Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive

HSE Mid West

Community Healthcare 2016

Limerick, Clare and North Tipperary

Vision

A healthier Ireland with a high quality health service

Mission

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

Values

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

- Care
- Compassion
- Trust
- Learning

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

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

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

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

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

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Introduction

Welcome to the operational plan for HSE Mid West Community Healthcare Organisation (CHO). Community Healthcare is the name we give to the range of Health and Social Care services provided by the HSE outside of the acute hospital system. HSE Mid West is one of nine CHO areas across the Country. CHO areas were designed in 2014 and commenced operation in 2015 replacing the then 17 areas. A key priority for 2016 is to progress the further development of the structures and processes intended to ensure that the CHO area achieves what is intended for the people of the Mid West – *high quality integrated services as close to home as possible.*

Our Services

HSE Mid West provides services to the people of Limerick, Clare and North Tipperary. Our range of responsibilities and services are extensive and are usually described in four Divisions. We are a part of and governed by the HSE at national level. The four Divisions for which we are responsible also operate at national level and the main focus of the CHO area in the Mid West is twofold;

First we must ensure that each Division delivers its services in a specialised way in accordance with national policy, legislation, regulation and plans.

Second we must ensure we integrate the activities of all four Divisions for the local population in a meaningful way where they experience the benefits of joined up services.

Our Health and Wellbeing Division

While many of our services and responses are targeted at those who are unwell or need specialist supports, the HSE has in recent years and, as part of government policy, Healthy Ireland, increased our focus on the well population. Working with a range of national and local supports we are engaged in rebalancing our priorities to not only respond to those with chronic disease but also to prevent it for future generations. Our health and wellbeing activity is increasingly obvious in all of our frontline services.

Our Primary Care Division

Primary Care services include General Practice, front line nursing and therapy professionals, oral health, targeted schemes often referred to as PCRS, palliative care and social inclusion functions. Working across the rural and urban parts of the three Counties these services work in teams serving local communities or specialist services supporting a number of those teams.

Our Mental Health Division

Mental Health services are delivered through Consultant led community teams made up of a number of disciplines. They are supported by specialised services with teams for Children and Adolescents, acute units for adults in Limerick and Ennis and resource supports in suicide prevention. Together with responding to people experiencing severe and disabling mental illness, this Division is also working with other services to promote positive mental health.

Our Social Care Division

Social Care is the overarching name for a wide range of services for people with disabilities and older people. Across nine public residential units in the Mid West (nursing homes) we care for people who no longer are able to live in their own home or who require a short term support to keep them at home. Through our partnership with funded agencies we provide specialist residential care for people with disabilities. The increasing focus of the modern day social care service here in the Mid West and nationally is to support people with disabilities to achieve their full potential living ordinary lives in ordinary places, and to support our older people to maintain independence at home to the greatest extent possible. Our social care ethos is about supporting our fellow citizens to live a life of their choosing to the greatest extent possible.

What Our Plan for 2016 Is About

This plan takes its reference from five key sources all of which can be read in conjunction with this document.

1. The National Service Plan for the HSE 2016.
2. The National Divisional Operational Plans for each of the four Divisions of Health and Wellbeing, Primary Care, Mental Health and Social Care.

This local plan for the Mid West sets out some of the key priorities, actions and information concerning the delivery of Community Healthcare in the Mid West for 2016. The plan is an aid to our staff and teams in guiding their work and is also a source of information for the public to understand some of the key points as to what we do and how we do it. In its attempt to be user friendly it contains high level information in a structured format. If you would like further information or detail on any aspect of the plan you can request same from cho.midwest@hse.ie.

All HSE plans in 2016, including this one, are heavily emphasised by the Corporate Plan published in 2015 and clearly state our ambition for the Health Service in the three years up to and including 2017. We have a vision of a high quality service valued by all with five key goals to realising that vision. Promoting health, providing fair access, fostering a culture for the modern era, engaging our workforce and managing resources effectively are the goals of the HSE and must be central to our plans and actions.

Here in HSE Mid West our Community Healthcare services are characterised by high levels of activity to meet increasing demand, new ways of working to meet the needs of people, responding to challenges some of which cannot always be foreseen and viewing quality and safety as a continuous process of improvement. As the demographic profile of our 380,000 people changes so too do their needs for health and personal social services and this demands of us an ability to adapt and be innovative.

In each of our four Divisions we want to improve quality, strengthen safety, give the greatest access possible and work within the resources available. Through demonstrating our effectiveness and providing evidence of performance we will advocate for continued growth as additional resources become available into the future. HSE Mid West Community Healthcare views itself not only as a service provider, not only as a commissioner of services through our partner organisations but also as an advocate for the people we serve.

Improving Quality and Reforming Service Delivery

Quality and Patient Safety

The HSE places a significant emphasis on the quality of services delivered and on the safety of those who use them. Here in the Mid West we are working to a national quality programme which has been put in place.

Five objectives which underpin quality and patient safety for 2016 are:

- Services must be accessible and responsive to individual patient and service user needs
- Patients and service users are empowered and enabled to interact with the service delivery system
- Health services will put quality of care at the centre of all that they do.
- Focus on safety of patients and service users by implementing the National Clinical Guidelines.
- The focus must be on improvement programmes and accountability for ensuring safe services.

Progress on patient safety, clinical effectiveness and quality improvement continues to enable integrated care and promote services that are appropriate, delivered with the patients and service users at the centre and are based on best clinical practice and integrated care pathways.

Key Quality Priorities in 2016

Leadership and Governance for Quality and Safety

HSE Mid West Community Healthcare will pursue the 10 priorities set out in the National Service Plan summarised as;

- Ensure that authority and accountability for the quality and safety of services.
- Further develop capacity for development of quality and patient safety within the Mid West.
- Ensure compliance with all national standards and regulations as they relate to quality and safety.
- Build capacity and capability for leadership and improvement in quality.
- Under the HSE Accountability Framework measure the performance in relation to quality and safe care..
- Put in place an assurance system.
- Establish positive and effective staff engagement as a keystone of quality improvement.
- Ensure that quality and safety is central by working within the National Framework for Improving Quality.
- Increase the number of Quality Key Performance Indicators (KPIs) developed and used in services.
- The Mid West will build on governance, structures and resources for quality and patient safety in place.

Safe care

HSE Mid West Community Healthcare will pursue the nine priorities set out in the National Service Plan summarised as;

- Promote the reduction of risk to the public, staff and healthcare services.
- Improve monitoring, investigation and learning processes from serious incidents across all service areas.
- Progress the implementation of recommendations from reports on serious incidents across all services.
- Continue to support and commit to National Clinical Guidelines as appropriate to our services.
- Manage, investigate incidents, learn from regulatory inspections, and promote open disclosure policy.
- Strengthen the HSE's regulatory capacity to fulfil responsibilities in the area of medical ionising radiation.
- Continue the implementation of the HCAI / AMR Clinical Programme .
- Ensure a reduction in medication errors.
- Support the national offices to establish a National Independent Review Panel for investigations.

Note : The Review Panel will initially focus on serious incidents that occur in disability services across the HSE and HSE funded services.

Effective care

HSE Mid West Community Healthcare will pursue the four of the five priorities set out in the National Service Plan summarised as;

- Prioritise the safeguarding of service users in residential intellectual disability services.
- Develop capacity to deliver on key national patient safety programmes in primary care, social care, mental health to address internationally recognised causes of harm to people (including HCAI, medication safety, pressure ulcers, falls prevention and nutrition and hydration).
- Implement the NCEC *Standards for Clinical Practice Guidance,* 2015.
- Support development of a national framework for Policies, Procedures, Protocols and Guidelines (PPPGs)

Service User Experience

HSE Mid West Community Healthcare will pursue the five priorities set out in the National Service Plan summarised as;

- Listen to and act on the views, concerns and experiences of care of patients, service users and staff.
- Commence patient experience surveys in primary care and community services.
- Work with a new national person-centred programme which engages, enables and empowers people to be at the centre of service delivery.
- Continue to develop access to advocacy for all patients and service users within the Mid West.
- Continue implementation in the Mid West of the open disclosure policy in all services.

Health Service Reform

Supporting the goals of the *Corporate Plan 2015–2017,* the reform programme for Community Healthcare will drive the delivery of person-centred, integrated care across the Mid West with better outcomes for patients and service users. The model of care which we provide must be fit for purpose and the best that it can be.

Provision of care must be integrated by providing better and easier access to services for the public which are close to where people live. Services are being re-organised to ensure they are delivered in the most appropriate way.

The nine CHO areas including the Mid West are in the process of being further developed under the leadership of the nine Chief Officers. 2016 will see the reorganisation of management and governance structures reporting to the Chief Officers and this will assist in the focus on improved services.

Clinical Strategy and Programmes

Clinical Strategy and Programmes are leading a large scale programme of work to develop a system of integrated care across health and social care services – a major element of health reform in Ireland. This is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in their care, in a way which puts them at the centre of all services.

The **National Clinical Programmes** continue to modernise and improve the way in which specific areas of health and social care services are provided and delivered by designing and guiding the implementation of standardised models of care, clinical guidelines, care pathways and associated strategies through 31 national clinical programmes.

The **Office of Nursing and Midwifery Services** leads and supports the nursing and midwifery professions to deliver safe, high quality person-centred healthcare that enables people to lead healthier and more fulfilled lives. The work is aligned to legislation and health policy.

The **Integrated Care Programmes** continue to progress the establishment, enablement and delivery of five integrated care programmes:

- Patient flow
- Older people
- Prevention and management of chronic disease
- Children
- Maternity care.

All of these to different extent involve the health and personal social services of HSE Mid West Community Healthcare. We are working with these programmes to improve our services.

The **Integrated Care Programme for Patient Flow** will progress a number of priority projects to tackle some of the most pressing patient flow challenges in our health system. While working with and availing of the design and testing of models at national level we in the Mid West together with our colleagues in the UL Hospitals Group have targeted patient flow through facilitated discharges from acute care. In 2015 we targeted in excess of 7,000 facilitated discharges and will build on this work in 2016.

The **Integrated Care Programme for Older People** will address the needs of older people including those with complex requirements through the establishment of a pioneer area. This will implement and evaluate the provision of integrated care services. By acting as a 'test and deploy area' the impact of integrated care can be established in terms of cost, quality and access. This bottom up approach will establish 'what works' best in terms of adoption of an integrated care model at a local level, allowing outcome measures to be evaluated. While waiting further on this programme at national level the HSE Mid West is supporting integrated care approaches to older people through a new initiative at St. John's Hospital involving Community Healthcare staff.

The **Integrated Care Programme for Prevention and Management of Chronic Disease** will facilitate the implementation of integrated care by the phased linking of CHOs and hospital groups in demonstrator projects. These will target the delivery of chronic disease management programmes and incorporating health promotion, illness prevention and self-management.

The **Integrated Care Programme for Children** will be established. It will work with and build on the models of care already developed by the Paediatric and Neonatology National Clinical Programme. It will aim to identify and progress a number of priority projects to integrate community and hospital services to enable children to have a high standard of care at any point in their care journey. In conjunction with UL Hospitals HSE Mid West has increased community paediatric services and focus for 2016 with a particular emphasis on complex paediatric care and support at home.

The **Integrated Care Programme for Maternity Care** will be guided and informed by the recommendations through the review of maternity services and the development of a national maternity strategy. HSE Mid West Community Healthcare will support all improved pathways and initiatives with UL Maternity Hospital.

Financial Plan

Budget 2016 v 2015

The HSE Mid-West Budget for 2016 is €336.4m, which is a €10m or 3.08% increase on 2015 carry over budget. While this increase is welcome and addresses some specific issues, significant financial challenges and risk remain.

The notified allocation by Division for CHO3 is set out below.

Division	Carry forward budget from 2015 €000s	Opening budget 2016 €000s	Increase/(Decrease) €000s	Increase/(Decrease) %
Primary Care	83,649	84,101	452	.54%
Social Care	185,091	194,736	9,645	5.2%
Mental Health	57,592	57,570	-22	(.04%)
TOTAL CHO 3	**326,332**	**336,407**	**10,075**	**3.08%**

Additional Allocation Received.

The €10m additional funding is inclusive of the following -

- Lansdowne Road and other Nationally Negotiated pay agreement. €1.8m
- Full Year Cost of Sleepover Funding. €1.1m
- Full year cost of School leavers. €1.2m
- LRC Recommendation Re – Twilight Costs €1.6m
- Social Care Safeguarding posts (2016). €0.1m
- PCRS Cost Pressures. €0.4m
- Additional Allocation towards the growth in 2015 levels of Home Support (There is also a sanctioned overspend of €1.5m which will be funded by the National Division). €1.5m
- HIQA Cost Pressures. €2.4m

Note: The allocation does not include funding notifications as follows:

- Mid-West share of Emergency Placement Funding.
- €1.1m for Mental Health (2013 & 2014 Development Post funding – this will be allocated as posts are filled during 2016).
- €500k funding for a Supported Living Project
- €100k for Daycare and Independent Living Projects
- €505k for Contract and Subvention FD Funded
- €129k for Suicide Prevention Resource Officers

Savings and Extra Revenue Targets

The allocation is net of value for money and efficiency measures of €1m which have been targeted across all divisions in HSE Mid-West.

Financial Challenge

Despite the additional allocation in 2016, there is significant risk for the HSE Mid-West to delivering a balanced budget. The risk arises due to a combination of demographic factors, emerging demand, regulatory cost pressures and full year effects of 2015 deficits including:

- Full year costs of Disability Emergency Cases (Placements and Home Based Supports costing €4.1m at close of 2015 with a full year impact of €6m) put in place during 2015
- Full year costs of additional Home Support put in place to deal with Accelerated Discharges from the Acute Hospital setting as well as Hospital avoidance measures, after receipt of additional allocations as detailed above (deficit of €3m expected for 2016).
- Full year effect of 2015 pressures in Mental Health (deficit of €2.5m expected for 2016)

Approach to Financial Challenge - Financial Risk Areas

The HSE Mid-West has identified a significant financial challenge in respect of maintaining existing levels of service within the net revenue allocation notified for 2016.

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

- **Governance** – intensify focus on budgetary control through enhanced accountability framework
- **Pay Bill Management -** develop an integrated strategy in respect of recruitment, agency conversion and workforce planning in 2016.
- **Non-Pay** – implement targeted cost-containment programmes for specific high-growth categories
- **Income** – sustain and improve wherever possible the level of income generation achieved in 2015

Notwithstanding the management of a projected deficit, it is critical that this deficit is not grown further and this may include additional controls and waiting times for some services.

SAP Stabilisation Project

The HSE Mid-West has agreed to fully participate in the SAP Stabilisation Project underway for 2016 and which will have a significant impact on how our business is done, particularly in the “Purchase to Pay” process.

Workforce Plan

Introduction

The health sector's workforce is at the core of the delivery of healthcare services working within and across all care settings in communities, hospitals and healthcare offices. The health service will continue 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.

Recruiting and retaining motivated and skilled staff remains paramount for the delivery of health services delivered every day to an increasing and changing demographic population. This challenge is even greater now as the Health Reform Programme requires significant change management, organisation redesign and organisational development support.

Over the last three years, work has been ongoing to develop a robust strategic intent for HR across the wider health system to ensure there is one unified and consistent HR function, embracing statutory and voluntary providers, that will ensure HR has an operating model that is fit for purpose and aligned to the services and evolving new structures. This will 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 services is delivered throughout the health system. Three areas of particular focus in 2016 will be the review of recruitment processes, HR structures and the development of a new development based 'performance management' approach. Performance indicators in relation to these areas will be developed and reported on in 2016.

Staff Engagement

An engaged and motivated workforce delivers better patient outcomes. It is only by listening to the views and experiences of staff that improvements to the health service, as a place to work, can be delivered. The messages from the first staff survey conducted in late 2014 have been identified and will need to be addressed. The next staff survey will be conducted in mid 2016.

Employee engagement is a core and central theme to the People Strategy 2015–2018 with a focus on developing mechanisms for more effective internal communications to support listening and learning across the whole sector, involving staff more in planning and decision-making and enabling them to propose and act on their ideas to improve the quality of care. This includes ensuring staff have the space to discuss their professional and career aspirations with their managers and that these engagements will inform learning and development.

The Workforce Position

Government policy on public service numbers and costs is focused on ensuring that the numbers of people employed are within the pay budgets available. It is estimated that the number of whole time equivalents (WTEs) in place at the end of 2015 will be 3901.51.

There was a particular focus in 2015 on agency and overtime to reduce direct expenditure in this area and free up funding for the investment in essential posts. Workforce management in 2016 will be aligned with the allocated pay envelope, adhering to government policy on public sector numbers, pay and workforce related costs. This will be underpinned by a revised and strengthened Accountability Framework.

Mid West WTE position 2015

CHO / Division	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care	Total
Mental Health	54.65	380.63	150.42	65.57	48.38	76.89	776.54
Primary Care	77	182	151	249	48	67	774
*Social Care - • Disabilities • Older People							 1568 783
Mid West total							**3901.51**

***includes Section 38 agencies in the Mid West**
**** In 2016 further work will be conducted to code staff correctly from historical into Divisions**

Health and Wellbeing National Staffing

Service	Medical / Dental	Nursing and Midwifery	Health and Social Care Professionals	Management / Admin.	General Support Staff	Other Patient and Client Care	Total
Health and Wellbeing	160	42	600	427	12	59	1,300

***Health and Wellbeing staffing is consolidated at National level and the Mid West benefits from the work of this staff.**

Managing the Workforce: Pay and Staff Numbers Strategy

The challenge to the management of the workforce in 2016 is:

- Continuing the transition from an employment control framework driven by moratorium on recruitment to one operating within allocated pay envelopes.
- Operating strictly within allocated pay frameworks, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed.
- Strictly complying with public sector pay arrangements and policy on public sector pay costs.
- Identifying further opportunities for pay savings to allow for re-investment purposes in the health sector workforce.

Pay and Staffing Controls will be enhanced in 2016. HSE Mid West will be required to submit monthly written assurance and exception reports in respect of 'starters and leavers'. Detailed challenges to any upward movements will be instigated with a view to eliminating further employment growth unless specifically funded in additional 2016 monies. There will be a focus on continued agency conversion and the elimination of further unfunded growth. There may be a need for targeted WTE reductions in 2016 to offset the full year costs of 2015 recruitment if operating outside of the allocated pay envelope.

The discretion now being provided in managing the workforce presents potentially greater and different management challenges. Managers will have to focus on stretching pay expenditure to deliver the capacity and capability of their workforce, while strictly adhering to the pay envelope.

The 2013 Incentivised Career Break Scheme of up to three years duration concludes at the start of July 2016 and the re-integration of experienced employees, where they wish to return to public health sector employment, will be managed centrally.

Maximising labour cost reductions, efficiencies, and value for money

There is a need to further reduce the cost and reliance on agency staff. The use of agency staffing and/or overtime will be strictly controlled in 2016 to deliver the necessary savings set out in this plan.

Other tools available to work with managers to ensure the best use of people and budgets may include:

- HR management information systems and payroll.
- The creation of staff banks, based on geographical or service clusters, will continue to be considered.
- Skill-mix changes within and across staff disciplines will continue to ensure most appropriate and cost effective delivery of services. Options around substitution with appropriate scope of practice and oversight will also be considered.
- Review of management structures will continue.

2016 New Service Developments and Other Workforce Additions

This plan provides for specific additional funding in 2016 for new improvements and additional demographic pressures, which is in addition to initial pay allocations. The planning, approval, notification, management, monitoring and filling of these new posts will be in line with the previous process for approved and funded new service developments specified in national service plans. Other workforce additions, not specifically funded, will be implemented only where offset by funding redirection within allocated pay envelopes.

The Lansdowne Road Public Service Stability Agreement 2013–2018

The *Lansdowne Road Agreement*, concluded in May 2015, between government and public sector unions represents an extension of the *Haddington Road Agreement* (HRA) until 2018. A key additional factor in the agreement is a strengthened oversight and governance arrangement for dealing with matters of implementation and interpretation in respect of disputes that may arise.

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

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

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

Workforce Planning

The DoH has committed to establishing a Workforce Planning Group in early 2016 in order to develop an Integrated Strategic Workforce Planning Framework for the health sector. The Group will address the workforce planning and development requirements contained in *Future Health*, *Healthy Ireland* and the HSE's *Corporate Plan 2015–2017*. HR will support the work of this group during 2016 and will operationalise the framework for the health sector in 2017. This will be achieved by supporting the clinical programmes, hospital groups, CHOs and central services to develop the capacity to undertake operational, programme and strategic workforce planning and workforce design. This support will be guided by relevant themes and work streams of the People Strategy 2015–2018, in conjunction with the Systems Reform Group and will involve:

- Supporting the workforce planning work streams in the dependant programmes and structures flowing from the Integrated Strategic Workforce Planning Framework.
- Developing a national workforce planning processes and structure that will support the service units in workforce planning, that will leverage the output of local and regional planning and will identify the workforce planning implications of clinical programmes, national health policy and national employment and migration policy.
- Building capacity to redesign / reconfigure services and the workforce based on best practice, evidence based models of care and anticipated future needs.
- Working with the DoH, Department of Education and Skills (DES), DJEI and other external bodies, to influence the quality and quantity of the future supply, acquisitions and deployment of healthcare workers.
- Assisting in the development and implementation of a relevant and effective resource allocation system.
- Integrating multi-discipline employee development strategies and programmes with workforce planning thereby building the internal supply.
- Providing workforce data intelligence, workforce profiles and research.

Leadership, Education and Development

In the context of a rapidly changed and evolving health service with new structures and integration of statutory and voluntary agencies it will be critical to support new emerging senior teams and to build managerial capacity. Part of this support will include implementation of a Leadership Development Programme (multi-disciplinary) across the management spectrum – with particular focus on line managers. Talent management and career mobility frameworks will be provided, and core and specialist competencies developed. These will be part of a people development planned interventions supported by coaching, mentoring and action learning. There will be a focus on building and enhancing organisational development and change management to support the reform and integration of CHOs and hospital groups. A HSE Graduate Intern Programme will be developed. Support for these initiatives will incorporate succession management and the development of talent pools across the health system. The senior leadership, clinical leadership and team leadership programmes will be adopted for newly formed clinical teams across the system.

There will be a focused emphasis on performance management and engagement at all levels in the health system with frequent manager / staff meetings in developing a culture of teamwork, communication and innovation.
It is planned to continue and expand the number of FETAC Level 5 Modules available to support staff and staff supervisors in 2016. Programmes will continue based on identified service requirements, training needs analysis and individual Personal Development Plans (PDPs) as part of the commitment to supporting employee continuous professional development needs.

Attendance Management

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

European Working Time Directive

The HSE is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for both non-consultant hospital doctors (NCHDs) and staff in the social care sector. Key indicators of performance include:

- A maximum 24 hour shift (in relation to NCHDs only)
- Maximum average 48 hour week
- 30 minute breaks
- 11 hour daily rest / equivalent compensatory rest
- 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest.

Actions to achieve EWTD compliance in relation to NCHDs will be progressed by mental health services. Actions to progress EWTD compliance in relation to social care staff will be progressed by social care services in the agencies we fund.

Code of Conduct for Health and Social Care providers

This Code of Conduct, which sets out employees' and managers' responsibilities in relation to achieving an optimal safety culture, governance and performance of the organisation, was approved and endorsed by the Minister in March 2015. The HSE will implement the Code in 2016.

The People Strategy is designed to support the workforce in the pursuit of safer and better healthcare and the implementation of the Code is integral to that.

Occupational Safety and Health (OSH) at Work

In 2016 safer workplaces will be created by reviewing and revising the Corporate Safety Statement, developing key performance indicators (KPIs) in Health and Safety Management and Performance, launching a new statutory occupational safety and health training policy, and developing and commencing a national proactive audit and inspection programme. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established.

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

The Accountability Framework 2016

Introduction

The HSE is the statutory body with responsibility for the delivery of health and personal social services within the resources allocated to it by the Minister. In discharging its public accountabilities, the HSE has in place a Governance Framework covering corporate, clinical and financial governance. While the HSE's primary accountability is to the Minister for Health, it also has a range of other accountability obligations to the Oireachtas, Oireachtas Committees and to its Regulators.

The HSE regularly reviews its Governance arrangements and in the context of the new health service structures currently being implemented through the 7 Hospital Groups and 9 Community Healthcare Organisations (CHOs), the HSE is further strengthening its **Accountability Framework** to bring greater clarity in relation to accountability obligations at each level of the organisation.

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

The introduction of an Accountability Framework as part of the HSE's overall governance arrangements is an important development. The key components of the Performance Accountability Framework 2016 are as follows:

- Strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group CEOs and the CHO Chief Officers.
- Formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers.
- A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance.
- The continuation of the national level management arrangements for the CHO Chief Officers
- The continuation of the **National Performance Oversight Group** with delegated authority from the Director General to serve as a key accountability mechanism for the Health Service and to support the Director General and the Directorate in fulfilling their accountability responsibilities.
- Accountability arrangements will be put in place in 2016 between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Operational Business Plans.

Introduction Accountability and Planned Changes to the Framework in 2016

The HSE developed and implemented an Accountability Framework in 2015 in line with the Ministers request. In the second half of 2015 a review of the operation, effectiveness and application of the Accountability Framework was commissioned and has been concluded. The learning from this and recommendations arising will be taken on board during 2016 as appropriate.

Areas for development and improvement during 2016 include:

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

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

Introduction to the Accountability Arrangements

The **Accountability Framework 2016** is described in full in the National Service Plan 2016.
The key components of the Accountability Framework are:

Section 1: Accountability Levels

In relation to Social Care, the Accountability Framework outlines accountability arrangements between the National Director of Social Care to the Director General, and in turn, accountability arrangements between each CHO Chief Officer and the National Director for Social Care. Relevant Service Managers and the CEOs of Section 38 and Section 39 agencies are accountable to the CHO Chief Officers.

Section 2: Accountability Suite (Plans, Agreements and Reports)

There are a number of documents that form the basis of the Accountability Framework. The **Corporate Plan 2015-2017** is the 3 year strategic Plan for the Health Service. The **National Service Plan** sets out prospectively the performance commitments of the HSE. It describes the type and volume of services which will be provided within the funding provided by Government. This Plan serves as the Contract between the HSE and the Minister for Health, against which the performance of the HSE is measured. **Operational Plans** are prepared for each of the HSE's service Divisions. These detailed plans, together with the Divisional component of the **National Service Plan** are the basis against which the performance of each National Director and their Division are measured and reported. A **CHO** Plan is produced for each of the nine CHO areas outlining details of the performance commitments of each Community Healthcare Organisation in relation to Social Care, Primary Care, Health and Wellbeing and Mental Health. A National **Performance Report** is produced on a monthly basis to retrospectively account for delivery of services is provided to the Minister for Health and subsequently published. The Division of Social Care sets out its performance against its National Service Plan commitments in this report. An **Annual Report** is also produced which having been submitted to the Minister for Health is laid before the Houses of the Oireachtas.

A key feature of the Accountability Framework is the formal **Performance Agreements**. They will be updated to reflect the 2016 National Service Plan. These Agreements will be in place at two levels.

- The first level will be the **National Director Performance Agreement** between the Director General and the National Director for Social Care.
- The second level will be the **CHO Chief Officer Performance Agreement** which will be a single performance agreement (covering all community service Divisions) between the four National Directors for Social Care, Primary Care, Mental Health and Health and Wellbeing and each of the nine CHO Chief Officers.

Performance Agreements at each level, while linked to specific Divisions and service organisations, will also set out expectations in relation to integration priorities and cross boundary working.

The National Director for Social Care will be accountable for the delivery of the Divisional component of the National Service Plan. This will be reflected in the Performance Agreement. The Performance Agreement will in addition focus on a number of key priorities contained in the Service Plan and Operational Plan. These priorities will be captured in a **Balanced Score Card** for older persons services and a Balanced Score Card for disability services (see appendix 2) which will ensure accountability for the four dimensions of **Access** to services, the **Quality and Safety** of those services, doing this within the **Financial resources** available and by effectively harnessing the commitment and expertise of its overall **Workforce**. The Balanced Score Cards set out both quantitative and qualitative measures.

The Agreement will also set out the core performance expectations, accountability arrangements and escalation, support and intervention measures that will be put in place. A consistent approach to these arrangements will continue during 2016 at each accountability level.

CHO Plans will continue to be the basis against which the performance of each individual service is measured and reported on by the CHO Chief Officer. Each CHO Chief Officer will continue to hold a formal monthly performance management process with their next line of managers. It is expected that any deviations from planned performance will be addressed at this level in advance of the CHO Performance Management meetings with the National Directors.

The HSE provides funding of more than €3 Billion annually to the non statutory sector to provide a range of health and personal social services. **Service Arrangements and Grant Aid Agreements** will continue to be the contractual mechanism governing the relationship between the HSE and each Section 38 and Section 39 Agency. Work will be undertaken during 2016 to streamline the Service Arrangement and Grant Agreement process with a particular focus on reducing the requirement for multiple agreements for single national agencies.

In 2016, the Social Care Division will strengthen the management of Service Arrangements. There will be a named manager responsible for managing the contractual relationship with each individual agency. This person will be responsible for overseeing the negotiation of the Service Arrangements or Grant Aid Agreements including specific service specification, financial and quality schedules etc. They are also responsible for monitoring the performance and financial management of the specified agreement. Social Care services will develop a strong national capability to ensure effective governance and accountability in respect of S38 and S39 Agencies. Part 1s have been signed from 2015 to 2018 and it is planned that all part 2's will be signed by the 29th of February 2016. The breakdown of number of SLAs per CHO is outlined on page 66 for disability services, and on page 80 for older persons services.

Section 3: Accountability Processes

National Directors will continue to be directly accountable to the Director General for their performance and that of their Divisions. The **Directorate-Leadership Team** will be the primary round table meeting to discuss the National Performance Report. A key feature of the HSE Accountability Framework is the continuation of the **National Performance Oversight Group** which is the principal performance accountability mechanism in the HSE. The main outputs from this Group are:

- Scrutiny of the Monthly **National Performance Report** for submission to the Director General
- A formal **Escalation Report** in relation to serious performance issues to the Director General by the Deputy Director General which is published as part of the monthly Performance Report.
- The National Directors for Clinical Strategy and Programmes and Quality Improvement may be requested to attend the meetings of the NPOG where required.
- Other National Directors, personnel may attend as required to deal with specific performance related issues.

The monthly Performance Management processes between the Director General and the National Director for Social Care and between the National Director for Social Care and CHO Chief Officers will be further strengthened in 2016.

- The **Directorate-Leadership Team** will be the primary round table meeting to discuss the National Performance Report.
- The National Directors for Clinical Strategy and Programmes and Quality Improvement may be requested to attend the meetings of the NPOG where required.
- Other National Directors, personnel may attend as required to deal with specific performance related issues.

The Deputy Director General will, on the basis of the Performance Report, report on overall health service performance to the Directorate. The Directorate will then formally consider the Performance Report before its approval and submission to the Minister.

A **post National Performance Oversight Group escalation meeting** with the Director General may be requested by the Deputy DG as Chair of the Group. Depending on the performance issue being escalated, the Chair may be accompanied at this meeting by the Chief Financial Officer, the National Director for Quality Assurance and Verification and other National Directors as required.

Section 4: Escalation and Intervention Framework 2016

One of the most important elements of the HSE's strengthened accountability arrangements is a requirement that Managers at each level ensure that any issues of underperformance are identified and addressed at the level where they occur. Where there are issues of persistent underperformance in any of the quadrants of the Balanced Score Card, the HSE will implement an enhanced **Escalation and Intervention Framework** and process as part of its Accountability Framework. The Escalation and Intervention Framework, detailed in the National Service Plan 2016 includes the:

- Responsibilities at each level for performance and escalation.
- The thresholds and tolerances for underperforming services at each level.
- The type of supports, interventions and sanctions to be taken at each level of escalation.

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 or **departs** from what is considered **normal practice**. Escalation can be described as the increased and intensified application of focus and scrutiny on a particular area of underperformance in order to improve performance.

The Escalation Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels. It is recognised that underperformance may be minor to severe and may be temporary or persistent. Any formal designation of service underperformance will recognise these conditions. The National Director for Social Care will be required therefore as part of the enhanced Accountability Framework 2016 to agree an overall set of thresholds and 'tolerance levels' against which underperformance issues will need to be escalated to a number of different levels.

An issue that requires escalation can start in any part of the organisation and this process ensures that Service Managers, Chief Officers of Community Healthcare Organisations and National Director for Social Care provide assurance or escalate issues in accordance with the processes set out in this document. Where escalation occurs, the accountability arrangements in place will require the relevant senior manager to ensure that appropriate interventions are commissioned and implemented.

The **4 point Escalation Framework** developed by the National Performance Oversight Group outlines escalation thresholds and actions to be taken from Level 1 (yellow) to Level 4 (black) which will be used to escalate issues and incidents as required.

- **Level 1 (Yellow)** is at Chief Officer CHO level
- **Level 2 (Amber)** is at National Director for Social Care level
- **Level 3 (Red)** is at National Performance Oversight Group level
- **Level 4 (Black)** is at Director General Level.

The Executive Management Committee (EMC) for Community HealthCare, comprising the four National Directors (i.e. Primary Care, Social Care, Mental Health, Health and Wellbeing) established in 2015 will continue in its current form in 2016. During 2015 the National Director for Social Care was appointed by the Director General to Chair the Committee. These arrangements will remain in place in 2016 and be updated as relevant.
It is at this Forum that each CHO Chief Officer is held to account and the Committee is expected to oversee community services performance in a coordinated way. Individual National Directors and their teams will continue to have ongoing interactions with the CHO Chief Officers and their teams in the normal course of the business of each Division. In this context National Directors will continue to hold their Divisional meetings with each CHO in discharging their delegated accountability.
During 2015 each of the National Directors for Community Services set out in writing the formal Performance Management Arrangements in place for their Division and in relation to their interactions with the CHOs. These were coordinated by the Chair of the Community Services Executive Committee and agreed with the Director General, together with their Performance Agreements. These arrangements will remain in place for 2016 and be updated as relevant.
CHO Chief Officers will continue to have a single reporting relationship to the Chair of the Executive Committee who is their line manager and to whom they will be accountable for the delivery of all services in their areas.

Health & Wellbeing

Health and Wellbeing Priorities 2016

Improving the health and wellbeing of the people in the Mid West as part of Ireland's population is a Government priority and is one of four pillars of healthcare reform. The implementation of the HSE's *HI Implementation Plan* is key to the creation of a more sustainable health and social care service and to the rebalancing of health priorities towards chronic disease prevention and population health improvement.

The HSE's *HI Implementation Plan* has identified three clear strategic priorities for action, because in one way or another, every part of the health service is engaged in improving health and wellbeing. These will be progressed in 2016 with a sector-wide focus on:

System Reform	Ensuring that we deliver the significant reforms which are underway to support a better health system
Reducing Chronic Disease	The biggest risk to our population's health and our services
Staff Health and Wellbeing	Ensuring we have a resilient and healthy workforce

The appointment of a Head of Health and Wellbeing to the Senior Management of HSE Mid West in 2016 will be a significant enabler to the translation of the goals and actions set out in the *HI Implementation Plan* within communities. A range of other critical developments and reforms will be delivered in 2016. They include:

Corporate Goal	Priority	Action
	**Healthy Ireland**	• Support the development and implementation of CHO Healthy Ireland Plans. • The continued support for the development of care pathways for key chronic conditions.
	Tobacco Free Ireland	• Maintain and strengthen the implementation of the HSE Tobacco Free Campus Policy. • We will build capacity amongst frontline workers to support smokers to quit – Brief Intervention. (75 Staff Target 2016)
	Healthy Eating and Active Living	• Increase opportunities for physical activity in partnership with other organisations such as the expansion of 'park run' with a focus on disadvantages areas and young people. • We will train our staff to promote healthy eating for children and their families.
	Deliver and Expand Screening programmes	• The continued, phased implementation of the Breast Check age extension programme to women aged 65 to 69 within our National Screening Service.
	Immunisation Programmes	• Within the Child Health area, the augmentation of the current Primary Childhood Immunisation (PCI) schedule to address agreed public health priorities. • Implement the recommendations from the review of models of delivery of immunisation services. • Improve immunisation uptake rates. • Implement changes to the Primary Childhood Immunisation and Schools Programmes. • Improve Influenza update rates amongst vulnerable groups and healthcare workers.

Corporate Goal	Priority	Action
	**Chronic Illness**	• "Making Every Contact Count" – We will use every opportunity to create awareness of risk factors so as to reduce chronic illness.
	Self-Care	• We will work within a new National Framework to support people in the management of their own care and health.
	Healthy Childhood	• We will pursue all child health priorities in screening, immunisation and early intervention. • Support the phased implementation of the action plan for breastfeeding 2015-2020.
	Alcohol	• Develop a three year alcohol implementation plan in conjunction with the National Office. • Through our Regional Drugs and Alcohol Forum we will promote all initiatives to reduce health related harm from alcohol.
	**Protecting the Population**	• Provide responses and increase capacity to address public health incidents including outbreaks of infectious disease, chemical, radiation and environmental incidents.
	Knowledge Management	• Increase the number of formal research partnerships to build a larger, cross sectoral agenda for health and wellbeing research. • Progress the transition of library services to the Health and Wellbeing Division to establish a unified national library structure.
	Emergency Management	• Review of the governance of the National Emergency Management Function.
	**Culture**	• Embed health and wellbeing indicators within HSE reform programmes and projects. • Involve people in the development of programmes and initiatives to improve health and wellbeing.
	**Workforce**	• Develop and implement a healthy workplace policy and initiatives to support and encourage staff to look after their own health and wellbeing building on work this year such as calorie posting. • Strengthen health and wellbeing management and capacity with CHO Mid West. • Provide training and support to staff to embed the concept of 'every contact counts'.
	**Resources**	• Progress phase 1 of the systems lifecycle(design, data migration, planning) in preparation for the National Child Health and Immunisation Information System (NICIS) implementation. • Increase the proportion of patients utilising self-management supports.

The *HI Implementation Plan* also presents six themes which the HSE has prioritised for action to reduce the burden of chronic disease and improve the health and well being of our staff. Many actions from the plan are outlined in this document, with a focus on delivery in 2016. These will be taken forward through the continued work of national policy priority programmes in areas such as Tobacco Free Ireland, Healthy Eating and Active Living (HEAL), Healthy Childhood Programme, Alcohol , Wellbeing and Mental Health, Positive Ageing and Sexual Health. In 2016 HSE Mid West will develop and commence the implementation of *Healthy Ireland in the Health Services* at local level for Limerick Clare and North Tipperary.

Health and Wellbeing and the Clinical and Integrated Care Programmes

The provision of care across the spectrum of primary, community, pre-hospital and hospital services should be person-centred and coordinated. HSE Mid West and the UL Hospitals Group will continue to expand on our 2015 initiatives to provide better, easier access to high quality services which are close to where people live and are delivered in a joined up way, placing their needs at its core. It is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in our care.

Health Inequalities

Addressing the wider causes of ill-health and reducing inequalities requires the collective efforts of whole of government and whole of society. Much of the focus of the *Healthy Ireland in the Health Services Implementation Plan* centres on the actions which are likely to be most effective in reducing health inequalities, and thereby giving us the greatest opportunity to narrow the gap and increase population health and wellbeing for all. These include, inter alia, early child development positive ageing; tackling causes of chronic diseases including tobacco, alcohol consumption, poor diet and lack of exercise. The Health Services' operations and services can directly shape and influence this through its day to day work and help achieve greater health equity. It also has an important role to play in advocating for the implementation of a broader range of actions in the wider Irish social, economic and regulatory environment.

HSE Mid West is promoting this through our collaborative work on the Local Community Development Committees (LCDC) and Children and Young People's Services Committees (CYPSC). In 2016 we will with the Limerick Local Authority pursue a Healthy Limerick model supported by the LCDC. As we learn from this we aim to expand the model to Clare and North Tipperary.

Supporting Service Delivery

Health and Wellbeing is of critical importance in all aspects of the work of HSE Mid West Community Healthcare. It is not simply a visible operation in its own right but cuts across all operational services in primary care, mental health and social care. All HSE Mid West services will be required to *HI* proof their work, plans and initiatives.

Our Accountability

Throughout the year we will be engaged with the National Health and Wellbeing Division and a central focus of those discussions will be our progress in the Mid West measured against the priorities and actions of the National Service Plan. This process is guided through the use of a balance scorecard focused on key metrics. The balance scorecard for Health and Wellbeing is set out in the appendices. If you would like to know more detail about our Health and Wellbeing priorities and actions please send your query to cho.midwest@hse.ie.

Primary Care

Primary Care Priorities 2016

2016 will be another important year in the ongoing reform of the HSE with continued focus on programmes of work to bring about strategic reform of the health services. A formal charter that lists out these projects for the Primary Care Division has been developed with the System Reform Group and agreed with the leadership team. In 2016 HSE Mid West in conjunction with the National Division will be progressing key projects within that charter. Infrastructural changes and service improvements to support safe patient care and the development of quality services are included in the Charter. The following are some of the key reform programmes for Primary Care in 2016:

- GP/GMS Contract(s) review
- Community Referral and Patient Management System procurement
- Implementation of prioritised chronic disease management programmes
- Individual Health Identifier implementation
- Direct access to diagnostics for GPs
- Roll out of minor surgery in general practice
- PCRS – Clinical Advisory Group recommendations and online medical card processing
- Quality Information Management System procurement
- CIT/OPAT System – Portal developments and infrastructural deployment.

Children First

The Children First implementation plan sets out key actions to ensure compliance with both the Children First legislation and national policy. Under legislation, the HSE and funded organisations providing services to children and young people will be required to undertake an assessment of risk and to use this risk assessment to develop and publish a Child Safeguarding Statement. The Safeguarding Statement will also outline how staff/volunteers will be provided with information to identify abuse which children may experience outside of the organisation, and what they should do with concerns about child safety.

In 2016, HSE Mid West will development a Children First implementation plan for all local health services with support from the Children First National Office; and the delivery of a suite of Children First training programmes for HSE staff and HSE funded organisations. Led by Primary Care this is a priority for all HSE Mid West staff.

Supporting Service Delivery

Primary Care is central to the delivery and improvement of our health service. All HSE Mid West primary care services will support and be supported by other delivery systems to achieve improved access and better outcomes for the people of Limerick, Clare and North Tipperary. Building on existing work we will in the Mid West further progress the intention of the Community Healthcare structure and will re-model our resources to;

- Have one dedicated senior manager (Head of Service – Primary Care) across the three Counties.
- Support our own staff and GPs working in teams by bringing those teams together in mapped networks to enhance delivery of service to people in their own communities.
- Repeat the 2015 performance of facilitating the discharge of people from acute hospitals by targeting our Primary Care and Social Care – 7,000 targeted discharges in 2015.
- Prioritise our Community Intervention Team and Out of Hours GP Services for hospital avoidance and timely discharge.
- Consolidate our primary care and social inclusion service improvements achieved to date for marginalised communities to reduce health inequalities.
- Continue to integrate our palliative care services with all other health services.

In addition, combined approaches with the mental health and social care divisions will facilitate:

- Improved access to primary care psychology and counselling with targeted developments in youth mental health at Limerick Youth Service and a new Limerick based Jigsaw project.
- Improved access to primary care speech and language therapy services with a sustained focus on waiting time reductions as demand for the service continues to increase.

Funding

The Mid West Primary Care Division 2016 funded position is as follows;

Mid West	Pay €m	Non Pay €m	Gross €m	Income €m	Net Budget €m
Primary Care	36.2	17.9	54.1	-1.5	52.6
Social Inclusion	1.9	6.4	8.3	-.2	8.1
Palliative Care	.0	11.6	11.6	.0	11.6
Core Services	**38.1**	**35.9**	**74.0**	**-1.7**	**72.3**
Local DLS	0	11.7	11.7	.0	11.7
Total	**38.1**	**47.7**	**85.7**	**-1.7**	**84.0**

Additional Funding

The Mid West also receives important financial input from the services and schemes (GMS) operated nationally through (PCRS). In this regard we share in €2,417m for a range of key services and items including GP Fees, Drug Refund, Pharmacy, Dental Treatment and a range of targeted schemes and supports for specific groups such as methadone treatment.

Some Key Actions – 2016

The National Primary Care Division has set a number of targets and priorities in 2016, all of which are aligned to the 5 Goals of the HSE Corporate Plan. HSE Mid West will work with the National Division to pursue these objectives. Some (not exhaustive) of the key actions we will be focused on are as follows.

If you would like a complete copy of the National Priorities and Actions for Primary Care please contact cho.midwest@hse.ie.

Corporate Goal	Priority	Action
	**Child Health** We will increase the percentage of children who receive vaccines in line with national targets	• % of children at 24 months who have received the MMR vaccine - target 95%. • % of children at 12 months who have received the 6-in-1 vaccine - target 95% • % of children at 24 months 3rd dose received on Men C vaccine - target 95% • % of first year girls who have received third dose of HPV vaccine - target 80% • % of 65 year olds and older will have received influenza vaccine - target 75%
	Healthcare Associated Infection (HCAI)	• Continue to implement hand hygiene guidelines in Mid West primary care services. • Participate in the national HALT study in 2016 (survey of long term care facilities). • Target out of hours service to improve antimicrobial stewardship and patient education on antibiotic use.
	**Quality Improvement** We will work with the National Division to achieve its aim to introduce three quality improvement initiatives in each of the areas of addiction, homelessness and palliative care.	• For 2016 the Mid West has targeted this national priority at local level in the HSE aspect of Homeless services.
	Pressure Ulcers to Zero Collaborative	• Participate in Nationally Approved training for Primary Care staff on the management and prevention of pressure ulcers
	GP Access to X Ray In addition to National actions aimed at improving access to diagnostics which we will fully avail of we will;	• In the Mid West advance GP access to certain films by use of our facility at St Camillus Hospital Limerick in conjunction with UHL Radiology Department.
	Primary Care Speech and Language Therapy	• In the Mid West we have self-selected to be part of the review of this therapy within primary care to be undertaken by the National Division. • We will aggressively pursue all options to reduce waiting lists in speech and language therapy.

Corporate Goal	Priority	Action
	**Oral Health**	• We will engage with all National initiatives to improve access to and quality of oral health services both in dentistry and orthodontics.
	Integrated Care Programmes	• We will ensure local benefit from the ongoing progress at National level in aspects of integrated care (all five programmes) with a Mid West 2016 focus particularly on Older Persons and Chronic Disease (specifically diabetes).
	Primary Care Reimbursement Service (PCRS) Extend the on line medical card application system.	• HSE Mid West in conjunction with PCRS will trial in Limerick a new system to assist people with difficulty in IT applications. A special package supported by staff will allow for a person to come to an office and have their application checked and uploaded directly into the PCRS system – this is a customer friendly initiative.
	Social Inclusion The new heads of service in Mental Health, Primary Care, Social Care, Health and Wellbeing will work with social inclusion staff to map and document the extent of social inclusion in the HSE Mid West with a particular focus on emerging trends and responses.	• ***Addiction*** Our addiction services will work with the national programmes to further improve services in line with the National Drug Strategy with a focus on improved access, expanding integrated care for dependent drug users, rehabilitation options and promoting the National Rehabilitation Framework as a multi sectoral priority. • ***Homelessness*** We will in the Mid West continue to build on our strong health related focus in the multi agency approach to homelessness. We will focus particularly on a care and case management approach to those who experience homelessness. • ***Access*** Access to Primary Care services for those who are homeless is a continued key priority. • ***Traveller and Roma Health*** Supporting Traveller Healthcare Workers and targeting chronic disease particularly Diabetes and Heart Disease will be a key focus.

Corporate Goal	Priority	Action
	**Social Inclusion (contd.)** The new heads of service in Mental Health, Primary Care, Social Care, Health and Wellbeing will work with social inclusion staff to map and document the extent of social inclusion in the HSE Mid West with a particular focus on emerging trends and responses.	• ***Domestic Sexual and Gender based violence*** Implement specific health related recommendations of the Action Plan on Women, Peace and Security with a focus on the HSE part to strengthen outreach to women and girls in Ireland who have been affected by conflict. • ***TUSLA*** We will continue to collaborate with TUSLA the Child and Family Agency to with particular reference to the revised strategy 2015 – 2020. • ***Intercultural Health*** We will continue our plans and actions to address the Health needs of people arriving in the Mid West under the Refugee Resettlement Programme.
	Palliative Care	• We will strengthen the very extensive Mid West service provision through the implementation of the National Standards for Safer Better Health Care. We will continue to work with the National Division to further the requirements and responses to children requiring Palliative Care. People in the Mid West who have a Palliative diagnosis will be prioritised in respect of access to services and supports which facilitate them in their wishes to the greatest extent possible.
	**Services in the Primary Care Division**	• We will in the Mid West participate in the National approach to capturing the views of the public on how they experience our services. • Quality and Safety actions have been strengthened in 2015 and will be further improved to ensure we promote quality, strengthen safety, identify incidents and learn from them. • We will continue our focus on GP training, GP recruitment and retention. The Mid West will work towards local practical solutions to mitigate the increasing risk to GP presence in isolated areas

Corporate Goal	Priority	Action
	**Quality and Safety**	• Establish the Primary Care Quality and Safety Committee. • Implement the National Framework for Improving Quality in the primary care setting. • Support a quality improvement and enablement project involving training, awareness and advice.
	Promoting Safe Services	• Ensure learning is shared on incidents through workshops during the year. • Implement effective complaints management systems in the Ombudsman's Report *Learning to get Better*.
	National Standards for Safer better Healthcare	• HSE Mid West will continue implementing the National Standards for Safer Better Health Care with a specific focus on addiction and homeless standards
	Patient Charter for Specialist Palliative Care	• Develop and communicate the charter in partnership with relevant stakeholders
	**Implement Children First**	• Ensure that all new primary care staff receive information on the HSE Child Protection and Welfare Policy as part of their induction process
	Public Health Nursing	• Implement a Service Improvement Framework for Public Health Nursing/collaborative project between Office of the Nursing and Midwifery Services Director and Primary Care Division.
	Social Inclusion	• Review intercultural health training. • Link with services on the provision of training for staff dealing with asylum seekers and refugees.

Corporate Goal	Priority	Action
	**Palliative Care**	• Identify three exemplar sites to facilitate the development of nurse prescribers
	**Primary Care Quality and Safety**	• Quality and Safety Dashboard: Further develop the Primary Care Quality dashboard to provide one mechanism for providing assurance and measuring quality and safety. The dashboard will complement the National Quality Scorecard in the NSP.

Our Accountability

Throughout the year we will be engaged with the National Primary Care Division and a central focus of those discussions will be our progress in the Mid West measured against the priorities and actions of the National Service Plan. This process is guided through the use of a balance scorecard focused on key metrics. The balance scorecard for Primary Care is set out in the appendices. If you would like to know more detail about our Primary Care priorities and actions please send your query to cho.midwest@hse.ie.

Mental Health

Mental Health Priorities 2016

Following the HSE Service Plan 2016 and the Mental Health Division Operational Plan 2016, this plan sets out the framework and actions that the Mid West Mental Health Services will put in place over the course of the year. These actions will deliver on the corporate goals and, specifically, the mental health service vision, mission and priorities.

The modern mental health service, integrated with other areas of the wider health service, extends from promoting positive mental health and suicide prevention through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness.

The ten-year national policy, the *Report of the Expert Group on Mental Health Policy - A Vision for Change* (2006) and any successor policy will continue to inform the roadmap, charting the way forward for the mental health service.

Connecting for Life 2015–2020 is the new national strategy to reduce suicide and sets out a vision of an Ireland where fewer lives are lost through suicide and where communities and individuals are empowered to improve their mental health and wellbeing. This vision will be achieved through the adoption of a number of goals. Each local Mental Health Service will develop a Multi-Agency Action Plan to ensure implementation of *Connecting for Life* 2015–2020 relevant to the Local Area.

We share the national vision for mental health services to support the population of Limerick, Clare and North Tipperary to achieve their optimal mental health through the following key priorities:

- Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services;
- Design integrated, evidence based and recovery focussed Mental Health Services;
- Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements;
- Promote the mental health of our population in collaboration with other services and agencies including reducing loss of life by suicide;
- Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

We are already working towards this vision in a system of continuous improvements and want to build on our key achievements in the Mid West in 2015 which include the following.

- St Joseph's Limerick was the last institution of the historical era in the Mid West to close when the remaining six residents of the Aurora Ward were relocated. This is a milestone achievement in the modernisation of mental health services.
- Completed phase 3 (final Phase) of the Redevelopment project in the Acute Psychiatric Unit in Limerick
- Tobacco Free Campus Policy implemented in all sites in HSE Mid West Mental Health Services. Difficulties were experienced with the introduction of this policy and ongoing auditing and monitoring is in place.
- Following the introduction of the Judgement Support Framework by the Mental Health Commission in July 2015, all four approved centres in the Mid West rolled out the new framework. All four approved centres were inspected in the latter part of 2015 under this new Judgment Support Framework. The condition attached to 5B, the Acute Psychiatric Unit in Limerick, was revoked due to the improvement in care planning.

Funding

Spend and Budget								
CHO	2014 Actual Net Spend	2015 Projected Spend - Ongoing Services	2015 Minor Works - Once Off	2015 Non Minor Works - Once Off	2015 Projected Total Spend	2016 Opening Budget	2013 & 2014 Dev Posts to start in 2016	2016 Closing Budget
Mid-West	56,146,569	58,803,321	1,021,470	245,000	60,069,791	57,570,141	1,105,913	58,676,054

Services Provided

Service	No. Provided	Service	No. Provided
General Adult		**Psychiatry of Old Age**	
No. of Adult Acute In Patient Beds	89 (currently operating between 79 and 84) for the duration of the Redevelopment Project in the Acute Psychiatric Unit, Limerick which is due for completion /Full operation in February 2016	POA Acute Inpatient Beds	5 (designated in Acute unit 5B) 5 (designated in APU Ennis, Clare)
No. of Community Mental Health Headquarters	11	Number of Day Hospitals	0
No. of Community Mental Health Teams	13	No. of Community Mental Health Teams	4*
Number of Day Centres	11	Number of Day Centres	0
No, of High Support Community Residences	9		
No. of Low and Medium support Community Residences	16	**Specialist Mental Health Services**	
		No. of Rehab and Recovery Teams	2
CAMHS		No. of Liaison Psychiatry Teams	1
Number of In Patient Beds	0	No. of MHID Teams	0**
No. of Day Hospitals	0	*Other*	
No. of Community Mental Health Teams	5		Forensic in reach to Limerick Prison

Some key Actions – 2016

The National Mental Health Division has set a number of targets and priorities for 2016, all of which are aligned to the goals of the HSE Corporate Plan. HSE Mid West will work with the National Division to pursue these objectives. Some (not exhaustive) of the key actions we will be focused on are as follows. If you would like a complete copy of the National Priorities and Actions for Mental Health please contact cho.midwest@hse.ie

Corporate Goal	Priority	Action
	**Promote Mental Health**	• Promote the mental health of our population in collaboration with other services and agencies including reducing loss of life by suicide. • Develop a local CHO suicide prevention interagency action plan
	**Services**	• Design Integrated, evidence based and recovery focussed mental health services. • Deliver timely, clinically effective and standardised safe Mental Health service in adherence to statutory requirements. • Develop mental health intellectual disability specialist teams. • Focus on the increase of rehab and forensic capacity to support general adult psychiatry. • Psychiatry of Later Life – develop CHO specialist mental health dementia unit in Clare. • Further develop Community Mental Health Teams and Psychiatry of Later Life. • Child and Adolescent Mental Health Services (CAMHS) – improve capacity of teams to 75% of their recommended multi-disciplinary numbers.
	**Service User Engagement**	• Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services
	**Staff**	• Enable the provision of mental health services by highly trained and engaged staff.
	**Infrastructure**	• Enable the provision of mental health services by fit for purpose infrastructure

In addition, key further deliverables / priorities in 2016 include the following:

- Continue our efforts to achieve optimal Legal and Regulatory compliance requirements, as validated by the Mental Health Commission.
- Continue with the reconfiguration of the General Adult CMHTs to serve populations of 50,000 as recommended in *A Vision for Change* and in line with the requirements of the *Community Health Care Organisations Report.*
- Prioritise the recruitment of the three additional Consultant Psychiatrist posts allocated from 2014/2015 development funding and develop a business case for additional funding.
- Address the gaps in CAMHS to enable the extension of services to 16/17 years olds in Clare and North Tipperary.
- Continue to review existing Residential / Hostel accommodation and continuing care bed provision in line with Vision for Change resulting in possible further closure of some Hostels. Support residents transitioning into new housing accommodation.
- Identify and continue to address our two biggest risks areas (i) Staffing, (ii) Accommodation / Facilities.
- Reduce variation in how services are provided and accessed
- Actively engage in the implementation of Clinical Care Programmes i.e. Early Intervention in Psychosis, Early Intervention in Eating Disorders and addressing Self Harm in Emergency Department.
- To develop a Mid West Mental Health Intellectual Disability Service.
- To transfer the Dementia Unit, Clare, under the umbrella of Mental Health Services.
- Improve access to primary care psychology and counselling with targeted developments in youth mental health at Limerick Youth Service and a new Limerick based Jigsaw project.

Social Care

Social Care Priorities 2016

This Social Care Operational Plan has been prepared consistent with and in line with related national policies, frameworks, performance targets, standards and resources. It sets out the type of social care services which will be provided directly or through a range of agencies funded by us during 2016, and the actions which we will take to deliver on the goals of the HSE Corporate Plan 2015-2017 for HSE Mid West.

Our objective is to provide high quality, sustainable health care grounded in our values of Care, Compassion, Trust and Learning. Our Social Care services are focused on:

- Enabling people with disabilities to achieve their full potential *living ordinary lives in ordinary places,* as independently as possible while ensuring that the voice of service users and their family is heard and that they are fully involved in planning services to meet their needs.

- Maximising the potential of older people, their families and local communities to maintain people in their own homes and communities, while delivering high quality residential care when required.

- Reforming our services to maximise the use of existing resources and developing sustainable models of service provision with positive outcomes for service users, delivering best value for money.

Services for Older People

HSE Mid West supports an average of 1775 people in long term nursing home care per week. We will in conjunction with the National Division grow this number in 2016 with a share of the new national additional funding of €35m.

We will continue to deliver a high volume of support to people at home noting that in 2015 we provided extensive Home Help Hours and Home Care Packages. Our resources are experiencing pressure and the 2016 target will be reviewed as the year progresses and the high demand period of quarter 1 is assessed.

Our 530 public beds for older people provide continuing care, rehabilitation, respite care, transition care and palliative care. In 2016 the nine sites across the three Counties will continue to maintain a focus on flexibility to respond to the emerging needs of people and improved regulatory compliance.

In 2015 we further improved our integration with and prioritisation of timely discharge from acute care settings. In 2016 working with the National Division we will be one of four pioneer sites aimed at maximising integrated care for older people across service areas.

The National Dementia Strategy will further advance in the Mid West with an identified project for funding over a three year period with Carebright in East Limerick where a new approach to care for those with a dementia diagnosis is being pursued.

Disability Services

In 2016 we will support 128 people leaving school and rehabilitative training who require specific support associated with their level of disability. This is consistent with the policy New Directions.

We continue to make progress in progressing disability services for children 0 – 18 years with 12 teams across the Mid West (six for early intervention and six for school going years). While these teams have advanced there is significant work to do in further improving services. We are particularly challenged in supporting children with disabilities to access Early Childhood Education (Pre School) because of the significant demands for the supports they need to be able to do so.

Recent years have seen increased focus and pressure on responding to two particular aspects of care, particularly residential care. The first is Safeguarding and the second is improving compliance with the National Standards (Residential) as regulated by HIQA since late 2013. The Mid West like many parts of the Country has challenges as we move from an historical institutional approach to care to one of supporting our fellow citizens to live a life of their choosing. Through pursuit of the intentions in the Congregated settings policy and all of the time focusing on the need to safeguard vulnerable people we are working with the National Division to improve services for those who depend on them.

Capital Investment

HSE Mid West will benefit from the recently announced Capital investment programmes in Social Care services, particularly residential services for both people with disabilities and public care facilities for older people.

We will work with the National Division to ensure our services in disability care are part of the €100m funding provided for 2016 – 2021. We have significant challenges to address in our larger congregated settings at the Daughters of Charity services in Limerick and Roscrea together with the Brothers of Charity services in Limerick. Our services in Clare in partnership with the Brothers of Charity are already consistent with the modern day approaches. This level of compliance will take time to achieve in Limerick and North Tipperary and we will work with the funded agencies and the regulator HIQA to manage the services in the intervening period to the maximum benefit of residents.

In our older persons services the nine facilities across the Mid West have received approval for expenditure of €40m over the period of the Capital programme and this will see commencement of and / or completion of works to bring the services to modern day standards.

Funding

The Mid West Social Care Division 2016 funded position is as follows; (excluding NHSS Fair Deal)

Mid West	Net Budget €m
Older Persons Services	€60.6m
Disability Services	€134.1m
Total	**€194.7m**

Some Key Actions – 2016

The National Social Care Division has set a number of targets and priorities in 2016, all of which are aligned to the 5 Goals of the HSE Corporate Plan. HSE Mid West will work with the National Division to pursue these objectives. Some (not exhaustive) of the key actions we will be focused on are set out below.

If you would like a complete copy of the National Priorities and Actions for Social Care please contact cho.midwest@hse.ie.

Disability Services

Corporate Goal	Priority	Action
	**Congregated Settings**	• We will work with service providers to ensure there is a coherent plan to implement the national policy. This will include assessment, prioritisation for use of available resources and a partnership with all sectors to achieve Community Transition Living Plans – 16 people in 2016.
	**Progressing Children's Disability Services**	• With our already established 12 teams we will focus on an outcomes framework together with service user involvement.
	New Directions	• Subject to further assessment of resources we will support 128 people who are leaving school or rehabilitative training and who because of their disability require particular supports.
	**Confidential Recipient**	• People with concerns can find it difficult to articulate them regardless of how open we are as service providers. The confidential recipient appointed by the HSE in 2015 will continue to receive maximum engagement from all staff to resolve the concerns of those who use our services in addition to the complaints and other feedback systems.
	Quality Improvement and Enablement Programme	**Actions to Monitor Recommendations from HIQA Inspection Reports** • Establish a process in the Mid West to monitor the percentage of recommendations implemented which have arisen from HIQA Inspection Reports.
	Service User Engagement	• In 2016 the HSE Mid West will develop and test a number of different approaches to service user and family involvement in all social care services. We will pursue more service user engagement through different processes such as family fora which will help us to include the views of service users in all of our plans.

Corporate Goal	Priority	Action
	**Leadership**	**Actions to Deliver Leadership Development Training** • Social Care Division will promote the availability of coaching and mentoring services • Social Care Division will release staff to participate on the Leadership Development Programme **Actions to Deliver Person In Charge Training** • PIM (HIQA) training • HIQA Compliance training • Social Role Valorisation Training • Audit Training
	Learning and Development	• In partnership with HR, work with professional bodies and staff representative associations to develop continuous professional development responses that support improved performance. • Explore with voluntary providers opportunities to develop on the job experiential learning through job rotation and shadowing. **Actions to Develop Continuous Professional Development Opportunities** • The Social Care Division will nominate a representative to work with National HR to develop continuous professional development responses that support improved performance. • Through the HR & Finance Group between the HSE and three umbrella organisations for disability services, this group will identify opportunities to develop on the job experiential learning through job rotation and shadowing.
	**Service Arrangements with Providers**	• There is a particular emphasis in HSE Mid West on providing services in partnership with funded agencies. The governance requirements of this extensive funding and service provision will be strengthened in 2016 with all agreements signed and in place by the end of February. We will be assisted in improving our relationship with agencies to the maximum benefit of service users through the national Service Improvement Team process.
	Quality and Standards	• Enhance the quality and safety of services for people with a disability and improve their service experience through putting in place a Quality Framework and Outcomes Measurement Framework. • Design a Quality Framework for disability service and associated self-audit. **Actions to Design a Quality Framework for Disability Services** • Research and evaluate existing national and international Quality Frameworks and Outcomes Measurement • Design an Outcome Measurement Framework • Design a Quality Framework for Disability Services with associated self-audit tools

Older Person Services

Corporate Goal	Priority	Action
	**Dementia Strategy**	• We will in conjunction with the National Division focus intensive home care packages with a focus on those who have a diagnosis of dementia. We will focus on the development of a new model of care with Carebright in East Limerick which will have a dedicated focus on alternative care for people with dementia.
	Carers Strategy	• The Mid West will continue its focus of partnership in Limerick with the local authority to advance the implementation of the Age Friendly Limerick strategy published in 2015. Our new Head of Social Care will on taking up appointment explore the expansion of this in North Tipperary (Already in Clare).
	Falls Prevention and Bone Health	• The Mid West will progress the further development of integrated care pathways for falls with the assistance of the national project team.
	Tobacco Free Campus	• 75% of public residential facilities for older people will be pursued in the smoke free campus initiative
	**Home Care**	• The Mid West has recently assessed a number of improvement requirements in Home Care particularly for older people and with the support of the National Division we will implement a series of changes. This is a significant challenge given the reliance on home care both as a means of reducing dependency on alternative care and also hospital avoidance and discharge.
	Short Stay Care	• The Mid West will continue to use public bed provision outside of the traditional understanding of long stay care and in this regard will provide flexible short stay care consistent with people's needs.
	Integrated Care	• It is a priority of HSE Mid West to work with other providers including the UL Hospitals to further improve pathways of care for older people.

Corporate Goal	Priority	Action
	**Safeguarding**	• All HSE Mid West services will benefit from the now appointed safeguarding teams both in the context of protecting older people from abuse but also now ensuring that this is the priority focus of all residential providers for people of all ages and needs. We will strengthen safeguarding in the Mid West not only through the use of our professional safeguarding staff but more importantly by making it everyone's business. Training, Awareness, Information and Audits will form part of our assurance in this regard. All actions from the National Social Care Division will be applied in the Mid West.
	Service User Involvement	• In 2016 the HSE Mid West will develop and test a number of different approaches to service user and family involvement in all social care services. We will pursue more service user engagement through different processes such as family fora which will help us to include the views of service users in all of our plans.
	Regulatory Compliance	• All residential settings for older people and people with disabilities are the subject to regulation and independent inspection and reporting (HIQA). We will work with the regulator to continue to improve our services, learn from inspection findings and communicate our plans and actions to the public. Our values of Care, Compassion, Trust and Learning are important in all of our services and regulatory compliance is one of the means by which we can have external validation of these.
	**Public Residential Care Workforce Plan**	• Implement, following reaching agreement through the auspices of the Labour Relations Commission, proposals regarding the matching of staffing levels and skill-mix to care needs requirements across all public residential care services. **Actions to Implement the Public Residential Care Workforce Plan** • Finalise consultation process with Unions under the auspices of the WRC on framework for sustainable workforce plans • Implementation across CHO of Framework Agreement • Progress discussions on nurse management structures in public residential care services to agree CHO design of governance arrangements • In partnership with the CHO's, National Older Persons services will develop a SMART action plan to implement the agreement reached at the Workplace Relations Commission regarding skill mix

Corporate Goal	Priority	Action
	**Demographic Pressures / Waiting Times**	• As demand for services grows each year we cannot meet all of the requirements at the time they arise. Where people have to wait for a particular service we will utilise all means available to us to support them in the intervening period and mitigate the risk and inconvenience that can arise in such circumstances.
	Service Arrangements with Providers	• There is a particular emphasis in HSE Mid West on providing services in partnership with funded agencies. The governance requirements of this extensive funding and service provision will be strengthened in 2016 with all agreements signed and in place by the end of February. We will be assisted in improving our relationship with agencies to the maximum benefit of service users through the national Service Improvement Team process.

Our Accountability

Throughout the year we will be engaged with the National Social Care Division and a central focus of those discussions will be our progress in the Mid West measured against the priorities and actions of the National Service Plan. This process is guided through the use of a balance scorecard focused on key metrics. The balance scorecard for Social Care is set out in the appendices. If you would like to know more detail about our Social Care priorities and actions please send your query to cho.midwest@hse.ie.

Appendices

Appendix One: Balanced Scorecard

Balanced Scorecard for Health and Wellbeing

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%		

Balanced Scorecard for Primary Care

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
Effective Care	
Community Intervention Teams (number of referrals)	
• Admission Avoidance (includes OPAT)	4,713
• Hospital Avoidance	164
• Early discharge (includes OPAT)	2,598
• Unscheduled referrals from community sources	935
***Health Amendment Act*: Services to persons with state acquired Hepatitis C**	1,016
• Number of patients who were reviewed	
Primary Care Reimbursement Service	
Effective Care	
Medical Cards	90%
• % of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	
• % 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	350
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	104,609
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%
Primary Care Reimbursement Service	
Medical Cards	
• % of completed Medical Card / GP Visit Card applications processed within 15 days	95%
• No. of persons covered by Medical Cards as at 31st December	1,675,767
• No. of persons covered by GP Visit Cards as at 31st December	485,192*
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)	260
• 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 commenced	28 days
Needle Exchange	
• No. of unique individuals attending pharmacy needle exchange	314

Access	Expected Activity / Target 2016
Palliative Care	
• Access to specialist inpatient bed within 7 days	98%
• Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital)	95%
• No. of patients in receipt of specialist palliative care in the community	386
• No. of children in the care of the children's outreach nursing team / specialist palliative care team	24

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years. Please also note these are national figures and includes CHO 3

Balanced Scorecard for Mental Health

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

Balanced Scorecard for Social Care

Disability Services

Quality and Safety		Access	
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 (from Q3)	**100%**	**Progressing Disability Services for Children and Young People (0-18s) Programme** • No. of Children's Disability Network Teams established	**100% (129/129)**
Congregated Settings • Facilitate the movement of people from congregated to community settings	**160**	**Disability Act Compliance** • % of assessments completed within the timelines as provided for in the regulations	**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) • % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	**99%** **90%**	**Day Services** • % of school leavers and RT graduates who have been provided with a placement	**100%**
Safety Incident Reporting • % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	**90%**	**Respite*** • No. of day only respite sessions accessed by people with a disability • No. of overnights (with or without day respite0 access by people with a disability	**35,000** **180,000**
Complaints • % of complaints investigated within 30 working days of being acknowledged by the complaints officer	**75%**	**Personal Assistance (PA)** • No. of PA service hours delivered to adults with a disability	**1.3m**
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 (from Q2) • % 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 (from Q2) • % compliance with inspected outcomes following HIQA inspection of Disability Residential Units	**100%** **100%** **100%** **75%**	**Home Support Service** • No. of Home Support Hours delivered to persons with a disability	**2.6m**
Service Improvement Team Process • Deliver on Service Improvement priorities	**100%**		
Transforming Lives - VFM Policy Review • Deliver on VFM Implementation priorities	**100%**		
Quality • 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%**		
Governance for Quality and Safety • Quality and Safety committees across all Divisions at Divisional, Hospital Group and Community Healthcare Organisation	**100%**		

Finance		Human Resources	
Budget Management including savings **Net Expenditure variance from plan (budget)** • Pay - Direct / Agency / Overtime • Non-pay • Income	**≤ .33%** **≤ .33%** **≤ .33%**	**Absence** • % of absence rates by staff category	**≤ 3.5%**
Service Arrangements/ Annual Compliance Statement • % of number of Service Arrangement signed • % of the monetary value of Service Arrangements signed • % of Annual Compliance Statements signed	**100%** **100%** **100%**	**Staffing Levels and Costs** • % variation from funded staffing thresholds	**≤ 0.5%**
Capital • Capital expenditure versus expenditure profile	**100%**	**Compliance with European Working Time Directive (EWTD)** • < 48 hour working week	**95%**
Governance and Compliance • % of internal audit recommendations implemented by due date • % of internal audit recommendations implemented, against total number of recommendations, within 12 months of report being received	**75%** **95%**	**Health and Safety** • No. of calls that were received by the National Health and Safety Helpdesk during the quarter	**15%**

*The introduction of an expanded range of KPIs in respect of respite, with more appropriate reporting of day and overnight respite, results in a combined target of 215,000 for 2016

Older Persons Services

Quality and Safety		Access	
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 Older Persons Services (Q3)	**100%**	**Home Care Packages** • Total no. of persons in receipt of a HCP including delayed discharge initiative HCPs • Intensive HCPs: Total no. of persons in receipt of an intensive HCP	**15,450** **130**
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) • % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	**99%** **90%**	**Home Help** • No. of home help hours provided for all care groups (excluding provision of hours from HCPs) • No. of people in receipt of home help hours (excluding provision from HCPs)	**10.4m** **47,800**
Safety Incident Reporting • % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	**90%**	**NHSS** • No. of persons funded under NHSS in long term residential care • No. of NHSS beds in Public Long Stay Units • No. of short stay beds in Public Long Stay Units	**23,450** **5,255** **2,005**
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 • % 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 (from Q2) • % 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 (from Q2)	**100%** **100%** **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%**		

Finance		Human Resources	
Budget Management including savings **Net Expenditure variance from plan (budget)** • Pay - Direct / Agency / Overtime • Non-pay • Income	 **≤0.33%** **≤0.33%** **≤0.33%**	**Absence** • % of absence rates by staff category	**≤ 3.5%**
Service Arrangements/ Annual Compliance Statement • % of number of Service Arrangement signed • % of the monetary value of Service Arrangements signed • % of Annual Compliance Statements signed	 **100%** **100%** **100%**	**Staffing Levels and Costs** • % variation from funded staffing thresholds	**≤ 0.5%**
Capital • Capital expenditure versus expenditure profile	**100%**	**Compliance with European Working Time Directive (EWTD)** • < 48 hour working week	**95%**
Governance and Compliance • % of internal audit recommendations implemented by due date • % of internal audit recommendations implemented, against total number of recommendations, within 12 months of report being received	**75%** **95%**	**Health and Safety** • No. of calls that were received by the National Health and Safety Helpdesk during the quarter	**15% increase**

Appendix Two: Key Performance Indicators

Health and Wellbeing KPIs

Health and Wellbeing					
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / National Target 2016**	**Expected Activity / CHO 3 Target**
National Screening Service					
BreastCheck					
No. of women in the eligible population who have had a complete mammogram	M	New PI 2016		149,500	
No. of women aged 50-64 who have had a complete mammogram	M	140,000	140,000	144,000	
No. of women aged 65+ who have had a complete mammogram	M	New PI 2016		5,500	
% BreastCheck screening uptake rate	Q	New PI 2016		> 70%	
% women offered an appointment for Assessment Clinic within 2 weeks of notification of abnormal mammographic result	Q	New PI 2016		>90%	
% women offered hospital admission for treatment within 3 weeks of diagnosis of breast cancer	Bi-annual	New PI 2016		> 90%	
CervicalCheck					
No. of unique women who have had one or more smear tests in a primary care setting	M	271,000	260,000	255,000	
% eligible women with at least one satisfactory CervicalCheck screening in a 5 year period	Q	New PI 2016		> 80%	
No. of women referred to colposcopy following cervical screening	Q	New PI 2016		19,500	
% of clients who are issued CervicalCheck results within 4 weeks	Q	New PI 2016		>90%	
% urgent cases offered a Colposcopy appointment within 2 weeks of receipt of letter in the clinic	M	New PI 2016		>90%	
Average high grade times from referral to first offered colposcopy appointment within 4 weeks	M	New PI 2016		> 90%	
Average low grade times from referral to first offered colposcopy appointment within 8 weeks	M	New PI 2016		> 90%	
BowelScreen					
No. of clients who have completed a satisfactory BowelScreen FIT test	M	New PI 2016	New PI 2016	106,875	
% of client uptake rate in the BowelScreen programme	Q	New PI 2016	New PI 2016	> 45%	
Diabetic RetinaScreen					
No. of Diabetic RetinaScreen clients screened with final grading result	M	78,300	78,300	87,000	
% Diabetic RetinaScreen uptake rate	Q	New PI 2016	New PI 2016	> 56%	
% of clients who are issued a Diabetic RetinaScreen result within 3 weeks	Q	New PI 2016		>95%	
Environmental Health					
No. of tobacco sales to minors test purchase inspections carried out	Q	480	460	384	
% of tobacco test purchases carried out which had compliant inspection	Q	New PI		79%	

Health and Wellbeing					
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / National Target 2016**	**Expected Activity / CHO 3 Target**
outcome		2016			
No. of establishments inspected under the *Public Health (Sunbeds) Act*	Q	400	400	200	
No. of test purchase inspections completed (Sunbeds) Act	Q	New PI 2016		32	
No. of mystery shopper inspections completed (Sunbeds) Act	Q	New PI 2016		32	
No. of official food control planned, and planned surveillance inspections of food businesses.	Q	33,000	35,882	33,000	
% of official food control planned inspections and planned surveillance inspection outcomes which were unsatisfactory	Q	New PI 2016		<25%	
% of environmental health complaints from the public risk assessed within one working day	Q	New PI 2016		95%	
Tobacco No. of smokers who received intensive cessation support from a cessation counsellor	M	9,000	11,000	11,500	
No. of frontline staff trained in brief intervention smoking cessation	M	1,350	1,120	1,350	75
% of smokers on cessation programmes who were quit at one month	Q	New PI 2016		45%	
Healthy Eating Active Living No. of 5k Parkruns completed by the general public in community settings	M	New PI 2016		150,000	5,005
No. of frontline healthcare staff who have completed the physical activity e-learning module	M	New PI 2016		486	56
No. of people who have completed a structured patient education programme for diabetes	M	New PI 2016		2,200	250
% of PHNs trained by dietician's in the Nutrition Reference Pack for Infants 0-12 months	Q	New PI 2016		50%	
No. of people attending a structured community based healthy cooking programme	M	New PI 2016		4,400	150
% of preschools participating in Smart Start	M	New PI 2016		15%	
% of primary schools trained to participate in the after schools activity programme - Be Active	M	New PI 2016		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	M	95%	93.5%	95%	
% of newborn babies visited by a PHN within 72 hours of discharge from maternity services	Q	97%	97.4%	97%	
% of babies breastfed (exclusively and not exclusively) at first PHN visit	Q	56%	53.5%	56%	
% of babies breastfed (exclusively and not exclusively) at 3 month PHN visit	Q	38%	34.6%	38%	
% of total number of maternity hospitals with Baby Friendly Hospital designation	Bi-annual	New PI 2016		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)	Q	95%	91.4%	95%	

Health and Wellbeing					
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / National Target 2016**	**Expected Activity / CHO 3 Target**
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV2)	Q	95%	91.2%	95%	
% children at 12 months of age who have received 1 dose of the Meningococcal group C vaccine (MenC2)	Q	95%	90.9%	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)	Q	95%	95.0%	95%	
% children aged 24 months who have received 3 doses Meningococcal C (MenC3) vaccine	Q	95%	87.2%	95%	
% children aged 24 months who have received 1 dose Haemophilus influenza type B (Hib) vaccine	Q	95%	90.7%	95%	
% children aged 24 months who have received 3 doses Pneumococcal Conjugate (PCV3) vaccine	Q	95%	91.5%	95%	
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	Q	95%	92.7%	95%	
% children in junior infants who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)	A	95%	81.3%	95%	
% children in junior infants who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine	A	95%	81.3%	95%	
% first year students who have received 1 dose Tetanus, low dose Diphtheria, Acellular Pertussis (Tdap) vaccine	A	95%	88.4%	95%	
% of first year girls who have received two doses of HPV vaccine	A	80%	85.0%	85%	
% of first year students who have received one dose meningococcal C (MenC) vaccine	A	95%	86.8%	95%	
% of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (acute hospitals)	A	40%	23.4%	40%	
% of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (long term care facilities in the community)	A	40%	25.7%	40%	
% uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	A	75%	60.2%	75%	
Public Health No. of infectious disease (ID) outbreaks notified under the national ID reporting schedule	Q	614	680	660	
No. of individual outbreak associated cases of infectious disease (ID) notified under the national ID reporting schedule	Q	New PI 2016		7,500	

Primary Care KPIs

All metrics highlighted in yellow background are those that are included in the Balance Scorecard

Primary Care KPI Title	NSP/ DOP	KPI Type	Report Frequency	2016 National Target/ Expected Activity	Reporting Level	CHO 3 2016 Target
Community Intervention Teams (number of referrals)				24,202		4,713
Admission Avoidance (includes OPAT)	NSP	Quality	M	914	CHO	164
Hospital Avoidance	NSP	Quality	M	12,932	CHO	2,598
Early discharge (includes OPAT)	NSP	Quality	M	6,360	CHO	935
Unscheduled referrals from community sources	NSP	Quality	M	3,996	CHO	1,016
Outpatient parenteral Antimicrobial Therapy OPAT Re-admission rate %	DOP	Access /Activity	MQ2	≤5%	HG	≤5%
Community Intervention Teams Activity (by referral source)				24,202	CHO	4,713
ED / Hospital wards / Units	DOP	Access /Activity	M	13,956	CHO	2,509
GP Referral	DOP	Access /Activity	M	6,386	CHO	795
Community Referral	DOP	Access /Activity	M	2,226	CHO	1,216
OPAT Referral	DOP	Access /Activity	M	1,634	CHO	193
GP Out of Hours						
No. of contacts with GP Out of Hours Service	NSP	Access /Activity	M	964,770	National	104,609
Tobacco Control						
% of primary care staff to undertake brief intervention training for smoking cessation	DOP	Quality	Q	5%	CHO	5%
Physiotherapy						
No of patient referrals	DOP	Activity	M	193,677	CHO	15,802
No of patients seen for a first time assessment	DOP	Activity	M	160,017	CHO	12,062
No of patients treated in the reporting month (monthly target)	DOP	Activity	M	36,430	CHO	2,305
No of face to face contacts/visits	DOP	Activity	M	775,864	CHO	50,877
Total No. of physiotherapy patients on the assessment waiting list at the end of the reporting period *	DOP	Access	M	28,527	CHO	3,294
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	No target	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	No target	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	No target	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	No target	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	No target	CHO	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	70%	CHO	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	95%	CHO	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	90%	CHO	90%
Occupational Therapy						
No of patient referrals	DOP	Activity	M	89,989	CHO	7,926
No of new patients seen for a first assessment	DOP	Activity	M	86,499	CHO	7,450

No of patients treated (direct and indirect) monthly target	DOP	Activity	M	20,291	CHO	1,474
Total No. of occupational therapy patients on the assessment waiting list at the end of the reporting period **	DOP	Access	M	19,932	CHO	874
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	No target	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	No target	CHO	No target
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	No target	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	No target	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	No target	CHO	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	70%	CHO	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	95%	CHO	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	80%	CHO	80%
Orthodontics						
No. of patients receiving active treatment at the end of the reporting period	DOP	Access	Q	16,887	National/ former region	
% of referrals seen for assessment within 6 months	NSP	Access	Q	75%	National/ former region	
% on waiting list for assessment ≤ 12 months	DOP	Access	Q	100%	National/ former region	
% of patients on the treatment waiting list less than 2 years	DOP	Access	Q	75%	National/ former region	
% of patients on treatment waiting list less than 4 years (grade 4 and 5)	DOP	Access	Q	95%	National/ former region	
No. of patients on the assessment waiting list at the end of the reporting period	DOP	Access	Q	5,966	National/ former region	
No. of patients on the treatment waiting list – grade 4 –at the end of the reporting period	DOP	Access /Activity	Q	9,912	National/ former region	
No. of patients on the treatment waiting list – grade 5 –at the end of the reporting period	DOP	Access /Activity	Q	8,194	National/ former region	
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	NSP	Access	Q	<5%	National/ former region	
Oral Health (Primary Dental Care and Orthodontics)						
No. of new patients attending for Scheduled Assessment	DOP	Access /Activity	M	Unavailable	CHO	Unavailable
No. of new patients attending for Unscheduled Assessment	DOP	Access /Activity	M	Unavailable	CHO	Unavailable
% of new patients who commenced treatment within 3 months of assessment	NSP	Access	M	80%	CHO	80%
Healthcare Associated Infections: Medication Management					CHO	
Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	NSP	Quality		<21.7	National	
Primary Care – Psychology						
No. of patient referrals	DOP	Activity	M	12,261	CHO	416
Existing patients seen in the month	DOP	Activity	M	2,626	CHO	118
New patients seen	DOP	Activity	M	9,367	CHO	190

Total No. of psychology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	6,028	CHO	422
No. of psychology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	No target	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	No target	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	No target	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	No target	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	90%	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	80%	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	60%	CHO	60%
Primary Care – Podiatry						
No. of patient referrals	DOP	Activity	M	11,589	CHO	1,305
Existing patients seen in the month	DOP	Activity	M	5,210	CHO	570
New patients seen	DOP	Activity	M	8,887	CHO	752
Total No. of podiatry patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	3,186	CHO	488
No. of podiatry patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	No target	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	No target	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	No target	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	No target	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	95%	CHO	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	90%	CHO	90%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	75%	CHO	75%
No of patients with Diabetic Active Foot Disease treated in the reporting month	DOP	Quality	M Q3	133	CHO	11
No. of treatments for Diabetic Active Foot Disease in the reporting month	DOP	Access /Activity	M Q3	532	CHO	44
Primary Care – Ophthalmology						
No. of patient referrals	DOP	Activity	M	26,913	CHO	2,407
Existing patients seen in the month	DOP	Activity	M	13,807	CHO	509

New patients seen	DOP	Activity	M	16,524	CHO	1,806
Total No. of ophthalmology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	14,267	CHO	1,833
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	No target	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	No target	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	No target	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	No target	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	90%	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	80%	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	60%	CHO	60%
Primary Care – Audiology						
No. of patient referrals	DOP	Activity	M	18,317	CHO	1,189
Existing patients seen in the month	DOP	Activity	M	2,850	CHO	215
New patients seen	DOP	Activity	M	16,459	CHO	1,390
Total No. of audiology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	13,870	CHO	803
No. of audiology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	No target	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	No target	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	No target	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	No target	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	90%	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	80%	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	60%	CHO	60%
Primary Care – Dietetics						
No. of patient referrals	DOP	Activity	M	27,858	CHO	2,026
Existing patients seen in the month	DOP	Activity	M	5,209	CHO	109
New patients seen	DOP	Activity	M	21,707	CHO	975
Total No. of dietetics patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	5,479	CHO	427
No. of dietetics patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	No target	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	No target	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	No target	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	No target	CHO	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	95%	CHO	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	85%	CHO	85%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	70%	CHO	70%
Primary Care – Nursing						
No. of patient referrals	DOP	Activity	M	159,694	CHO	17,796
Existing patients seen in the month	DOP	Activity	M	64,660	CHO	21,934
New patients seen	DOP	Activity	M	123,024	CHO	16,509
Number of new patients accepted on the caseload and waiting to be seen over 12 weeks	NSP	Access	M	0	CHO	0
Primary Care – Speech and Language Therapy* **						
No. of patient referrals	DOP	Activity	M	50,863	CHO	4,062
Existing patients seen in the month	DOP	Activity	M Q2	New PI 2016	CHO	New PI 2016
New patients seen for initial assessment	DOP	Activity	M	41,083	CHO	3,381
Total No. of speech and language patients waiting initial assessment at end of the reporting period ****	DOP	Access	M	13,050	CHO	832
Total No. of speech and language patients waiting initial therapy at end of the reporting period ****	DOP	Access	M	8,279	CHO	393
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	100%	CHO	100%
Health Amendment Act - Services to persons with state acquired Hepatitis C						
No. of patient who were reviewed.	NSP	Quality	Q	798	National	65

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

All metrics highlighted in yellow background are those that are included in the Balance Scorecard

Quality and Patient Safety KPI Title	NSP/ DOP	KPI Type	Report Frequency	2016 National Target/ Expected Activity	Reporting Level	CHO 3
Service User Experience						
% ratio of compliments to complaints by CHO	DOP	Quality	Q	New PI 2016	CHO	New PI 2016
% of complaints investigated within 30 working days of being acknowledged by the complaints officer (mandatory)	NSP	Quality	M	75%	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	100%	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	99%	CHO	99%
% of investigations completed within 120 days of event occurrence)	NSP	Quality	M	90%	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	90%	CHO	90%
% of claims received by State Claims Agency that were not reported previously as an incident	NSP	Quality	A	New PI 2016	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

All metrics highlighted in yellow background are those that are included in the Balance Scorecard

Social Inclusion KPI Title	NSP/ DOP	KPI Type	Report Frequency	2016 National Target/ Expected Activity	Reporting Level	CHO 3
Total no. of clients in receipt of opioid substitution treatment (outside prisons)	NSP	Access	M 1 Mth in Arrears	9,515	CHO	260
No. of clients in opioid substitution treatment in Clinics	DOP	Access	M 1 Mth in arrears	5,470	CHO	125
No. of clients in opioid substitution treatment with level 2 GP's	DOP	Access	M 1 Mth in arrears	1,975	CHO	40
No. of clients in opioid substitution treatment with level 1 GP's	DOP	Access	M 1 Mth in Arrears	2,080	CHO	95
No. of clients transferred from clinics to level 1 GP's	DOP	Access	M 1 Mth in Arrears	300	CHO	14
No. of clients transferred from level 2 GP's	DOP	Access	M 1 Mth in Arrears	134	CHO	10
No. of clients transferred from level 2 to level 1 GPs)	DOP	Access	M 1 Mth in Arrears	119	CHO	0
Total no. of new clients in receipt of opioid substitution treatment (outside prisons)	DOP	Access	M 1 Mth in Arrears	617	CHO	30
Total no. of new clients in receipt of opioid substitution treatment (clinics)	DOP	Access	M 1 Mth in Arrears	498	CHO	30
Total no. of new clients in receipt of opioid substitution treatment (level 2 GP)	DOP	Access	M 1 Mth in Arrears	119	CHO	0
Average waiting time from referral to assessment for Opioid Substitution Treatment (days)	NSP	Access	M 1 Mth in Arrears	14 days	CHO	14 days
Average waiting time from Opioid Substitution assessment to exit from waiting list or treatment commenced	NSP	Access	M 1 Mth in Arrears	28 days	CHO	28 days
Number of Pharmacies providing of opioid substitution treatment	DOP	Access	M 1 Mth in Arrears	653	CHO	43
Number of people obtaining opioid substitution treatment from Pharmacies	DOP	Access	M 1 Mth in Arrears	6,463	CHO	251
No. of substance misusers who present for treatment	DOP	Access	Q 1 Q in arrears	6,972	CHO	208
No. of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	Q 1 Mth in Arrears	4,864	CHO	164
% of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	Q 1 Mth in Arrears	100%	CHO	100%
No. of substance misusers (over 18 years) for whom treatment has commenced following assessment	DOP	Quality	Q 1 Mth in Arrears	5,584	CHO	164
No. of substance misusers (over 18) for whom treatment has commenced within one calendar month following assessment	DOP	Quality	Q 1 Mth in Arrears	5,024	CHO	132
% of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	NSP	Access	Q 1 Mth in Arrears	100%	CHO	100%
No. of substance misusers (under 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Mth in Arrears	268	CHO	0
No. of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1 Mth in Arrears	260	CHO	0
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	NSP	Access	Q 1 Mth in Arrears	100%	CHO	100%
% of substance misusers (over 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%

% of substance misusers (over 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%
No. of substance misusers (under 18 years) for whom treatment has commenced	DOP	Access	Q 1 Qtr in Arrears	268	CHO	0
% of substance misusers (under 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%
% of substance misusers (under 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%
No. of problem alcohol users who present for treatment	DOP	Access	Q 1 Qtr in Arrears	3540	CHO	16
No. of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	Q 1 Qtr in Arrears	2,344	CHO	12
% of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	Q 1 Qtr in Arrears	100%	CHO	100%
No. of problem alcohol users (over 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Qtr in Arrears	3228	CHO	12
No. of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	DOP	Access	Q 1 Qtr in Arrears	3228	CHO	12
% of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	DOP	Access	Q 1 Qtr in Arrears	100%	CHO	100%
No. of problem alcohol users (under 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Qtr in Arrears	56	CHO	0
No. of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1 Qtr in Arrears	56	CHO	0
% of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1Qtr in Arrears	100%	CHO	100%
% of problem alcohol users (over 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%
% of problem alcohol users (over 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%
% of problem alcohol users (under 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	CHO	100%
% of problem alcohol users (under 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	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	Q 1 Qtr in Arrears	300	CHO	20
No. of pharmacies recruited to provide Needle Exchange Programme	DOP	Quality	TRI M 1 Qtr in Arrears	119	CHO	13
No. of unique individuals attending pharmacy needle exchange	NSP	Access	TRI M 1 Qtr in Arrears	1,731	CHO	314

No. of pharmacy needle exchange packs provided	DOP	Access	TRI M 1 Qtr in Arrears	3,433	CHO	527
Average No. of needle / syringe packs per person	DOP	Quality	TRI M 1 Qtr in Arrears	16	CHO	16
No. and % of needle / syringe packs returned	DOP	Quality	TRI M 1 Qtr in Arrears	1,032 (30%)	CHO	158 (30%)
No. and % of individual service users admitted to homeless emergency accommodation hostels/ who have medical cards	DOP	Quality	Q	1108 (75%)	CHO	182 (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	Q	302 (70%)	CHO	31 (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	Q	85%	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	Q	80%	CHO	80%
Number of people who received health information on type 2 diabetes and cardiovascular health	NSP	Quality	Q	3,470	CHO	350
Number of people who received awareness and participated in positive mental health initiatives	DOP	Quality	Q	3470	CHO	350

Palliative Care

All metrics highlighted in yellow background are those that are included in the Balance Scorecard

Palliative Care KPI Title	NSP/ DOP	KPI Type	Report Frequency	2016 National Target/ Expected Activity	Reporting Level	CHO 3 2016 Target
Inpatient Palliative Care Services						
Access to specialist inpatient bed within 7 days (during the reporting month)	NSP	Access	M	98%	CHO	98%
Access to specialist palliative care inpatient bed from 8 to14 days (during the reporting month)	DOP	Access	M	New metric 2016	CHO	2%
Total number of referrals for specialist inpatient Palliative care services received	DOP	Access /Activity	M	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for admission - cancer	DOP	Access /Activity	M	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for admission - non cancer	DOP	Access /Activity	M	New metric 2016	CHO	New metric
No. of patients in receipt of treatment in specialist palliative care inpatient units (during the reporting month)	DOP	Access /Activity	M	474	CHO	70
No. of new patients seen or admitted to the specialist palliative care service (monthly cumulative)	DOP	Access /Activity	M	2,877	CHO	400
No. of admissions to specialist palliative care inpatient units (monthly cumulative)	DOP	Access /Activity	M	3,310	CHO	460

Palliative Care KPI Title	NSP/COP	KPI Type	Report Frequency	2016 National Target/ Expected Activity	Reporting Level	CHO 3 2016 Target
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	M	95%	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	M	New metric 2016	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	M	New metric 2016	CHO	2%
Total number of referrals received for specialist Palliative care services in the normal place of residence	DOP	Access /Activity	M	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for services - cancer	DOP	Access /Activity	M	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for services - non cancer	DOP	Access /Activity	M	New metric 2016	CHO	New metric
No. of patients in receipt of specialist palliative care in the community (monthly cumulative)	NSP	Access /Activity	M	3,309	CHO	386
No. of new patients seen or admitted to specialist palliative care services in the community	DOP	Access /Activity	M	9,353	CHO	887

KPI Title	DOP/NSP	KPI Type	Report Frequency	2016 National Target/ Expected Activity	Reporting Level	CHO3
No. of patients in receipt of specialist palliative day care services (during the reporting month)	DOP	Access /Activity	M	349	CHO	36
No. of new patients in receipt of specialist palliative day care services (monthly cumulative)	DOP	Access	M	985	CHO	129
No. of patients in receipt of care in designated palliative care support beds (during the reporting month)	DOP	Access /Activity	M	165	CHO	19
Children's Palliative Care Services						
No. of children in the care of the children's outreach nursing team / specialist palliative care team	NSP	Access	M	370	CHO	24
No. of children in the care of the children's outreach nursing team / specialist palliative care team (Acute setting)	DOP	Access /Activity	M	New metric 2016	CHO	0
No. of children in the care of the children's outreach nursing team / specialist palliative care team (community)	DOP	Access /Activity	M	New metric 2016	CHO	24
No. of new children in the care of the children's outreach nursing team / specialist palliative care team	DOP	Access /Activity	M	190	CHO	14
No. of new children in the care of the children's outreach nursing team / specialist palliative care team (Acute settings)	DOP	Access /Activity	M	New metric 2016	CHO	0
No. of new children in the care of the children's outreach nursing team / specialist palliative care team (Community)	DOP	Access /Activity	M	New metric 2016	CHO	14
Total number of new referrals for inpatient services seen by the specialist palliative care team	DOP	Access /Activity	M	Expected activity to be determined	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	M	Target to be determined	CHO	Baseline to be determined
Bereavement Services						
Total number of family units who received bereavement services	DOP	Access /Activity	M	621	CHO	New metric
% patients triaged within 1 working day of referral (acute service)	NSP	Quality	M 2016 Q4 Reporting	90%	CHO	90%
% patients with a multidisciplinary care plan documented within 5 working days of initial review	NSP	Quality	M 2016 Q4 Reporting	90%	CHO	90%

Mental Health KPIs

Key Performance Indicators Service Planning 2016	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
Mental Health KPI Title			2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO3 / HG3
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by General Adult Community Mental Health Team	Quality	M	90%	92%	90%	CHO	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Team	Quality	M	75%	74%	75%	CHO	75%
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	Access /Activity	M	18%	22%	18%	CHO	18%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	Quality	M	99%	98%	98%	CHO	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	Quality	M	95%	94%	95%	CHO	95%
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	Access /Activity	M	2%	3%	3%	CHO	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.	Quality	M	95%	71%	95%	National	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	Quality	M	New	New	95%	CHO	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	Quality	M	78%	78%	78%	CHO	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	Quality	M	72%	72%	72%	CHO	72%

Key Performance Indicators Service Planning 2016	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
Mental Health KPI Title			2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO3 / HG3
%. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	Access /Activity	M	10%	12%	10%	CHO	10%
Total No. to be seen for a first appointment at the end of each month.	Access /Activity	M	2,632	2,509	2,449	CHO	289
Total No. to be seen 0-3 months	Access /Activity	M	1,153	1,138	1,308	CHO	107
Total No. on waiting list for a first appointment waiting > 3 months	Access /Activity	M	1,479	1,371	1,141	CHO	182
Total No. on waiting list for a first appointment waiting > 12 months	Access /Activity	M	0	203	0	CHO	0
No. of admissions to adult acute inpatient units	Access /Activity	Q in arrears	12,947	12,726	12,726	CHO	980
Median length of stay	Access /Activity	Q in arrears	10	12.4	10	CHO	10
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	Access /Activity	Q in arrears	70.5	70.5	70.5	CHO	70.0
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	Access /Activity	Q in arrears	23.1	23.1	23.1	CHO	18.6
Acute re-admissions as % of admissions	Access /Activity	Q in arrears	67%	67%	67%	CHO	73%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area	Access /Activity	Q in arrears	47.6	47.6	47.6	CHO	51.4
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	Access /Activity	Q in arrears	21.6	21.6	21.6	CHO	20.8
No. of adult involuntary admissions	Access /Activity	Q in arrears	1,714	1,724	1,724	CHO	128
Rate of adult involuntary admissions per 100,000 population in mental health catchment area	Access /Activity	Q in arrears	9.3	9.3	9.3	CHO	10.5

Key Performance Indicators Service Planning 2016 Mental Health KPI Title	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
			2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO3 / HG3
% 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		Q	>50%	N/A	N/A	National	N/A
Number of General Adult Community Mental Health Teams	Access	M	114	114	114	CHO	11
Number of referrals (including re-referred) received by General Adult Community Mental Health Teams	Access /Activity	M	41,499	43,637	43,637	CHO	4,041
Number of Referrals (including re-referred) accepted by General Adult Community Mental Health Teams	Access /Activity	M	39,424	39,122	41,448	CHO	3,837
No. of new (including re-referred) General Adult Community Mental Health Team cases offered first appointment for the current month (seen and DNA below)	Access /Activity	M	46,846	37,624	41,810	CHO	3,268
No. of new (including re-referred) General Adult Community Mental Health Team cases seen in the current month	Access /Activity	M	38,465	29,471	35,430	CHO	2,770
No. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	Access /Activity	M	8,381	8,153	6,380	CHO	498
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	Access /Activity	M	18%	22%	18%	CHO	18%
Number of cases closed/discharged by General Adult Community Mental Health Teams	Access /Activity	M	31,539	23,009	33,158	CHO	3,069
Number of Psychiatry of Old Age Community Mental Health Teams	Access	M	25	26	26	CHO	2
Number of referrals (including re-referred) received by Psychiatry of Old Age Mental Health Teams	Access /Activity	M	10,986	11,664	11,664	CHO	1,068
Number of Referrals (including re-referred) accepted by Psychiatry of Old Age Community Mental Health Teams	Access /Activity	M	9,887	10,953	11,082	CHO	1,014
No. of new (including re-referred) Old Age Psychiatry Team cases offered first appointment for the current month (seen and DNA below)	Access /Activity	M	11,238	9,748	10,384	CHO	692
No. of new (including re-referred) Old Age Psychiatry Team cases seen in the current month	Access /Activity	M	10,960	9,472	10,083	CHO	672

Key Performance Indicators Service Planning 2016	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
Mental Health KPI Title			2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO3 / HG3
No. of new (including re-referred) Old Age Psychiatry cases offered appointment and DNA in the current month	Access /Activity	M	278	276	301	CHO	20
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	Access /Activity	M	2%	3%	3%	CHO	3%
Number of cases closed/discharged by Old Age Psychiatry Community Mental Health Teams	Access /Activity	M	7,910	7,058	8,866	CHO	812
No. of child and adolescent Community Mental Health Teams	Access	M	64	62	66	CHO	5
No. of child and adolescent Day Hospital Teams	Access	M	4	4	4	CHO	0
No. of Paediatric Liaison Teams	Access	M	3	3	3	CHO	0
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	Access /Activity	M	231	256	281	CHO	0
No. of children / adolescents admitted to adult HSE mental health inpatient units	Access /Activity	M	<30	95	30	National	N/A
i). <16 years	Access /Activity	M	0	3	0	National	N/A
ii). <17 years	Access /Activity	M	0	37	0	National	N/A
iii). <18 years	Access /Activity	M	<30	55	30	National	N/A
No. and % of involuntary admissions of children and adolescents	Access /Activity	Annual	15	15	15	National	N/A
No. of child / adolescent referrals (including re-referred) received by mental health services	Access /Activity	M	17,254	17,964	18,864	CHO	1,982
No. of child / adolescent referrals (including re-referred) accepted by mental health services	Access /Activity	M	13,803	13,694	15,092	CHO	1,586
No. of new (including re-referred) CAMHs Team cases offered first appointment for the current month (seen and DNA below)	Access /Activity	M	14,155	13,494	13,895	CHO	1,194

Key Performance Indicators Service Planning 2016	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
Mental Health KPI Title			2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO3 / HG3
No. of new (including re-referred) child/adolescent referrals seen in the current month	Access /Activity	M	12,718	11,906	12,628	CHO	1,085
No. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	Access /Activity	M	1,437	1,588	1,259	CHO	108
%. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	Access /Activity	M	10%	12%	10%	CHO	10%
No. of cases closed / discharged by CAMHS service	Access /Activity	M	11,042	12,442	12,072	CHO	1,268
Total No. to be seen for a first appointment by expected wait time at the end of each month.	Access /Activity	M	2,632	2,509	2,449	CHO	289
i) 0-3 months	Access /Activity	M	1,153	1,138	1,308	CHO	107
ii). 3-6 months	Access /Activity	M	534	595	585	CHO	80
iii). 6-9 months	Access /Activity	M	314	355	346	CHO	50
iv). 9-12 months	Access /Activity	M	614	217	210	CHO	52
v). > 12 months	Access /Activity	M	0	204	0	CHO	0

Social Care KPIs

Key Performance Indicators Service Planning 2016	KPIs 2016	
Disability KPI Title	2016 National Target / Expected Activity	CHO3
No. of requests for assessments received	5,539	268
% of assessments commenced within the timelines as provided for in the regulations	100%	100%
% of assessments completed within the timelines as provided for in the regulations	100%	100%
% of service statements completed within the timelines as provided for in the regulations	100%	100%
Proportion of established Children's Disability Network Teams having current individualised plans for all children	100%	100%
Number of Children's Disability Network Teams established	100% (129/129)	100% (12/12)
No. of work / work-like activity WTE 30 hour places provided for people with a disability (ID/Autism and Physical and Sensory Disability)	1,605	241
No. of people with a disability in receipt of work / work-like activity services(ID/Autism and Physical and Sensory Disability)	3,253	383
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)	15,907	1,188
No. of Rehabilitative Training places provided (all disabilities)	2,583	206
No. of people (all disabilities) in receipt of Rehabilitative Training (RT)	2,870	231
% of school leavers and RT graduates who have received a placement which meets their needs	100%	100%
No. of people with a disability in receipt of residential services (ID/Autism and Physical and Sensory Disability)	8,885	871
No. of new referrals accepted for people with a disability for respite services (ID/Autism and Physical and Sensory Disability)	1,023	119
No. of new people with a disability who commenced respite services (ID/Autism and Physical and Sensory Disability)	782	110
No. of existing people with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	5,964	534
No. of people with a disability formally discharged from respite services (ID/Autism and Physical and Sensory Disability)	591	102
No. of people with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	5,274	377
No. of overnights (with or without day respite) accessed by people with a disability (ID/Autism and Physical and Sensory Disability)	180,000	12,691
No. of day only respite sessions accessed by people with a disability (ID/Autism and Physical and Sensory Disability)	35,000	9,838
No. of people with a disability who are in receipt of more than 30 overnights continuous respite (ID/Autism and	51	1

Key Performance Indicators Service Planning 2016	KPIs 2016	
Disability KPI Title	2016 National Target / Expected Activity	CHO3
Physical and Sensory Disability)		
No. of new referrals accepted for adults with a physical and / or sensory disability for a PA service	271	66
No. of new adults with a physical and / or sensory disability who commenced a PA service	223	60
No. of existing adults with a physical and / or sensory disability in receipt of a PA service	2,284	386
No. of adults with a physical or sensory disability formally discharged from a PA service	134	31
No. of adults with a physical and /or sensory disability in receipt of a PA service	2,186	388
Number of PA Service hours delivered to adults with a physical and / or sensory disability	1,318,819	265,721
No. of adults with a physical and / or sensory disability in receipt of 1 - 5 PA Hours per week	957	104
No. of adults with a physical and / or sensory disability in receipt of 6 - 10 PA hours per week	538	85
No. of adults with a physical and / or sensory disability in receipt of 11 - 20 PA hours per week	397	82
No. of adults with a physical and / or sensory disability in receipt of 21 - 40 PA hours per week	256	77
No. of adults with a physical and / or sensory disability in receipt of 41 - 60 PA hours per week	73	25
No. of adults with a physical and / or sensory disability in receipt of 60+ PA hours per week	83	27
No. of new referrals accepted for people with a disability for home support services (ID/Autism and Physical and Sensory Disability)	1,416	41
No. of new people with a disability who commenced a home support service (ID/Autism and Physical and Sensory Disability)	1,273	78
No. of existing people with a disability in receipt of home support services (ID/Autism and Physical and Sensory Disability)	6,380	392
No. of people with a disability formally discharged from home support services (ID/Autism and Physical and Sensory Disability)	466	50
No of people with a disability in receipt of Home Support Services (ID/Autism and Physical and Sensory Disability)	7,312	929
No of Home Support Hours delivered to persons with a disability (ID/Autism and Physical and Sensory Disability)	2,600,000	141,279
No. of people with a disability in receipt of 1 - 5 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	3,140	339
No. of people with a disability in receipt of 6 – 10 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	1,197	65
No. of people with a disability in receipt of 11 – 20 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	753	23
No. of people with a disability in receipt of 21- 40 Home Support hours per week (ID/Autism and Physical and	402	9

Key Performance Indicators Service Planning 2016	KPIs 2016	
Disability KPI Title	2016 National Target / Expected Activity	CHO3
Sensory Disability)		
No. of people with a disability in receipt of 41 – 60 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	97	1
No. of people with a disability in receipt of 60 +Home Support hours per week (ID/Autism and Physical and Sensory Disability)	127	1
Facilitate the movement of people from congregated to community settings	160	16
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%	100%
% of compliance with outcomes of Disability Units following HIQA inspections by CHO	75%	75%
Service Improvement Team Process Deliver on Service Improvement priorities	100%	
Transforming Lives Deliver on VfM Implementation Priorities	100%	
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 Disability Services (reporting to commence by Q3)	100%	

Key Performance Indicators Service Planning 2016	KPIs 2016	
Older Persons KPI Title	**2016 National Target / Expected Activity**	**CHO3**
Total no. of persons in receipt of a HCP/DDI HCP(Monthly target)	15,450	940
No. of new HCP clients, annually	6,000	325
Intensive HCPs number of persons in receipt of an Intensive HCP at a point in time (Capacity)	130	
No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	10,437,000	926,000
No. of people in receipt of home help hours (excluding provision of hours from HCPs) (Monthly target)	47,800	3,650
No. of persons funded under NHSS in long term residential care during reporting month	23,450	
% of clients with NHSS who are in receipt of Ancillary State Support	10%	10%
% of clients who have CSARs processed within 6 weeks	90%	90%
No. in receipt of subvention	187	24
No. of NHSS Beds in Public Long Stay Units.	5,255	346
No. of Short Stay Beds in Public Long Stay Units	2,005	184
Average length of Stay for NHSS clients in Public, Private and Saver Long Stay Units	3.2	3.2
% of population over 65 years in NHSS funded Beds (based on 2011 Census figures)	4%	4%
Service Improvement Team Process Deliver on Service Improvement priorities.	100%	
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 (reporting to commence by Q3)	100%	
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 Reporting to begin by Quarter 2 2016	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 Reporting to begin by Quarter 2 2016	100%	
Total no. of preliminary screenings for adults under 65 years / aged 65 and over		
No. of staff trained in safeguarding policy		

Home Care Expected Activity Older Persons

Home Care Targets/Expected Activity 2016				
CHO	LHO	HCP Proposed 2016 Target	HH Hours Proposed 2016 Target	HH Clients 2016 Expected Activity
3	LHO Clare	230	207,000	
	LHO Limerick	450	384,000	
	LHO Nth Tipperary	260	335,000	
CHO 3 Total		**940**	**926,000**	3,650

Public Long Stay Residential Care Beds - Older Persons

CHO Area	LHO Area	Name of unit	No. of Beds at 31st December 2015	
			NHSS	Short Stay
CHO Area 3	Limerick	St Camillus Community Hospital	66	34
	Limerick	St Ita's Community Hospital	65	27
	Limerick Total		**131**	**61**
	N. Tipperary / East Limerick	Hospital of the Assumption	31	29
	N. Tipperary / East Limerick	St Conlon's Community Nursing Unit	24	3
	N. Tipperary / East Limerick	Dean Maxwell Community Nursing Unit	22	5
	N. Tipperary / East Limerick Total		**77**	**37**
	Clare	Ennistymon Community Nursing Unit	19	8
	Clare	Raheen Community Nursing Unit	15	10
	Clare	Regina House	20	10
	Clare	St Joseph's Community Hospital	84	58
	Clare Total		**138**	**86**
CHO AREA 3 TOTAL			**346**	**184**

KPIs pertaining to Quality and Safety structures and Effective and Safe Care which will be collected at CHO level are as follows:

Priority Area	Metric	Performance Measure / Target
Governance for Quality and Safety		
HCAI Committee	% of CHOs who have in place a HCAI or Infection Control Committee	100%
Drugs & Therapeutic Committee	% of CHOs who have in place Drugs and Therapeutic Committee / Medication Management Committee	100%
Risk Registers	% of CHOs who have in place a CHO-wide Social Care Risk Register	100%
Effective Care		
HIQA Notifications	% of CHOs who have in place a system for receipt and collation of HIQA Notification Forms submitted by HSE provided services	100%
	% of CHOs who review the trends from the collation of HIQA Notification Forms submitted by HSE provided-services and take appropriate action by Q3.	100%
Service User Surveys	% of CHOs who conduct annual service user experience surveys amongst representative samples of their Social Care service user population by Q3	100%
Safe Care		
Recommendations	% of CHOs who have a process in place to ensure the recommendations of any serious incident investigations are implemented, and learning shared by Q2	100%
Incidents	% of CHOs who carry out an analysis of all reported incidents (numbers, types, trends)	100%

Social Care Service Arrangement Funding Summary

Disability Services

Summary	Care Group	Disability funding €	CHO Area 3 €
			Clare Limerick North Tipperary / East Limerick
S38 – SA	Disability	705,056,123	74,054,275
S39 – SA	Disability	422,372,114	43,842,427
S39 – GA	Disability	5,650,550	274,890
Total S39	Disability	428,022,663	44,117,317
Total Voluntary	Disability	1,133,078,786	118,171,592
For Profit – SA	Disability	63,516,176	2,991,663
Out of State – SA	Disability	7,503,740	0
Total Commercial	Disability	71,019,915	2,991,663
Total All	**Disability**	**1,204,098,701**	**121,163,255**

Section 38 Service Arrangements

Parent agency	Disability Funding €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
Saint John of God Community Services Limited	102,158,194	0
Daughters of Charity Disability Support Services Limited	94,481,475	37,599,128
St. Michael's House	68,420,349	0
Brothers of Charity (Galway)	45,191,741	0
COPE Foundation	44,331,970	0
Stewart's Care Ltd	42,599,039	0
Muiriosa Foundation	41,146,083	0
Brothers of Charity Southern Services	38,808,331	0
National Rehabilitation Hospital	29,204,416	0
Brothers of Charity Services South East	28,609,138	0
Brothers of Charity (Limerick)	25,039,829	25,039,829
Sunbeam House Services	22,416,952	0
Cheeverstown House	22,121,565	0
Peamount	19,761,435	0
KARE	16,236,288	0
Central Remedial Clinic (CRC)	15,451,892	354,261
Brothers of Charity (Roscommon)	14,273,073	0
Brothers of Charity (Clare)	11,329,789	11,061,057
Sisters of Charity - Kilkenny	10,675,575	0
Carriglea Cairde Services	8,793,393	0
The Children's Sunshine Home	4,005,596	0
Section 38 Service Arrangements Funding Tool	**705,056,123**	**74,054,275**

Section 39 Service Arrangements - Agencies in Receipt of funding in excess of €5m (19 Agencies)

Parent agency	Disability Funding €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
Rehabcare	43,238,328	11,908,629
I.W.A. Limited	37,567,410	4,900,501
Enable Ireland	35,735,297	7,606,087
Western Care Association	27,844,425	0
The Cheshire Foundation in Ireland	23,743,012	2,326,789
Ability West	22,623,770	35,685
National Learning Network Limited	14,291,234	744,054
St. Joseph's Foundation	13,862,674	5,646,621
Peter Bradley Foundation Limited	9,916,242	1,765,690
Camphill Communities of Ireland	8,922,416	245,073
Kerry Parents & Friends Association	8,704,867	0
St. Christopher's Services Ltd	8,267,804	0
SOS Kilkenny Ltd	8,263,569	0
St. Catherine's Association Ltd	7,174,080	0
Gheel Autism Services	6,996,837	0
Prosper Fingal	6,962,571	0
NCBI Services	6,496,661	429,151
CoAction West Cork	6,045,625	0
Autism Spectrum Disorder Initiatives Limited	5,469,650	0
Section 39 Service Arrangements Funding (> €5m) Total	**302,126,472**	**35,608,280**

Agencies in receipt of funding in excess of €1m

Parent agency	Disability Funding €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
Rehabcare	43,238,328	11,908,629
I.W.A. Limited	37,567,410	4,900,501
Enable Ireland	35,735,297	7,606,087
Western Care Association	27,844,425	0
The Cheshire Foundation in Ireland	23,743,012	2,326,789
Ability West	22,623,770	35,685
National Learning Network Limited	14,291,234	744,054
St. Joseph's Foundation	13,862,674	5,646,621
Peter Bradley Foundation Limited	9,916,242	1,765,690
Camphill Communities of Ireland	8,922,416	245,073
Kerry Parents & Friends Association	8,704,867	0
St. Christopher's Services Ltd	8,267,804	0
SOS Kilkenny Ltd	8,263,569	0
St. Catherine's Association Ltd	7,174,080	0
Gheel Autism Services	6,996,837	0
Prosper Fingal	6,962,571	0
NCBI Services	6,496,661	429,151
CoAction West Cork	6,045,625	0
Autism Spectrum Disorder Initiatives Limited	5,469,650	0
Walkinstown Association for People with an Intellectual Disability Limited	4,519,613	0
Cork Association for Autism	4,255,393	0
St. Hilda's Service for the Mentally Handicapped	4,235,824	0
Irish Society for Autism	4,224,004	113,085
St. Aidan's Day Care Centre	4,186,000	0
Childvision	4,041,957	0
The National Association for the Deaf	3,946,009	303,669
Catholic Institute for Deaf People (CIDP)	3,812,752	50,969
County Wexford Community Workshop (Enniscorthy) Ltd (CWCW)	3,811,477	0
Ard Aoibhinn Centre	3,261,505	0
St. Mary's Centre (Telford) Ltd	3,231,752	0
Prosper Meath	3,031,954	0
Genio Ltd	3,000,000	0
St. Paul's Hospital & Special School	2,909,463	0
Headway (Ireland) Ltd - The National Association for Acquired Brain Injury	2,817,851	228,032
L'Arche Ireland	2,745,723	0
Delta Centre	2,702,928	0
The Multiple Sclerosis Society of Ireland	2,554,291	63,673
Anne Sullivan Foundation for Deaf/Blind	2,417,294	192,934
St. Margaret's Centre	2,377,272	0
North West Parents & Friends	2,338,797	5,755
Waterford Intellectual Disability Association (WIDA)	2,248,501	0
Moorehaven Centre	2,209,149	371,504
St. Gabriel's Centre	2,034,019	2,034,019
Dara Residential Services Limited	1,817,382	0

Parent agency	Disability Funding €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
Disability Federation of Ireland	1,566,979	0
Centre for Independent Living (CIL) - Cork Ltd	1,565,900	0
West Limerick Independent Living Limited	1,485,861	1,485,861
St. Cronan's Association Limited	1,476,312	1,006,598
St. Vincent's Centre	1,474,662	0
Centre for Independent Living (CIL) - Laois/Offaly	1,377,586	0
Steadfast House Ltd.	1,360,864	0
County Wexford Community Workshop (New Ross) Ltd (CWCW)	1,266,090	0
Donegal Centre for Independent Living Limited	1,263,436	0
Order of Malta Regional Services Drogheda Limited	1,220,138	0
Muscular Dystrophy Ireland	1,127,495	2,000
Clann Mór	1,106,713	0
Drumlin House Training Centre	1,031,448	0
Section 39 Service Arrangements Funding over €1m	**398,180,866**	**41,466,379**
Nua Healthcare Services	15,409,328	446,338
Talbot Group	14,087,604	2,118,874
Three Steps Ltd	3,614,953	0
Galro	2,798,729	0
Resilience Healthcare Ltd	2,121,164	78,318
Simplicitas Ltd (UK)	1,930,976	0
Moorehall Lodge Healthcare Services Ltd	1,793,768	0
Tara Winthrop Private Clinic	1,636,094	0
Vurzol Ltd	1,396,365	0
Guardian Healthcare Ltd	1,382,817	0
All In Care	1,116,830	0
Talura House Ltd	1,040,389	0
For Profit Service Arrangements Funding above €1m	**48,329,017**	**2,643,530**
Praxis Care	5,556,539	0
Out of State Service Arrangements Funding over €1m	**5,556,539**	**0**

Older Persons

Older Persons Services – Total Funding	Older Persons Total €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
S38 – SA	48,471,796	0
S39 – SA	88,788,552	12,515,134
S39 – GA	16,674,569	1,993,795
Total S39	105,463,120	14,508,929
Total Voluntary	153,934,916	14,508,929
For Profit – SA	63,574,392	4,093,967
Out of State – SA	133,000	0
Total Commercial	**63,707,392**	**4,093,967**
Total All	**217,642,309**	**18,602,896**

Agencies in receipt of Funding in excess of €1m

Parent agency	Older Persons Total €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
Royal Hospital Donnybrook	16,689,136	0
Leopardstown Park Hospital	11,685,544	0
Incorporated Orthopaedic Hospital of Ireland	9,800,000	0
Peamount	7,712,016	0
Cappagh National Orthopaedic Hospital	2,585,100	0
Section 38 Service Arrangements Funding Total	**48,471,796**	**0**
Alzheimer Society of Ireland	10,235,068	1,484,439
Clarecare	5,058,261	5,058,261
The Carers Association	4,022,023	1,288,262
Marymount University Hospital and Hospice Limited	3,774,189	0
Fold Housing Association Ireland Limited	3,581,760	0
Dublin North Inner City Home Help	3,452,800	0
Roscommon Home Services Co-operative Limited	3,160,776	0
CareBright	2,424,477	2,396,816
St. Luke's Home	2,338,768	0
Ballymun Home Help	2,287,023	0
Fingal Home Help	2,267,311	0
Finglas Home Help/Care Organisation Ltd	2,165,041	0
Rehabcare	2,163,932	0
Caritas Convalescent Centre Ltd	2,047,000	0
Charter Medical Group Limited	1,971,870	0
Crumlin Home Care Service Limited	1,961,440	0
Blanchardstown & Inner City Home Care Association Ltd	1,862,568	0
Ballyfermot Home Help Ltd	1,703,789	0
Nazareth House Management Ltd	1,569,790	0
Nazareth House - Cork	1,439,883	0
Northside Homecare Services Ltd	1,379,163	0
Drumcondra Home Help & Care Services Ltd	1,321,954	0
Donnycarney / Beaumont Home Help	1,320,943	0
Terenure Home Care Services	1,151,493	0

Parent agency	Older Persons Total €	CHO Area 3 €
		Clare Limerick North Tipperary / East Limerick
CLR Home Help	1,135,705	0
Wicklow Community & Family Services	1,132,019	0
Greystones Home Help Services Ltd	1,081,205	0
West of Ireland Alzheimer's Foundation	1,000,699	0
Arklow South Wicklow Home Help Service Ltd	1,000,363	0
Section 39 Service Arrangements Funding Over €1m	**70,011,313**	**10,227,778**
Comfort Keepers (Elder Homecare Ltd)	13,633,923	1,753,787
All In Care	6,555,645	0
Homecare & Health Services (Ireland) Ltd (Homecare Independent Living)	4,344,101	0
Lynmara Healthcare Ltd	2,630,000	0
Caspian BMP Ltd	2,160,000	0
Talura House Ltd	2,085,568	0
MK Expert Providers Ltd	1,605,528	0
Limerick Senior Care Ltd	1,511,925	1,511,925
Sandra Cooney Home Care	1,295,279	0
Galway Senior Care Ltd	1,150,000	0
Byzantium MOD Limited	1,133,779	0
For Profit – SAs Funding €1m	**38,105,748**	**3,265,712**

Mid West Capital Programme

Older Persons

Centres Refurbished & Completed by end of 2016				
CHO	Residential Care Unit	County	Refurbish /Extension	Replacement
Area 3	Ennistymon Community Nursing Unit	Clare	Yes	

Centres Refurbished & Completed by end of 2017				
CHO	Residential Care Unit	County	Refurbish/ Extension	Replacement
Area 3	Regina House Community Nursing Unit Kilrush	Clare	Yes	

Centres with Refurbishment / Replacement Completed by end of 2018				
CHO	Residential Care Unit	County	Refurbish/ Extension	Replacement
Area 3	St. Ita's Newcastle West	Limerick	Yes	

Centres with Refurbishment/ Replacement completed by end of 2019				
CHO	Residential Care Unit	County	Refurbish/ Extension	Replacement
Area 3	Raheen Community Hospital	Clare	Yes	

Centres with Refurbishment / Replacement completed by end of 2021				
CHO	Residential Care Unit	County	Refurbish/ Extension	Replacement
Area 3	St. Conlon's Community Nursing Unit Nenagh	Tipperary		Yes
Area 3	Dean Maxwell CNU Roscrea	Tipperary	Yes	
Area 3	St. Joseph's Community Hospital, Ennis	Clare		Yes
Area 3	St. Camillus' Community Hospital	Limerick		Yes

Primary Care

CHO 3: Clare, Limerick, North Tipperary/East Limerick									
Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
Windmill Court, Garryowen, Limerick City	Primary Care Centre, by lease agreement.	Q4 2016	Q4 2016	0	0	0.00	0.00	0	0.00
Borrisokane, Co. Tipperary	Extension of primary care facility.	Q4 2016	Q4 2016	0	0	0.28	0.46	0	0.00