.3	+3,519	+66.6	153,865	3.4	+35,663	+30.2

DEATHS 2014	**Number**	**Rate**		**Number**	**Rate**	
55 Total deaths for all causes 2014	2,743	7.0 per 1000 population		29,095	6.3 per 1000 population	
56 Total deaths for Malignant Neoplasms	770	2 per 1000 population		8,880	1.9 per 1000 population	
57 Total deaths for Circulatory System Diseases	902	2.3 per 1000 population		8,899	1.9 per 1000 population	
58 Total deaths for Respiratory System Diseases	350	0.9 per 1000 population		3,388	0.7 per 1000 population	
59 Total deaths for External Causes (Injury and Poisoning)	146	0.4 per 1000 population		1,560	0.3 per 1000 population	
60 Total deaths for all other causes	575	1.5 per 1000 population		6,368	1.4 per 1000 population	

Appendix 6: PROFILE OF CHO 1 (COUNTIES DONEGAL, SLIGO, LEITRIM, CAVAN AND MONAGHAN)

This profile gives facts on health and wellbeing in Community Healthcare Organisation Area 1 (CHO 1). It is sourced from the Institute of Public Health (IPH) All Ireland Public Health Repository, part of the Health Well website which intends to inform health professionals and enable them to improve health services and reduce health inequalities. Each indicator is furnished at county and National level, as data is not currently available directly at CHO 1 level.

GEOGRAPHY

CHO 1 is made up 5 Counties, 12 PCNs, 37 PCTs and 459 EDs; (Donegal - 149, Sligo - 79, Leitrim - 73, Cavan – 86/89 (3 EDs are in Area 8), Monaghan -70, Louth - 1, Meath – 1).

POPULATION

CHO 1 has a total population of 389,048 which composes just less than 9% of the National population.

OBESITY

- 33.4% of people aged 18 years or over consume less than five portions of fruit or vegetables per day across all counties composing CHO 1 the same as Nationally.
- In CHO 1 counties 29.2% of people are physically inactive, just higher than the National average of 28.4%.
- All counties in CHO 1 had 10% of people with high cholesterol in 2007, in comparison to 11.8% for Ireland.
- According to figures from SLAN for 2007, CHO 1 counties had almost 16% of people who are obese, this was 1.5% higher than the National average of 14.4%.
- All counties composing CHO 1 were higher than the National average of 12.7% for people aged 18 years or over, having been told by a doctor in the previous 12 months, that they have hypertension (ranging from the lowest 13.2% in counties Cavan and Monaghan to 14% in counties Leitrim and Sligo).
- 3.6% of people aged 18 years or over in counties Leitrim and Sligo have diabetes (Type I and Type II) in 2010. This is slightly higher than 3.4% for counties Cavan and Donegal, and 3.3% in Monaghan which is marginally higher than Ireland (3.2%). Figures show this trend continues for prevalence of diabetes in counties in CHO 1, in 2015 and in 2020; similarly diabetes is predicted to increase by 0.3% in 2010, 2015 and 2020 Nationally.
- 0.8% of people aged 18 years or over in counties Leitrim and Sligo in 2010 have been told by a doctor that they have had a stroke; slightly lower at 0.7% for counties Cavan, Donegal, Monaghan and Ireland.
- The estimated 2.7% of people in counties Leitrim and Sligo, aged 18 years or over who have been told by a doctor in the previous 12 months that they have angina or have had a heart attack (coronary heart disease (CHD)) is marginally higher than counties Donegal (2.6%), Cavan and Monaghan (2.5%) and Ireland (2.4%).

- Both counties Leitrim and Sligo have a higher percentage of hypertension, diabetes, stroke and CHD in comparison to the other counties making up CHO 1 and National average (across the years 2010, 2015 and 2020).
- Data for 2011 shows 63% of children aged 5-12 years, are driven to school in county Sligo, slightly higher than nationally (61.3%). County Leitrim has the lowest percentage at 53.6%.
- All counties in CHO 1 have a lower percentage of children aged 5-12 years walking to school, ranging from almost 11% in Donegal to 16% in Sligo; in comparison to almost 26% for Ireland. This trend is mirrored with only 16.3% of adolescents aged 13-18 walking/cycling to school in county Monaghan, which is the highest for the counties composing CHO 1, compared to almost 26% nationally.
- In addition, almost 52% of adolescents aged 13-18 years drive or are driven to school in county Sligo, 10% higher than the average for Ireland (almost 42%).
- CHO 1 average authority expenditure on Leisure Facilities Operations, Outdoor Leisure Areas Operations, Community Sport and Recreational Development per person ranges from 3.8 in Donegal to 30.9 in Leitrim, compared to 33.2 nationally.
- The directly age and gender standardised rate of admissions (including day cases) to hospital for diseases of the circulatory system is highest in county Sligo at 7413.7 per 100,000 European standard population, compared to 3959.5 for county Donegal and the comparative rate for Ireland (4495 per 100,000 European standard population).
- In county Monaghan 0.58 children's playgrounds are directly provided or facilitated by the local authority per 1,000 population – the highest in CHO 1, compared to 0.31 in county Donegal.

6. STROKE

- 12% of people in CHO 1 have high blood pressure, according to SLAN data for 2007; this is slightly lower than Ireland (12.6%).
- In 2007 CHO 1 had 26.8% of people who currently smoked cigarettes; this is lower than the National trend of 28.5%.
- The 0.8% estimated people in CHO 1, aged 18 years or over who have been told by a doctor in the previous 12 months that they have had a stroke is slightly higher than Ireland (0.7%) for 2015.
- Data projecting forwards to 2020, estimates 0.9% of people in counties Leitrim and Sligo, and slightly lower at 0.8% in counties Cavan, Donegal and Monaghan aged 18 years or over will be told by a doctor in the previous 12 months that they have had a stroke, similarly projections for Ireland illustrate a slight rise to 0.8% (from 0.7% for 2015 data).
- County Sligo has the highest percentage of the population with 14.14% having long-lasting conditions or difficulties in CHO 1 ranging to the lowest in county Monaghan with 11.8%; county Cavan with 11.9% is similar to the National trend (12.9%) for 2011.

- Counties Leitrim and Sligo with 65.8 General Practitioners per capita per 100,000 people, is the highest in CHO 1, which is higher than Ireland (60.1) in 2011. This falls to 49.4 in counties Cavan and Monaghan; Donegal is similar to National figure with 59.6 per 100,000 population.
- The directly age and gender standardised rate (DSR) of admissions to hospital for coronary artery bypass graft or angioplasty (CABG) of 154.6 per 100,000 European standard population is much higher in county Cavan than in Ireland (131.6). Counties Donegal and Monaghan with 138.4 and 153.4 respectively are also higher than the National trend. County Leitrim (115.1 per 100,000 European standard population) has the lowest DSR for CABG in CHO 1.
- All counties composing CHO 1 have a higher percentage of the working age population aged 15-64 years in receipt of Disability Benefit for diseases of the circulatory system, in 2014, with county Leitrim having the highest, at 0.33% ; higher than Nationally (0.23%),

7. DIABETES

- In 2013, the directly age and gender standardised rate (DSR) of all emergency (i.e. non-elective) admissions to hospital for asthma and diabetes of 1393.4 per 100,000 European standard population is highest for all counties in CHO 1; in addition the DSR is higher for all counties making up CHO 1, than in Ireland (907.7); ranging from 918.7 being the lowest in CHO 1 for county Donegal to, highest rate at 1393.4 per 100,000 European standard population for county Cavan.

8. MENTAL HEALTH

- 79.6% of people aged 18 years or over believe that people in their area can be trusted in county Leitrim, much higher than the National average (67.8%) for 2002.
- 29.2% of people aged 18 years or over are physically inactive in CHO 1, which is slightly higher than in Ireland (28.4%) according to SLAN data for 2007.
- 26.8% across all counties composing CHO 1 have a lower than National percentage (28.5%) of people aged 18 years or over who currently smoke cigarettes.
- 1.3% of people aged 18 years or over experience a severe lack of social support in all counties making up CHO 1, this is slightly lower than the 1.9% National figure for 2007.
- All counties in CHO 1 have a higher percentage of persons aged 65 years and over living alone in private households in 2011 than the average for Ireland. This ranges from the highest percentage in county Leitrim at 34.1% to 29% in county Donegal, compared to 27.7% for Ireland.
- All counties making up CHO 1 have a higher than National average of the working age population aged 15 years and over in the labour force in "Semi-skilled" and "Unskilled" social classes as per Census 2011; ranging from the lowest in county Leitrim (17.9%) to 23.3% in county Monaghan compared to 17.2% Nationally.

- Similarly all counties in CHO 1 have equal / higher percentage of households that consist of one person in comparison to Ireland for 2011. In CHO 1 county Leitrim has the highest percentage of people living alone at 30.5%.
- The percentage of the population aged 15 years and over which are unemployed (looking for first regular job or having lost or given up previous job) is generally higher in CHO 1, with exception of county Sligo (10.8%) which is lower than Ireland (11.8%).
- 1.12% of the working age population aged 15-64 years are in receipt of Disability Benefit for depression and/or anxiety in county Leitrim – this is the highest rate in CHO 1, marginally higher than National trend (1.09%); in comparison to 0.84% of people in county Donegal. This is further reflected in the percentage of the working age population aged 15-64 years in receipt of Disability Benefit for mental and behavioral disorders which is generally similar or lower than Ireland, with exception of county Monaghan 0.04% compared to 0.03% Nationally.
- The directly age and gender standardised rate (DSR) of admissions to hospital (including day cases) for alcohol abuse per 100,000 European standard population is highest in county Cavan at 212.4/100,000 population, higher than the National rate (1960.8/100,000). In CHO 1 county Donegal has the lowest rate at 826.8/100,000 population.
- All counties in CHO 1 have a lower directly age and gender standardised rate (DSR) of admissions to hospital (including day cases) for drug misuse per 100,000 European standard population in 2013, ranging from county Donegal at 9.2/100,000 population to county Cavan at 41.7/100,000 population, considerably lower than the rate for Ireland (70.4/100,000 population).
- 2.4/1,000 population were admitted to Irish Psychiatric Units and Hospitals for mood (affective) disorders in 2013 in county Sligo, which was highest for counties composing CHO 1 and marginally higher than Nationally (2/1,000 population), compared to 0.8/1,000 population in county Monaghan.
- In county Leitrim 2.5% of people of working age (aged 15-65 years) were unable to work due to illness in 2013 – this was the highest for CHO 1, in addition to being higher than Ireland (1.9%).
- This is combined with county Leitrim having the highest percentage population
    a. in receipt of Disability Benefit for depression and/or anxiety
    b. percentage living alone
    c. percentage living alone aged 65 or over years.
- The rate of suicide and the rate of undetermined injury per 100,000 population is highest in county Monaghan at 17.9/100,000 in 2014. This was higher than the rate for Ireland (11.5/100,000 population)
- In CHO 1 County Monaghan also had the highest percentage
    a. Population aged 15-64 years in receipt of Disability Benefit for mental and behavioral disorders
    b. of the working age population aged 15 years and over in the labour force in "Semi-skilled" and "Unskilled" social classes.

Facts and Health Summary Adapted from The Health Well Chronic Health and Wellbeing Indicators

Key Note: Minimum scores for county in CHO 1 with the lowest score is coloured whilst, maximum scores for county in CHO 1 with the highest score is coloured to aid in identifying range within CHO 1 level.

INDICATOR		IRELAND	CHO 1				
Obesity	Region	Ireland	County Cavan	County Donegal	County Leitrim	County Monaghan	County Sligo
1	Percent eat < 5 fruit & veg RoI 2007	34.4	33.4	33.4	33.4	33.4	33.4
2	Percent inactive RoI 2007	28.4	29.2	29.2	29.2	29.2	29.2
3	Percent high cholesterol RoI 2007	11.8	10	10	10	10	10
4	Percent obese RoI 2007	14.4	15.9	15.9	15.9	15.9	15.9
5	Percent Prev hypertension RoI 2010	12.7	13.2	13.5	14	13.2	14
6	Percent Prev diabetes RoI 2010	3.2	3.4	3.4	3.6	3.3	3.6
7	Percent Prev diabetes RoI 2015	3.5	3.6	3.7	3.8	3.6	3.8
8	Percent Prev diabetes RoI 2020	3.8	3.8	3.9	4.1	3.8	4.1
9	Percent Prev stroke RoI 2010	0.7	0.7	0.7	0.8	0.7	0.8
10	Percent Prev CHD RoI 2010	2.4	2.5	2.6	2.7	2.5	2.7
11	Percent children age 5-12 driven to school, RoI 2011	61.3	61.9	61	53.6	59.5	63
12	Percent children aged 5-12 that walk or cycle to school, RoI 2011	25.8	14.1	10.5	15.1	14.5	16
13	Percent adolescents aged 13-18 that walk or cycle to school, RoI 2011	25.5	12.2	11.7	15	16.3	16.1
14	Percent adolescents aged 13-18 that drive or are driven to school, RoI 2011	41.9	38.1	39.8	42.7	42.7	51.5
15	Sports expend per capita RoI 2014	33.2	6.9	3.8	30.9	4	4.4
16	DSR/ 100,000 adm circulatory RoI 2013	4495.6	5697.4	3959.5	6203.6	4888.2	7413.7
17	Rate/1,000 childrens playground RoI 2013		0.37	0.31	0.53	0.58	0.23

INDICATOR		IRELAND	CHO 1				
Stroke	Region	Ireland	County Cavan	County Donegal	County Leitrim	County Monaghan	County Sligo
18	Percent high BP RoI 2007	12.6	12	12	12	12	12
19	Percent smoke RoI 2007	28.5	26.8	26.8	26.8	26.8	26.8
20	Percent Prev stroke RoI 2015	0.7	0.8	0.8	0.8	0.8	0.8
21	Percent Prev stroke RoI 2020	0.8	0.8	0.8	0.9	0.8	0.9
22	Percent disability, RoI 2011	12.98	11.91	14.05	13.49	11.88	14.14
23	GP per capita, per 100,000 population, RoI 2011	60.1	49.4	59.6	65.8	49.4	65.8
24	DSR/100,000 population CABG RoI 2013	131.6	154.6	138.4	115.1	153.4	127
25	Percent benef circulatory RoI 2014	0.23	0.28	0.25	0.33	0.31	0.26

INDICATOR		IRELAND	CHO 1				
Diabetes	Region	Ireland	County Cavan	County Donegal	County Leitrim	County Monaghan	County Sligo
26	DSR/ 100,000 population emer adm asthma & diab RoI 2013	907.7	1393.4	918.7	937.1	968.6	1308.7

INDICATOR		IRELAND	CHO 1				
Mental Health	Region	Ireland	County Cavan	County Donegal	County Leitrim	County Monaghan	County Sligo
27	Percent trust neighbours RoI 2002	67.8	68	66.7	79.6	76	67.3
28	Percent inactive RoI 2007	28.4	29.2	29.2	29.2	29.2	29.2
29	Percent smoke RoI 2007	28.5	26.8	26.8	26.8	26.8	26.8
30	Percent lack social supp RoI 2007	1.9	1.3	1.3	1.3	1.3	1.3
31	Percent live alone 65+ 2011	27.7	29.8	29	34.1	29.2	29.6
32	Percent Semi & unskilled, RoI 2011	17.2	20.4	20.5	17.9	23.3	18.2
33	Percent live alone, 2011	23.7	24.5	25.7	30.5	23.7	27.6
34	Percent unemployment, RoI 2011	11.8	13.1	15.2	12.2	12.7	10.8
35	Percent benef dep/anxiety RoI 2013	1.09	0.89	0.84	1.12	1.05	1.08
36	Percent benef mental beh RoI 2013	0.03	0.03	0.02	0.01	0.04	0.02
37	DSR/100,000 population adm alcohol RoI 2013	1960.8	2121.4	826.8	916.6	1759.5	991.3
38	DSR/100,000 population adm drug RoI 2013	70.4	41.7	9.2	20.1	29.5	14.1
39	Rate/1,000 population adm psych hosp RoI 2013	2	1.2	1.9	1.7	0.8	2.4
40	Percent illness benefit, RoI 2013	1.9	2.2	1.9	2.5	2	2.2
41	Rate/ 100,000 population suicide & undet intent 2014	11.5	16.2	9.3	9.3	17.9	15.3

Interpret these data cautiously.

Statistical precision

Indicator values are prone to statistical error (the difference between an estimated value and the true value). The statistical error associated with an indicator depends on the population subgroup (e.g. the population of a county or LGD) that it refers to. Such differences in levels of statistical error can distort what we see in maps and charts. They can make some relationships involving indicators and attributes appear "real" (practically meaningful or statistically significant) when they are in fact spurious; other relationships that are "real" can be masked. These differences in statistical error can even distort the shape of plots or the colour patterns we see in maps.

For example,

- Many indicator values estimates are derived from sample surveys, and different sample sizes from different population subgroups will lead to different levels of precision in the indicator values for these subgroups.
- Different population subgroups have different population sizes which means that rate estimates for these subgroups will also have different confidence limits.
- The true value of a percentage or a rate can influence the level of statistical error of any estimate.

Sources

The data contained in this Profile has been extracted from The All-Ireland Health and Wellbeing Dataset, created by the Institute of Public Health in Ireland. The Health and Wellbeing Dataset is based on a set of over 100 health related indicators (forming the All Ireland Health and Wellbeing Dataset (AIHWDS)) that have been collated for every administrative county in the Republic of Ireland and every Local Government District in Northern Ireland. Further information can be found on the Health Well website http://www.thehealthwell.info/community-profiles.

OBESITY

(1) Percentage of people aged 18 years or over who consume less than five portions of fruit or vegetables per day, RoI, 2007. Derived from SLAN 2007. *Date data covers:* 01/01/2007 to 31/12/2007.
(2) Percentage of people aged 18 years or over who are physically inactive, RoI, 2007. Derived from SLAN 2007. *Date data covers:*01/01/2007 to 31/12/2007.
(3) Percentage of people aged 18 years or over who have high cholesterol, RoI 2007. Derived from SLAN. *Date data covers:* 01/01/2007 to 31/12/2007.
(4) Percentage of people aged 18 years or over who are obese, RoI 2007. Derived from SLAN 2007. *Date data covers:* 01/01/2007 to 31/12/2007. When these data are available at local level they will improve comparability of obesity data across the island.
(5) Modelled estimate of the percentage of people aged 18 years or over who have been told by a doctor in the previous 12 months that they have hypertension.

Numerator: INIsPHO 2010. Denominator: CSO population estimates/projections, 2010. The IPH estimated prevalence per cents may be marginally different to estimated prevalence per cents taken directly from the reference study.
(6) Modelled estimate of the percentage of people aged 18 years or over who have ever been told by a doctor that they have diabetes (Type I and Type II).

(7-8) Modelled estimate of the percentage of people aged 18 years or over who have ever been told by a doctor that they have diabetes (Type I and Type II). Numerator: INIsPHO 2015. Denominator: NISRA population estimates/projections, 2015.

(9) Modelled estimate of the percentage of people aged 18 years or over who have ever been told by a doctor that they have had a stroke. Numerator: INIsPHO 2010 Denominator: NISRA population estimates/projections.

(10) Modelled estimate of the percentage of people aged 18 years or over who have been told by a doctor in the previous 12 months that they have angina or have had a heart attack. Numerator: INIsPHO 2010 Denominator: CSO population estimates/projections, 2010 Numerator: INIsPHO 2010 Denominator:

(11) Percentage of children aged 5-12 years driven to school. *Date data covers:* 01/04/2011 to 01/04/2011

(12) Percentage of children aged 5-12 years that walk to school. Numerator: CSO 2011. *Date data covers:* 01/01/2011 to 31/12/2011

(13) Percentage of adolescents aged 13-18 years that walk or cycle to school. CSO 2011. *Date data covers:* 01/04/2011 to 01/04/2013.

(14) Percentage of adolescents aged 13-18 years that drive or are driven to school. CSO 2011.

(15) Local Authority expenditure on Leisure Facilities Operations, Outdoor Leisure Areas Operations, Community Sport and Recreational Development per person, RoI, 2014. Source: Local Authority Budgets 2014 and Department of Environment, Heritage and Local Government 2014.

(16) Directly age and gender standardised rate of admissions (including day cases) to hospital for diseases of the circulatory system per 100,000 European standard population. Source: Healthcare Pricing Office, September 2014. Includes primary and secondary diagnoses. Excludes admissions to private hospitals. *Date data covers:*01/01/2013 to 31/12/2013 Data cells containing 5 or fewer cases in a particular combination of age, sex, and area were not disclosed hence a random value between 1 and 5 was assigned in order to calculate standardised rates.

(17) Number of children's playgrounds directly provided or facilitated by the local authority per 1,000 population. LGMA, 2013. No values are available for RoI.

STROKE

(18) Percentage of people who have high blood pressure, RoI 2007. SLAN 2007. *Date data covers:*01/01/2007 to 31/12/2007.

(19) The percentage of people who currently smoke cigarettes, RoI 2007. SLAN 2007. *Date data covers:*01/01/2007 to 31/12/2007. *Cautionary notes:* The apparent increase in smoking rates between 2002 and 2007, notably in young men (aged 18-29) needs to be treated with caution because this category had been under-represented in respondents interviewed in SLÁN 2002.

(20) Modelled estimate of the percentage of people aged 18 years or over who have been told by a doctor in the previous 12 months that they have had a stroke. INIsPHO 2015. *Date data covers:* 01/01/2015 to 31/12/2015.

(21) Modelled estimate of the percentage of people aged 18 years or over who have been told by a doctor in the previous 12 months that they have had a stroke. INIsPHO 2020. *Date data covers:*01/01/2020 to 31/12/2020.

(22) Percentage of the population who have any of the following long-lasting conditions or difficulties: a) Blindness or a serious vision impairment, b) Deafness or a serous hearing impairment, c) A difficulty with basic physical activities such as walking, climbing stairs, reaching, lifting or carrying, d) An intellectual disability, e) A difficulty with

learning, remembering or concentrating, f) A psychological or emotional condition, g) A difficulty with pain, breathing or any other chronic illness. CSO, 2011. *Date data covers:* 01/01/2011 to 31/12/2011.

(23) Number of General Practitioners per 100,000 people, RoI, 2011. HSE, Primary Care Reimbursement Service 2011. *Date data covers:* 01/01/2011 to 31/12/2011.

(24) Directly age and gender standardised rate of admissions to hospital for coronary artery bypass graft or angioplasty per 100,000 European standard population. Hospital Inpatient Enquiry (HIPE), 2013. *Date data covers:* 01/01/2013 to 31/12/2013. *Cautionary notes:* Includes primary and secondary diagnoses. The crude rate was directly age and gender standardised to the European standard population. Data cells containing 5 or fewer cases in a particular combination of age, sex, and area were not disclosed hence a random value between 1 and 5 was assigned in order to calculate standardised rates. Excludes admissions to private hospitals.

(25) Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for diseases of the circulatory system. Department of Social Protection, 2014. *Date data covers:* 01/01/2014 to 31/12/2014.

DIABETES

(26) Directly age and gender standardised rate of all emergency (i.e. non-elective) admissions to hospital for asthma and diabetes per 100,000 European standard population. Includes primary and secondary diagnoses. Excludes admissions to private hospitals. *Date data covers:* 01/01/2013 to 31/12/2013. *Cautionary notes:* Includes primary and secondary diagnoses.

MENTAL HEALTH

(27) Percentage of people aged 18 years or over who believe that people in their area can be trusted. SLAN, 2002.

(28) Percentage of people aged 18 years or over who are physically inactive. SLAN, 2007.

(29) The percentage of people aged 18 years or over who currently smoke cigarettes. SLAN 2007. *Cautionary notes:* The apparent increase in smoking rates between 2002 and 2007, notably in young men (aged 18-29) needs to be treated with caution because this category had been under-represented in respondents interviewed in SLÁN 2002.

(30) Percentage of people aged 18 years or over experiencing a severe lack of social support. SLAN, 2007.

(31) Percentage of persons aged 65 years and over living alone in private households, 2011. Census 2011. *Date data covers:*10/04/2011 to 10/04/2011.

(32) The percentage of the working age population aged 15 years and over in the labour force in "Semi-skilled" and "Unskilled" social classes as per Census 2011. *Date data covers:* 10/04/2011 to 10/04/2011.

(33) Percentage of households that consist of one person, 2011. CSO, 2011. *Date data covers:* 01/01/2011 to 31/12/2011.

(34) Percentage of the population aged 15 years and over that are unemployed (looking for first regular job or having lost or given up previous job). Census, 2011. *Date data covers:* 01/01/2011 to 31/12/2011.

(35) Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for depression and/or anxiety. Department of Social Protection, 2013 and CSO 2011. *Date data covers:* 01/01/2013 to 31/12/2013.

(36) Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for mental and behavioral disorders. Department of Social Protection, 2013 and CSO 2011. *Date data covers:* 01/01/2013 to 31/12/2013.

(37) Directly age and gender standardised rate of admissions to hospital (including day cases) for alcohol abuse per 100,000 European standard population. Hospital Inpatient Enquiry (HIPE) 2013, Population Census 2011 and Healthcare Pricing Office, September 2014. *Date data covers:* 01/01/2013 to 31/12/2013. *Cautionary notes:* Includes primary and secondary diagnoses. The crude rate was directly age and gender standardised to the European standard population. Data cells containing 5 or fewer cases in a particular combination of age, sex, and area were not disclosed hence a random value between 1 and 5 was assigned in order to calculate standardised rates. Excludes admissions to private hospitals.

(38) Directly age and gender standardised rate of admissions to hospital (including day cases) for drug misuse per 100,000 European standard population, 2013. (Same as point 37 above)

(39) Number of admissions to Irish Psychiatric Units and Hospitals for mood (affective) disorders per 1,000 people, 2013. Activities of the Irish Psychiatric Units and Hospitals, 2013 and CSO population 2011. *Date data covers:* 01/01/2013 to 31/12/2013.

(40) Percentage of people of working age (aged 15-65 years) unable to work due to illness, RoI, 2013. Department of Social Protection 2013 and Census of population 2011. *Date data covers:*01/01/2013 to 31/12/2013.

(41) The rate of suicide and the rate of Undetermined injury per 100,000 population. CSO, 2014. The suicide prevention strategies expressed concern about the accuracy of suicide data. The following factors are likely to affect the accuracy of suicide data: There may be difficulty in determining the intent behind a death and some suicide deaths are likely to be recorded as deaths of undetermined intent. This would underestimate the rate of suicide. Similarly, there may be different practices in different areas in classifying the intent behind a death and some suicide deaths may be classified as deaths of undetermined intent. Again, this would underestimate the rate of suicide. There can be substantial delays in registering suicide deaths due to the time taken to complete inquests so it is advisable to allow a number of years time lag before reporting a particular year's suicide data. This will improve the completeness of the data. Rate based on year of registration. *Date data covers:* 01/01/2014 to 31/12/2014.