COMMUNITY HEALTHCARE ORGANISATION - AREA 7

(Dublin South City, Dublin South West, Dublin West, Kildare/West Wicklow)

Operational Plan 2016

Health and Wellbeing
Primary Care Services
Mental Health Services
Social Care Services

3 March 2016

Goal 5 Values

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

- Care
- Compassion
- Trust
- Learning

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

Vision

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

- **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

INTRODUCTION 4
Community Healthcare Organisation 7 ..... *4*
South Dublin/Kildare West Wicklow *4*

IMPROVING QUALITY & REFORMING SERVICE DELIVERY 11
Quality and Safety *11*
Health Service Reform. *14*
Clinical Strategy and Programmes. *15*

OPERATIONAL FRAMEWORK 16
Financial Framework - Funding and Financial Outlook *16*
The Workforce Position *33*

ACCOUNTABILITY FRAMEWORK. 37
Governance & Accountability *37*

OPERATIONAL SERVICE DELIVERY – CORPORATE GOALS IMPLEMENTATION 42
Health & Wellbeing Division *43*
Primary Care *50*
Mental Health Services CHO 7 ..... *61*
Social Care *70*

APPENDICES 86
Appendix 1: Primary Care Financial Tables *86*
Appendix 2 – Balance Scorecard & Key Performance Indicators *87*
Appendix 3 Key Performance Indicators (KPIs) *99*
Appendix 4 – Capital Projects Primary Care *137*

Introduction

Community Healthcare Organisation 7
South Dublin/Kildare West Wicklow

Area 7 – Population 668,250 (14.5% of the National Population).
Kildare West Wicklow LHO, Dublin West LHO, Dublin South City LHO and Dublin South West LHO.

Community Healthcare Organisation 7 covers for all or part of Local Authority Areas: Kildare, Wicklow, South Dublin CC and Dublin City Council.

Demographic Highlights:

0-18	185,810
0-5	68,885
65+	67,854
75+	25,185

103,578 persons born overseas comprising 15.5% of the population:

Polish	20,490
UK	10,745
Lithuanian	5,648
Other EU	20,849
Elsewhere	46, 026

A key priority in 2016 is to progress the further development of the structures and processes to ensure that this Community Healthcare Organisation supports the health needs of the population with high quality services provided to them as close to their homes as possible.

Next steps in this process include the appointment of Heads of Services across the various Divisions to form a management team for this CHO. Work will also progress in relation to the reconfiguration of services into 14 Community Health Networks which will, in time, become the principal unit of local service delivery to the population.

The Dublin Midlands Hospital Group provides acute health services within this CHO and it is essential that linkages forged between Community Services and St James's Hospital, Tallaght Hospital and Naas General Hospital are maintained and strengthened so as to ensure that the public we serve receive the care they are entitled to.

This area faces challenging targets for 2016 particularly in terms of meeting increasing demand for services within a constrained financial framework. We must also address the challenge of increasing regulatory requirements and the need to maintain a high quality of service.

At the same time there are opportunities in the HSE Service Plan 2016 across each of the Divisions to improve services in our catchment area.

Health & Wellbeing:

- Work will progress on the Healthy Ireland implementation plan this year.
- Immunisation rates and Child Health Screening remain a concern given the decreasing resource available within Primary Care to provide core services.
- Within this CHO the Integrated Care Programmes will support a range of initiatives this year including Older Persons and Chronic Disease Management.
- Staff will continue the good work in implementing the Tobacco Strategy across Divisions and increased numbers of staff will be released for training to support this programme.
- This CHO has engaged heavily with South Dublin County Council and Kildare County Council and are key partners within the LCDC structures. However, issues remain regarding the engagement with Dublin City Council which it is hoped can be addressed with the assistance of the Division in 2016.

Primary Care

- Significant issues remain in relation to the provision of Primary Care services within the CHO. Given the projected shortfall between allocated budget and expenditure a range of measures to avoid cost increases as well as reducing current expenditure levels will be required.
- The full implementation of the Pay Bill Management Framework will lead to a reduction in both frontline professional staff and administrative support during 2016. In addition, the opening of new facilities will be contingent on a funding source being identified.
- The 14 proposed Community Health Networks will form the cornerstone of service provision into the future. Work on the development of these networks will continue in 2016.
- Service Developments in the HSE National Service Plan will support the development of Chronic Disease Management initiatives in conjunction with General Practice. Potential service initiatives with Tallaght Hospital, Trinity College and local General Practitioners will also be explored through the Tallaght Project during the year.
- The implement Children First in Primary Care is a key priority during 2016 and staff engagement in relation to this will continue under the guidance of the Division.
- Participate in GP Out of Hours Service review
- Participate in Primary Care Electronic Patient Management System Project
- Implement Healthy Ireland priority actions in relation to Tobacco Control, Obesity and Immunisations

Palliative Care.

- The redevelopment of St. Brigid's Hospice with the support of the Friends of St. Brigid's will progress this year.
- Continue to support our partner agencies in ensuring that a quality patient centred approach is at the heart of service provision.

Social Inclusion

- Support health recommendations of the National Homelessness initiative
- Work with minority groups to improve access to Primary Care (Travellers & Roma)
- Work with National Office for Suicide Prevention in relation to the Traveller Suicide Initiative

Social Care - Older Persons Services:

- Home Support through Home Help and Home Care Packages have proven to be essential support to keeping older persons in their homes as long as possible. Significant challenges exist in 2016 to match demand for these services with the available finances. Significant assistance and support from the Social Care Division is essential in addressing the gap between the current demand for service and the available resource.
- We will continue to work with the Social Care Division and the Acute Hospitals in our catchment to provide targeted support to patients discharging from hospital to help them to remain at home through intensive Home Care Packages within the available resource.
- The Single Assessment Tool was successfully piloted in this area in partnership with Tallaght Hospital in 2015. This work will continue in 2016.
- The Clinical Programme for Older Persons will support a more Intensive integrated system of support for the integrated care of Older People between Community Services and Tallaght Hospital. This is a significant opportunity to further work in partnership with the Social Care Division and Tallaght Hospital to enhance services to older persons in this community.
- Specific issues remain in our Community Nursing Units in relation to the cost of care. The excessive cost of care will be reduced through focussed management intervention throughout the year to bring our costs in line with our peers.
- The continued implementation of the HSE Policy in relation to the Safeguarding of Vulnerable Adults will be supported through the further rollout of training to appropriate staff.

Disability Services:

- The financial position in relation to Disability Services is of extreme concern. Work will continue to address significant run rate issues in 2016. A range of measures are currently underway to minimise this but significant assistance from the Social Care Division will be required to agree a plan for a sustainable level of service that addresses the needs of the population of this CHO.
- Progressing Children's Disability Services:
  The reconfiguration of Children's Disability Services will continue across the CHO in partnership with CHO 6 and our voluntary partners.
- Significant risk remains in relation to compliance with the Disability Act 2005. Assessment of Need continues to be an issue given the very young population and the relative dearth of resource in the area.
- Value for Money/Congregated Settings:
  Focussed plans to move individuals from their current residential placements into community living arrangements will be finalised and implemented in partnership with our Voluntary organisations.

- Emergency Placements: Work will continue with our voluntary providers to cater for emergencies that arise during the year from existing resources. A full review of current placements will be undertaken to try and ensure better value for money while maintaining safe placements

- School Leaver in 2016: The HSE Service Plan makes provision for the resources required to ensure that 2016 school leavers have appropriate onward placements and work will continue with the Division to access those resources. Risk remains in relation those school leavers with very high needs.

- A comprehensive bid will be made to secure an appropriate share of new development posts for this CHO.

Mental Health

- Mental Health Services in this CHO have previously been part of two separate Supercatchment Areas, one comprising the Kildare West Wicklow Service and the Midlands, and, the other, comprising the St James's Service and the St Loman's' Service. Work will continue in 2016 to integrate all of the services, including Child & Adolescent Mental Health Services, into one integrated service.

- Work on the National Children's Hospital will continue in 2016 and this CHO will continue to develop plans with the Mental Health Division for the Child & Adolescent Mental Health component of the services to be provided at that location.

- Service users in this Community Healthcare Organisation have benefitted significantly from the additional funding made available through the HSE National Service Plan in recent years. However, services generally remain underfunded in comparison with national norms and significant risks remain across the full range of services. In particular, the capacity of the Kildare West Wicklow Service is inadequate and a range of supports for both community based and acute inpatient services are essential to address risk issues in 2016.
- The continued development of Psychiatry of Old Age Services in 2016 is a welcome addition to services given the demographic profile of the CHO

- Mental Health Services comprise an essential component of the overall service provision to the population and services will continue the process to reconfigure teams in to networks of approximately 50, 000 to mirror other community services.

- The Connected for Life Programme will commence in two locations across the CHO this year and it is hoped that two additional Jigsaw programmes will also commence.

- Service User representation is recognised as an essential component within Mental Health Services and initiatives to enhance this will continue this year.

- This CHO will also bid for additional resources to build capacity in sector teams and address acute capacity issues.

Capital:

- Primary Care Centres at Tallaght, Blessington and Kildare town are due to be completed in 2016. However, due to funding issues the opening of these facilities will be contingent on a funding source being identified.
- Capital approval for the enhancement/replacement of the Community Nursing Units within the HSE is a positive development and work will proceed in line with the timeframes outlined in the capital plan.
- Capital support to assist the de-congregation of institutional settings in the Disability Services will allow for significant progress this year in those services.

Quality & Patient Safety

- Significant risks exist within the CHO arising from the lack of a dedicated resource for Quality & Patient Safety. This deficit will be addressed with the support of the Divisions which will allow the CHO put in place the necessary QPS structures.
- Recruitment of additional Quality, Safety & Risk Managers will be required during the year.
- Consolidation of existing Quality, Safety & Risk committees across the Community Healthcare Organisation will continue as a key part of the formation and evolution of the CHO structures.
- Implementation of HSE Serious Incident Management Plan will continue
- Systems analysis training for staff will enhance the internal capacity to meet Quality & Patient Safety requirements.
- Ongoing implementation of HIQA Standards across services both in residential services and within the Primary Care services remains a key priority across all divisions.

Accountability Framework

The HSE's Accountability Framework was introduced in 2015 and has been further enhanced and developed for 2016. As part of the HSE's overall governance arrangements, the Accountability Framework is an important development which will support the implementation of the new health service structures. The Balance Scorecard dimensions of Access, Quality, Finance, and HR form the basis for the National Performance Reports each month and are based on a number of key priorities of the National Service Plan. The Chief Officer, CHO 7 is responsible for the delivery of the key result areas, identified in the Balance Scorecard, as part of a Formal Performance Agreement between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers. This is managed through a series of monthly performance meetings with the National Divisions. Arrangements are in place with the interim CHO 7 management team to report on the delivery of the key result areas in the balance scorecard.

Workforce

The staff of CHO 7 continues to be its most valuable resource and is central to improvement in service user care, productivity and performance. Engagement and involvement of staff in the new service design and delivery is a key priority for 2016. Recruiting and retaining motivated and skilled staff is a key objective and the effective management of the workforce will underpin the accountability framework in 2016. This requires that our organisation has the most appropriate configuration to deliver services in the most cost effective and efficient manner to maximum benefit.

Employment controls in 2016 will be based on the configuration of the workforce within funded levels. This requires an integrated approach, with service management being supported by HR and Finance. It further requires finance and HR workforce data, monitoring and reporting to be aligned. This will be developed once the Heads of Finance and HR are in place.

Reconfiguration and integration of services in line with the CHO report, the implementation of service improvement initiatives and the reorganisation of existing work and staff will all contribute to delivering a workforce that is more adaptable, flexible and responsive to the needs of the services.

Risks to the Delivery of the Operational Plan

HSE structural reforms will impact on CHO 7 in 2016 as services across former ISA's Dublin South Central and Dublin South West/Kildare West Wicklow are aligned at local level. We will continue to strive to prioritise service delivery in an equitable and transparent way.

Structural reform challenges, together with limited financial and human resources will impact on service delivery and risk in the following areas:

Structural Risks

- Management of capacity risk including financial management, given the scale of change being delivered. This is of particular concern in 2016 in the context of legislation regarding supplementary budgets.
- Organisational capacity to support the implementation of the reform programme will be essential to ensuring the overall governance and stability of services at CHO level.
- Implementation of national priorities will continue to be a risk in a climate of transition to a CHO structure.
- The extent of organisational capacity required to develop the required primary care networks and primary care teams and the associated scaling of models and pathways of care required to deliver high quality services
- Non-integration of ICT systems not fit for purpose from Clinical, HR and Financial perspective.

Service Risks

- Demographic pressures over and above those planned for delivery in 2016.
- Meeting HIQA standards for public long stay residential facilities, disability and primary care services.
- Financial risks associated with statutory and regulatory compliance.
- The ability to recruit and retain skilled and qualified clinical staff.
- The potential of pay cost growth which has not been funded.
- The deficit in Acute Mental Health Bed Capacity will continue to be a risk.
- The increase in demand for Home Care Packages beyond those funded is of a particular risk in 2016 in the context of a continued focus on alleviation of pressures in ED departments.
- Significant cost containment measures are required within this CHO to ensure that services are delivered within the financial allocation.

Conclusion

CHO 7 will continue to work towards maximising the safe delivery of services within the financial and human resources available while at the same time ensuring that quality and patient safety remains at the core of the delivery system. However, our ability to expand or put in place any additional new services in 2016, other than those specifically provided for in the Letter of Determination will be limited. This will be challenging as we re-structure our services in this CHO, whilst ensuring equality of services across our organisation in an ever increasing demand led environment. While it is acknowledged this list is not exhaustive, every effort will be made to mitigate the risks outlined above however it may not be possible to eliminate them in full within the current budgetary envelope.

David Walsh
Chief Officer
Community Healthcare Organisation 7
South Dublin/Kildare/West Wicklow
February 2016

Improving Quality & Reforming Service Delivery.

Quality and Safety

The HSE is committed to putting in place a quality, safety and enablement programme to support high quality, evidence based, safe effective and person centred care. Quality improvement, quality assurance and verification, will underpin the HSE approach to quality and safety in 2016, as is essential in times of constrained resources and change.

Leadership, including clinical leadership, is essential to embed a quality ethos in all services delivered and funded by the HSE and extends from the Directorate, the service Divisions and across the health and social care services. The appointment of Chief Executive Officers to the Hospital Groups and Chief Officers to the Community Healthcare Organisations paves the way for strong leadership so that quality is at the core of all we do.

Quality and safety priority areas for 2016 are:

- Proactive approach to service user and staff engagement.
- Completion of Self assessment against the *National Standards for Safer Better Healthcare* at CHO and divisional level (where applicable), Development and implementation of Quality Improvement Plans
- Ensure Community Healthcare Organisations have clear structures to govern and deliver quality care.
- Quality improvement capacity building and the establishment of quality improvement collaboratives.
- The development and use of appropriate quality performance measures.
- Establishment of Key performance indicators for quality improvement and patient safety and monitoring of this system.
- Introduction of Quality Profiles to measure and support improvement.
- The development and implementation of a quality assurance and verification framework.
- The management of Reportable and Serious Reportable Events in accordance with HSE protocol.
- Identification and management of Risk through the Implementation of the Risk Register system at divisional and CHO level.

Strategic Priorities for 2016

Person Centred Care

- Develop strong partnerships with patients and service users to achieve meaningful input into the planning, delivery and management of health and social care services to improve patient and service user experience and outcomes.

Effective Care

- Ensure that patients or service users are responded to and cared for in the appropriate setting including:
- Home, community and primary care, mental health and social care settings.
- Implement the National Clinical Guideline - Sepsis Management.
- Support the work of the National Clinical Effectiveness Committee and the implementation of the National Clinical Effectiveness Committee guidelines.
- Establish a revised Primary Care Medicines Management Programme to review all aspect of medicines procurement, prescribing and usage to ensure that potential health outcome from medicine are realised
- Health & Wellbeing will work to improve the uptake rate of the influenza vaccine amongst frontline healthcare workers in acute hospitals and long-term facilities in the community

Safe Care

- Continue quality improvement programmes in the area of Healthcare Associated Infections (HCAI) and implement the national guidelines for Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile and Sepsis, and the *National Standards for the Prevention and Control of Healthcare Associated Infections* with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms.
- Continue quality improvement in Medication Management and Safety.
- Implementation of HSE Open Disclosure policy across all health and social care settings.
- Implementation of the *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy & Procedures* (December 2014)

Improving Quality

- Development of models of frontline staff engagement to improve services.
- Mental Health services will lead a national safety programme which will aim to reduce avoidable harm in mental health services with an initial focus on acute inpatient care and post discharge period.
- Build capacity (Diploma, methodologies and toolkits).
- Develop further quality improvement collaborative in key services.
- Lead, in consultation with the services, a programme focused on the improvement of hydration and nutrition for service users.
- Development and implementation of a system of Healthcare Quality Improvement Audits.
- Develop a Quality Profile framework for application within all Health and Wellbeing Services and Functions
- Agree and implement a strategic approach to improving quality and patient safety to support the HSE in continuing to deliver on its overall priority on quality and patient safety.

Assurance and Verification

- Development and Implementation of measurable performance indicators and outcome measures for quality and risk.
- Development of quality and risk performance standards.
- Ensure routine assessment and reports on key aspects of quality and risk indicators.
- Implementation the National Adverse Events Management System (NAEMS) across all services.
- Development and Implementation of a system to facilitate the identification, assessment and management of risk at CHO, Divisional and service level
- Implementation remedial actions, additional control measures where required.
- Development, Implementation and audit of a process for the management of serious events requiring reporting and investigation in accordance with the safety incident management policy 2014.
- Implementation of a system for the dissemination, implementation and monitoring of recommendations from investigations.
- Develop and maintain CHO and divisional Risk Registers
- Manage complaints to ensure that learning is derived

Key Performance Indicators (KPIs)

During the year, all services will work towards measuring the structures and processes to produce measurable improvements in patient experience, effectiveness, safety, health and wellbeing and assurance for quality and safety within their services. The performance indicators in the table below are a subset of performance indicators based on strategic priorities.

Strategic Priority Area	KPI	Performance Measure / Target	Division
Person Centred Care			
Service User Engagement	All Divisions, Hospital Groups and Community Healthcare Organisations to have a plan in place on how they will implement their approach to patient / service user partnership and engagement	Phased over 2016	All
Effective Care			
Reduction in delayed discharges	Delayed discharges • reduction in bed days lost • reduction in the number of people whose discharge is delayed	 10% reduction 15% reduction	Primary Care and Social Care Divisions
Quality Improvement Audits	Number of audits completed	20	All
Safe Care			
Open disclosure policy	Each division to identify and train a cohort of open disclosure leads	20 per division	All
Vulnerable adults policy			
Safeguarding & Protection Team			
Number of Preliminary screenings received by the Safeguarding and Protection Team under 65			
Number of Preliminary screenings received by the Safeguarding and Protection Team 65 years and over			
Number of people trained in the Safeguarding Policy			
Number of Designated Officers trained in Safeguarding Policy			
Quality Assurance			
Serious Reportable Events	% of serious Reportable Events being notified within 24 hours to designated officer	99%	All
	% of mandatory investigations commenced within 48 hours of event occurrence	90%	All
	% of mandatory investigations completed within 4 months of notification of event occurrence	90%	All
Reportable Events	% of events being reported within 30 days of occurrence to designated officer	95%	All
Health and Wellbeing			
Healthcare worker vaccination	Flu vaccination take up by healthcare workers • Hospitals • Community	40%	All
Governance for Quality and Safety			
Quality and Safety Committees	Quality and Safety committees across all Divisions and Community Healthcare Organisation	100%	All

Health Service Reform.

Brief Description

Supporting the goals of the Corporate Plan 2015–2017, the reform programme will drive the delivery of person-centred, integrated care across the health and social care services, leading to 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 based on need, and are delivered in the most appropriate way.

To drive health service reform, service delivery reform programmes are in place for CHOs and Hospital Groups, National Ambulance Services, National Clinical and Integrated Care programmes and all of the key enabling programmes (including quality and safety, HR, ICT, Finance). Changes in the national divisional structures reflecting the changes to service delivery are being developed as part of the National Centre Programme.

Maintaining momentum in this reform programme in the context of increasing operational pressure on the health and social care delivery system is a key focus for 2016. An Action Plan for Health Service Reform is being agreed to support NSP 2016 and will map out the key service improvement deliverables for the reform programme for 2016 and beyond to 2019.

Governance and Management Arrangements to local CHO PMO

The nine CHOs are in the process of being established under the leadership of their Chief Officers. The CHO Implementation Programme will deliver on the recommendations of the CHO Report to establish appropriate governance and management arrangements for the delivery of services at local community level
A significant programme of change is underway to enable and drive the establishment of CHOs with the aim of delivering integrated services and better outcomes for service users. A robust programme management and governance structure is being adopted at national and local levels to support the programme, manage implementation and ensure that the benefits to the service users remain at the driving force for all programme activities.

Local and National CHO Programme Management Offices

The CHO Implementation Programme will be managed through a CHO National PMO and PMOs in each of the CHOs. The local PMOs are being established to oversee local implementation of CHO Reform Projects and other care service improvement and corporate change initiatives. Dedicated staff will be assigned to the National and Local PMOs to oversee the CHO Implementation, as well as project resources to drive the project delivery. The local PMOs will operate in conjunction with the CHO National PMO and the newly established PMOs in the Care National Divisions and the Corporate Services Divisions. The local PMO will report to the Chief Officer and will work closely with the National PMO. Local PMO and other staff working on projects have available to them supports in the form of Project and Change Management training and IT Programme Management tools.

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 a different extent involve the health and personal social services of CHO 7. We are working with these programmes to improve our services.

CHO7 specific Programmes

- CHO 7 is a pilot site for the Older People Integrated Care Programme and a service will be developed across primary and acute settings in the Tallaght area in 2016.
- The National Service Plan allocates resources to CHO 7 to further develop services for the Prevention & Management of Chronic Diseases in 2016.

Operational Framework

Financial Framework - Funding and Financial Outlook

CHO7 has received a total revenue allocation of €480.60m in 2016 to provide health and social care services within its catchment area. This is the budget allocated by Corporate Finance and is replicated in the Divisional Operational Plan.

When compared to the National Budgeting system (Rosetta), there may be differences which will be accounted for through recurring Budget posted on Rosetta after October 2015, as well as budget adjustments subsequent to the drafting of the Operations plan.

The total funding available for existing services represents a decrease of €3.41m (0.7%) on the final outturn budget for 2015. When taking into account the reduction in regional Contract Beds & Subvention in Older Persons services of c.€5m (assumed at break even in 2016) and Transitional Care Bed (TCB) funding of €3.6m, the budget for 2016 has increased by €5.2m on these two factors alone. However, as the TCB monies were used to assist in balancing the overall SCOP position in 2015, the retraction of these monies reflects a higher opening deficit carried into 2016.

On a direct Budget comparison basis, and when factoring in and/or extracting items not continuing into 2016, the overall Budget has increased by c. €4m (0.8%). Almost €2m of the increase in is Demand Led Schemes, with another €1m in Primary Care services to deal with paediatric home care packages.

Overall, the remaining net increase of €940k represents just 0.2% growth against the base allocation. This needs to be factored against the backdrop of economic and other factors such as wider population growth of 0.7% nationally (0.79% for CHO7), increased levels of service demand associated with an ageing population, the extra day's cost in 2016 and the overall non-funding of increments and non pay inflation.

Saving targets across the sectors in 2016 are included in the overall Budget figure at €2.29m.
2015 also saw significant cost pressure growth in emergency placements in Disability settings and in Home Care package expenditure in Older Persons services, where such expenditure was designed to alleviate overcrowding in Acute Hospital settings. This will continue to present as a significant challenge in 2016.

Table 1 below outlines a summary of the relative financial position for Statutory services and Section 38 (Voluntary) Agency services between 2015 and 2016.

Table 1 - 2015 - 2016 Spend and Allocation by Division - CHO7 (Statutory funded & S38)

Statutory & S38 Services	Outturn 2015 (€m)	Budget 2015 (€m)	Deficit/ (Surplus) 2015 (€m)	Deficit/ (Surplus) 2015 (%)	Projected Outturn 2016 (€m)	Advised Budget 2016 (€m)	Deficit/ (Surplus) before Cost Containment 2016 (€m)	Deficit/ (Surplus) 2016 (%)
Primary Care	78.85	77.52	1.34	1.7%	80.01	78.59	1.42	1.8%
Social Inclusion	46.14	45.99	0.15	0.3%	46.81	46.00	0.82	1.8%
Palliative Care	22.26	23.02	(0.75)	-3.3%	23.34	23.36	(0.02)	-0.1%
S/T (exc schemes)	147.26	146.52	0.73	0.5%	150.16	147.94	2.22	1.5%
Local Schemes	45.10	44.28	0.82	1.8%	46.27	46.27	0.00	0.0%
Primary Care Total	192.36	190.81	1.55	0.8%	196.43	194.21	2.22	1.1%
Mental Health Total	72.56	71.94	0.62	0.9%	75.43	72.88	2.55	3.5%
Older Persons	68.36	67.26	1.10	1.6%	71.84	65.47	6.37	9.7%
Disability Services	153.90	147.18	6.72	4.6%	159.15	148.04	11.11	7.5%
Social Care Total	222.26	214.44	7.81	3.6%	230.98	213.51	17.48	8.2%
Totals	487.18	477.19	9.98	2.1%	502.84	480.60	22.24	4.6%

Table 2 provides a similar summary of the relative financial position for Statutory services only between 2015 and 2016.

Table 2 - 2015 - 2016 Spend and Allocation by Division - CHO7 (Statutory funded only)

Statutory Services Only	Outturn 2015 (€m)	Budget 2015 (€m)	Deficit/ (Surplus) 2015 (€m)	Deficit/ (Surplus) 2015 (%)	Projected Outturn 2016 (€m)	Advised Budget 2016 (€m)	Deficit/ (Surplus) before Cost Containment 2016 (€m)	Deficit/ (Surplus) 2016 (%)
Primary Care	78.85	77.52	1.34	1.7%	80.01	78.59	1.42	1.8%
Social Inclusion	46.14	45.99	0.15	0.3%	46.81	46.00	0.82	1.8%
Palliative Care	2.83	2.82	0.01	0.3%	2.81	2.82	(0.02)	-0.7%
S/T (exc schemes)	127.83	126.33	1.50	1.2%	129.63	127.41	2.22	1.7%
Local Schemes	45.10	44.28	0.82	1.8%	46.27	46.27	(0.00)	0.0%
Primary Care Total	172.93	170.61	2.31	1.4%	175.90	173.68	2.22	1.3%
Mental Health Total	72.56	71.94	0.62	0.9%	75.43	72.88	2.55	3.5%
Older Persons	56.23	55.11	1.12	2.0%	60.50	54.13	6.37	11.8%
Disability Services	58.33	52.23	6.10	11.7%	63.22	52.11	11.11	21.3%
Social Care Total	114.56	107.34	7.22	6.7%	123.72	106.24	17.48	16.4%
Totals	360.05	349.90	10.15	2.9%	375.04	352.80	22.24	6.3%

As outlined above the significant deficit drivers will be in Older Persons and Disability services. Mental Health services require significant cost containment or other measures to avoid a deficit position at the end of 2016. Primary Care services represent a challenge of €2.22m, or 1.3%, and will be dealt with through cost containment measures.

The cost containment summary is outlined below as follows:

Table 3 - 2016 Cost Containments (Statutory funded & S38)

Statutory & S38 Services	Deficit/ (Surplus) before Cost Containment 2016 (€m)	Type 1 CC Plan (€m)	Type 2 CC Plan (€m)	Type 3 CC Plan (€m)	Total Cost Containment (€m)	Remaining Deficit/(Surplus) (€m)	Deficit/ (Surplus) 2016 (%)
Primary Care	1.42	0.79	0.77	0.00	1.56	(0.14)	-0.2%
Social Inclusion	0.82	0.31	0.51	0.00	0.82	0.00	0.0%
Palliative Care	(0.02)	0.00	0.00	0.00	0.00	(0.02)	-0.1%
S/T (exc schemes)	2.22	1.09	1.28	0.00	2.38	(0.16)	-0.1%
Local Schemes	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
Primary Care Total	2.22	1.09	1.28	0.00	2.38	(0.16)	-0.1%
Mental Health Total	2.55	0.16	0.20	0.00	0.36	2.19	3.0%
Older Persons	6.37	3.00	0.00	0.00	3.00	3.37	5.1%
Disability Services	11.11	0.50	2.78	0.00	3.28	7.83	5.3%
Social Care Total	17.48	3.50	2.78	0.00	6.28	11.20	5.2%
Totals	22.24	4.75	4.26	0.00	9.01	13.24	2.8%

The types of cost containments can be summarised as follows:

Type 1 - cost reduction driven by improved practices and targeted cost reductions, particularly in Agency, Overtime, Paybill and Non Pay
Type 2 - reduction in service delivery
Type 3 - additional sanctioned spend

The 2016 allocation includes funding for cost increases arising from the Lansdowne Road Agreement and for the rollover of funded 2015 service developments, such as Sleepover monies and School leavers in Disability settings as well as Demand Led Scheme growth and Paediatric Home Care Packages in Primary Care.
No funding has been provided for increments, the additional day in 2016, or other pay/non pay cost pressures over which CHO7 has limited control. Where possible, these increases will require re-allocation from existing resources to prevent the emergence of deficits.

CHO7 is fully committed to delivering efficiencies where possible, whilst acknowledging the requirement to continue to provide safe and effective services to a growing and ageing population. The above financial summary reinforces the inherent financial risk associated with the current budgetary allocation for CHO7.

Primary Care Financial Framework

The National Service Plan 2016 sets out the details of the primary care budget of €3,624.4m for 2016, which is an increase of 5.55% on the Budget for 2015.

In January 2016, Primary Care Division advised CHO7 of its 2016 Statutory services Budget as follows:

Statutory Services	Deficit at end 2015 (€k)	2016 Budget (€k)	2015 Budget (€k)	Inc / (Dec) (€k)	% Inc / (Dec) (€k)
Primary Care	1,337	78,449	77,518	931	1.2%
Social Inclusion	152	45,997	45,985	12	0.0%
Palliative Care	10	2,825	2,824	1	0.0%
Net of Local DLS	1,498	127,271	126,327	944	0.7%
Local DLS	817	46,274	44,283	1,991	4.5%
Total	2,315	173,545	170,610	2,935	1.7%

The 2016 opening Budget includes c. €1.9m in once-off monies which will reverse out of CHO7 budgets at the end of 2016.

The Budget per the National Budgeting system (Rosetta) in January 2016 shows additional once-off monies in relation to a staff secondment which hadn't been notified in the original figures as shown above. The net impact of the 2016 vs 2015 allocation on Rosetta can be summarised as follows:

Rosetta - Movement in Primary Care Funding for CHO7 2015 v 2016		
Includes Pall/Soc Inclusion, Excludes Demand Led Services		
	€000s	€000s
Budget 2016		127,406
Budget 2015	126,327	
Increase in Core Funding		1,079
% Increase		0.85%

The table above shows the underlying deficit in Statutory services, net of Local Demand Led schemes, at the end of 2015 was €1.5m. The table illustrates that 2016 funding has increased by just €944k or 0.7%, which ensures that services are carrying a deficit of c. €550k into 2016, before additional costs are taken into account, such as:

- Additional day (€350k);
- Increments (approx €508k);
- Programme Refugee Costs in Monasterevin (€312k);
- Opening of four new Health Centres (€374k);
- Growth in Paediatric HCP cases (€400k).

Taken in total, CHO7 Statutory services are projecting a deficit of €2.354m for 2016, which will be subject to appropriate cost containment measures to be agreed with the Primary Care Division.

Our Lady's Hospice Harold's Cross Palliative Care Services for 2015 are summarised below:

Entity	2015 Spend (€k)	2015 Budget (€k)	Var (€k)	% Var
Our Lady's Hospice Harold's Cross	23952	23854	98	0.4%
broken down between				
Fair Deal	4521	3659	863	23.6%
Palliative Care	19430	20195	-765	-3.8%

It is necessary that further work takes place in 2016, involving Primary Care and Social Care Division to agree a basis for splitting the above cost/budget equitable between the Fair Deal and Palliative Care entities within the Hospice.

The Budget for Palliative Care services for the Hospice in 2016 has been notified as €20,450k, representing an increase of €255k against the 2015 closing allocation, or c. 1.3%.

Incoming Deficit

CHO7 Statutory Services closed 2015 with a deficit of €2.315m or 1.36%. Local Demand led services accounted for approximately €817k of the deficit, with the bulk of the remaining growth in expenditure and consequent deficit split between Paediatric Home Care Packages, Children's Dental Services, including General Anaesthetic, Health Centre running costs and Adult Homeless services.

Existing Level of Service

ELS refers to the cost of maintaining existing service level. CHO7 has estimated its cost for 2016 as €174,752k. This represents a variance of c. €1,207k against the notified Budget and doesn't take account of additional services such as Opening of health Centres and Programme refugee additional costs and additional paediatric packages of care.

Savings and Extra Revenue Targets (Divisional)

The revenue allocation for the Division is net of assumed savings and efficiency measures of €112.9m as follows;

- **€2.9m** - General reductions in non-pay budgets including savings to be made through the procurement process.
- **€110m** - Targeted reductions in drug and prescribing costs; this will involve additional measures in areas such as probity and prescribing behaviour.

HSE Prioritised Initiatives (Divisional)

The DoH holds further funding on behalf of primary care of **€13.5m** in respect of GP Contract developments including extending care without fees to children up to 12 and provision for rural GP practices, access to diagnostics and minor surgery.

Pay and Pay Related Savings (Divisional)

The Division commenced the implementation of a plan for the conversion of agency in 2015 and this will continue in 2016. In line with Pay Bill Management Policy, the replacement of existing posts will be dependent on individual CHO being able to deliver its planned services within allocated funding.

Financial Risk Areas

In 2016 all services will be required to operate within the notified Budget.

For CHO7, this has been estimated as representing a financial challenge of €2.354m. There is a requirement for some restructuring of Budgets between services, however the significant deficits as broken down by service is as follows:

- Health Centres - €846k;
- Adult Homeless - €820k;
- Paediatric packages - €591k;
- Childrens Dental Services - €285k.

Some of these deficits areas are offset by surpluses in General Primary Care services and Adult Dental Services and will be part of a process of budget re-alignment in 2016.

Mental Health Financial Framework

- MHD have notified a Budget figure for 2016 of €73.036m. This includes an amount of €1.9m for Developments posts brought forward from planned developments in 2013/2014, leaving a net Budget figure of €71.130m. When taking account of other net additions/changes in 2016 of €125k, the notified brought forward base budget for 2016 is €71.005m.
  This compares to an opening base figure for 2016 on the national Rosetta system of €71.201m.

- Expenditure on MH services in 2015, excluding Once-offs, amounted to €71.798m. When compared to the starting net Budget for 2016 of €71.130m, this equates to an opening deficit of €0.668m.

- Expenditure in 2016 is set to rise on foot of expenditure trend increases during 2015. This increase resulted from significant pressures in our Lakeview Acute unit which regularly operated beyond safe capacity, thereby resulting in the requirement for placements to 3rd Part service providers. We estimate the deficit under this heading to be in the region of €1.3m for 2015.

- Other significant cost drivers include Nursing costs in Lakeview as well as Medical Agency costs in Mid West, Mid East and North East Community settings. Persistent difficulties in recruiting staff to services have hampered our ability to reduce Agency costs in any significant manner

- CHO7 is likely to likely to be showing a deficit of c. €2.6m in 2016. This is largely within the Kildare West Wicklow service which has been shown to be consistently under resourced in MHD comparatives. A strategy to manage both financial and service risk is being agreed with the Mental Health Division.

A Summary of the movement in the Mental Health funding position as at Jan 2016 on the national Budgeting system (Rosetta) shows that the net Budget between 2015 and 2016, when taking account of once-off Minor Capital works monies received across year-end, increased by €204k, or 0.29%.

There are additional adjustments to be received on Rosetta, which will amend this figure over the course of 2016, including Development posts monies of €1.9m

Rosetta - Movement in Mental Health Funding for CHO7 2015 v 2016		
Excludes Minor Works monies received in 2015/2016		
	€000s	€000s
Budget 2016		71,384
Budget 2015	71,181	
Increase in Core Funding		204
% Increase		0.29%

Existing Level of Service

CHO7 is particularly mindful of published comparisons which show it to be relatively less well off in resource terms by comparison to its peers. This will have a detrimental impact on finding any significant levels of cost containments to deal with the budgetary issues highlighted above

New Monies

CHO7 welcomes the initiative from MHD to enhance the already detailed analysis of its' resources and to use this information source to allocate the 2016 development funds of €35m, maximising equity across regions, age and social need as appropriate.
CHO7 is confident that this initiative will greatly assist in moving towards a more equitable budget base, relative to its population size.

Approach to Financial Challenge

CHO7 Chief Officer communicated the funding difficulties for 2016 to MHD in early February. It recognised that some cost containments can be delivered within the St Lomans/St James services which will focus on savings in planned ECT arrangements of c. €200k and more broad based savings of €157k across a range of categories including reductions in the use of Agency Nursing and security and energy cost savings within the new CAMHS Unit.

The financial challenge within the Kildare West Wicklow service is estimated at €2.25m. The service operates in a high-risk situation on a permanent basis with over occupancy of the inpatient unit and significant deficits in community services and a lack of access to hostel accommodation. There is therefore no opportunity to contain costs pending the provision of remedial investment funding. However, discussions with the Mental Health Division to address these issues are at an advanced stage.

Pay Cost Pressures

CHO7 will seek to implement measures where possible to enable compliance with public pay policy without impacting services or giving rise to further growth in the funding deficit.

CHO7 is committed to improving pay bill controls in 2016 and is taking action where possible to do so. A key part of this commitment will be to develop an integrated strategy in respect of recruitment, agency conversion and workforce planning in 2016.

It must also be acknowledged that there are a variety of factors, including quality and safety issues, driving upward pressure on staff numbers overall.

Non Pay Cost Pressures

CHO 7 anticipates that Non Pay Cost Pressure in Mental Health for **Private Placements** will continue into 2016, arising largely from capacity issues in existing acute facilities, and as a response to continued demand for additional capacity in dealing with increased episodes of acute illness and due to more complex presentations.

Savings and Efficiency Measures - €2.5m

The MHD revenue allocation for 2016 is net of assumed savings and efficiency measures of €2.5m. CHO7 shares in these savings as follows:

- €23k – general reductions in non-pay budgets including savings to be made through the procurement process.
- €119k - additional Value for Money / Efficiency Savings needed to cover our share of a national fund to support Integrated Care Programmes (€9m), Quality Improvement and Assurance Initiatives (€3m) and support for CHOs/HGs (€1.2m) which benefit all service users.

Income Focus

Income – CHO7 will ensure compliance with the 2011 Health (Charges for In-Patient Services) Regulations and the National Guidelines for Long Stay Charges.

Financial Risk Areas

In identifying potential risks to the delivery of the Financial Plan, it is acknowledged that while every effort will be made to mitigate these risks, it may not be possible to eliminate them in full. These financial risks largely resulting from increased demand for services, increased regulatory requirements and staff recruitment and retention issues are outlined in the previous Risks section of this plan.

Community Costing

The Chief Officer will:

- Ensure that the CHO 7 has a robust approach to costing services and cycles of care in order to fully inform commissioning of services and the objective allocation of resources.
- Ensure that there is robust financial analysis to allow a better understanding of the drivers of costs. This will allow better forecasting of future costs and improved service reports.

CHO 7 will support the divisional work on this initiative in maximising the evidence base for improved resource allocation methods and approaches for deployment of mental health resources.

Finance Work Plan

A specific emphasis by the HSE throughout 2016 will be on standardising and streamlining finance processes, with an initial focus on service arrangements and invoice payments and progressing ledger alignment, to facilitate a common understanding and to support financial performance management.

CHO 7 acknowledges the requirement to operate within the limits of the funding notified to it and will ensure this receives the very significant management focus required in 2016. Given the scale of the demographic, regulatory and other service pressures, there is a substantial financial risk being managed within this plan. In the context of the Accountability Framework, particular attention will be focused on driving financial performance across the CHOs in light of the scale of the financial challenge.

2016 CHO7 MH Allocation (Notified)

All figures are in (€000's)	2014 Actual Net Spend	2015 Proj Spend Ongoing Services	2015 MW OO	2015 NMW OO	2015 Proj Tot	2016 Op Bud	2013/2014 Dev Posts	2016 Closing Bud (Notified Allocation)
CHO7	68,532	71,798	435	328	72,561	70,974	1,906	72,880

Social Care Financial Framework

Social Care - Allocation (National)

The national Social Care allocation for 2016 is €3,201.5m representing an increase of €104.8m or 3.3% on the projected outturn 2015. Whilst continuing efforts will be made to reform and improve services based on existing values with service users at the centre of all decision making, there will also be a focus on the cost and sustainability of services while ensuring at all times that services are delivering best value for money for the public and service users. The additional €104.8m funding is welcome, however, the challenge for 2016 is Social Care's capacity to meet the increasing demand of an ageing population, together with changing needs and an increasing number of people with a disability with more complex service requirements. Demand for services continues to increase as the population of 65 years and over will increase by 3.1% between 2015 and 2016, equating to an additional 19,400 people. The population 85 years and over (which places the largest pressure on services) is growing at a rate of 4.2% between 2015 and 2016.

Budget Framework 2016

TABLE 2	Disabilities	Older Persons	NHSS	Total Social Care
Opening Base Allocation 2016	1,461.1	657.8	873.9	2,992.8
2015 Additional Base Funding				
HIQA Cost Pressures	45.5			45.5
Non-Pay Clinical	0.0	5.0		5.0
Subtotal 2015 Additional Base Funding	**45.5**	**5.0**	**0.0**	**50.5**
2016 Existing Level of Service Funding				
Pay Including Lansdowne Road Agreement (LRA)				
LRA	11.9	3.4		15.3
PSPR and Other Pressures	0.7	0.3		1.0
LRC Recommendations	8.0			8.0
Subtotal Pay Including Lansdowne Road Agreement (LRA)	**20.6**	**3.7**	**0.0**	**24.4**
2016 Non Pay Funding				
Non Pay	0.0	0.4	12.1	12.5
Non Pay – Therapy	2.0			2.0
Non Pay - School Leavers	6.0			6.0
Non Pay - Emergency Places	16.5			16.5
NHSS Demographics	0.0		14.7	14.7
Subtotal 2016 Non Pay Funding	**24.5**	**0.4**	**26.8**	**51.7**
Full Year Cost 2015 Commitments				
ED - Winter Plan		6.8		6.8
Delayed Discharges		12.4	39.3	51.7
Subtotal Full Year Cost 2015 Commitments	**0.0**	**19.2**	**39.3**	**58.5**
2016 Existing Level of Service Funding	**45.1**	**23.3**	**66.1**	**134.6**
2016 Savings Measures				
Cost Savings 2016	(0.2)	(0.3)		(0.5)
ADJ ICPs Other	(1.6)	(2.5)		(4.1)
2016 Savings Measures	**(1.8)**	**(2.8)**	**0.0**	**(4.6)**
2016 Additional Funding Available for Existing Service				
2016 Total Funding available for Existing Services	1,550.0	683.3	940.0	3,173.3
2016 New Initiatives				
Disability School Leavers	7.3			7.3
Expansion of Respite Beds	1.0			1.0
2016 New Initiatives	**8.3**	**0.0**	**0.0**	**8.3**
2016 Net Determination	**1,558.2**	**683.3**	**940.0**	**3,181.5**
*Time related savings from Development Funding allocated once off		20.0		20.0
Total 2016 Net Determination	**1,558.2**	**703.3**	**940.0**	**3,201.5**

The cost of providing the existing services at the 2015 level will grow in 2016 due to a variety of factors including national pay agreements / public pay policy requirements, quality and safety requirements, regulatory requirements, unfunded emergency places, other clinical non pay costs, price rises etc. A total of €316.1m has been provided towards the expected growth in costs in 2016 of existing services for all HSE services, of this figure €130m has been provided for Social Care services, made up of €20.5m services for Older Persons, €66.1m NHSS and €43.4m Disability Services. The balance of 2016 expected cost growth is to be dealt with by way of additional savings and other financial measures. These measures will be specified by CHO and underpinned by a robust pay bill management strategy with a particular emphasis on agency conversion. In addition each CHO must implement a robust review mechanism for the appropriateness of current levels of Home Help/ Homecare Packages and Replacement Residential/Emergency Placements to establish the possibility of recycling hours/packages/places.

Table 2 above Budget Framework 2016 - sets out the budget allocations for Social Care in respect of 2016

Additional Base Funding and ELS for Social Care

- Additional recurring funding of €50.5m (€45.5m disability services, €5m services for older persons) has been provided in respect of the 2015 base allocation this will assist the Social Care in addressing the unfunded costs brought forward from 2015 with the balance to be dealt with by way of savings and other financial measures.
- A total of €58.5m has been provided in 2016 for the cost of initiatives commenced in 2015 which will have a full year incremental cost in 2016, €6.8m has been allocated to the winter initiative and €51.7m for the Delayed Discharge Initiative. Both initiatives are intended to alleviate pressures on the acute hospital system.
- €6m funding has been provided for the full year cost of 2015 school leavers and €2m for the full year cost of 2015 therapy posts.
- €16.5m is allocated for provision of full year costs of replacement of residential capacity and emergency places approved by the HSE and commenced in 2015.

Pay Funding and ELS for Social Care

- €24.4m has been allocated to Social Care for both Statutory and Section 38 Providers to off-set the growth in pay costs associated with the Lansdowne Road Agreement, Labour Relations Commission recommendations and other pay pressures.

Non Pay Funding

- Additional funding of €26.8m has been provided to the Nursing Home Support Scheme, €14.7m for demographics to continue to maintain the waiting time at no longer than 4 weeks, provided that the demand for the scheme remains unchanged, €12.1m has been provided to deal NTPF awarded price increases for private nursing home provision within the NHSS scheme.

New Initiatives

- School Leavers - Additional funding of €7.25m will be made available in 2016 for the provision of a day centre place for approximately 1,500 young adults for persons with a disability who are exiting school or rehab training places. In implementing this initiative, providers will be required to adhere to the principles of the *New Directions*.
- Home Respite Initiatives **–** an additional €1m has been allocated in 2016 for the development of community based home respite initiatives within the disability sector.

- €8m is being held by the DoH for provision of therapeutic services for young people, including early intervention teams and in particular speech and language therapy services. In line with Progressing Disability Services for Children and Young Adults (0-18s Programme) €4m of this held funding is allocated for 75 new therapy posts. This will assist with the significant programme of reconfiguration already underway within the service which will see the creation of 129 Children's Disability Network Teams. This initiative also includes an initiative to address waiting lists for therapeutic services for children and young people – in particular speech and language therapy. €4m has been provided for these initiatives in 2016 and detailed plans are being prepared in conjunction with Primary Care. Full year funding for this initiative will be made available in 2017.

An important aspect of the budgetary framework for Social Care in 2016 is that approval has been given to utilise €20m in expected time related savings from the €58.5m new initiatives money held by the DoH to maintain 2015 outturn levels in Home Care and Transitional Care.

Approach to Financial Management 2016 (CHO7)

Financial Risk Areas - Disability Services (Statutory)

CHO7 has identified a significant financial challenge of €11.076m in Statutory Disability services in respect of maintaining existing levels of service and meeting commitments within the net revenue allocation notified for 2016 of €52,152k.

The challenge can be summarised as commencing from the 2015 closing deficit position of €6,100k as follows:

Breakdown of Deficit at end 2015	**(€k)**
Capitation	3,944
Grants	118
Statutory	2,039
Total	**6,100**

The working assumption is that a significant portion of once-off Budget monies in 2015, approximately €433k, reflect expenditure which will not recur in 2016. It equally follows that the 2016 Budget will be adjusted to return monies provided to the Voluntary services providers in error relating to school leavers monies provided in the base rollover in 2015 and again in 2016 in relation to the same cohort of service users.

Assuming the budgetary position on Rosetta, adjusted for school leavers monies to revert to CHO7 statutory services, equates to €52,152k for 2016, CHO7 expects to be in a deficit position by the end of 2016 of €11,076k, explained as follows:

Reconciliation of 2015 deficit to 2016 projected deficit	
Deficit c/f from 2015	6,100
Run Rate increases impact in 2016	2,592
TUSLA Cases	1,176
New/Enhanced Placements	1,144
Own staff Increments	64
Total Deficit	**11,076**

The key approach to address the financial risk will be a measure of containments, including as follows

- review of existing emergency placements, c €500k;

- cessation of Agency/Private AON services, c. €400k;
- non actioning of TUSLA cases €1,176k;
- non actioning/paring back of critical emergency cases €1,200k

The above cost containments have the potential to reduce the potential deficit from c. €11.1m to €7.8m. Additional assistance has been sought from the Division in terms of securing an appropriate share of the €16m available nationally to deal with Emergency Placement costs.
CHO7 recognises the need to operate within the planned cost level for 2016 in order for the HSE to deliver a balanced position, whilst also recognising the extremely limited scope to address the significant cost drivers with this health area.

Financial Risk Areas - Disability Services (Voluntary)

The tables below illustrate the relative budget movement for CHO7 Section 38 (Voluntary) agencies. The overarching assumption taken by CHO7 management is that each Agency will break even against its' Budget, and the CHO will actively engage with each Agency in order to assist in doing so.

Cheeverstown House has received an increase in allocation for 2016 of €379k over 2015 levels. The table below summarises the position per the National budgetary system (Rosetta). The 2016 budget is adjusted for a retraction of School Leavers funding of €22k, while the 2015 budget is adjusted for supplementary and one off funding of €392k received which was not carried into the 2016 allocation.

The budget increase of €379k (1.66%) relates mainly to additional LRA funding €334k & School leavers funding of €72k, with a deduction of €28k for saving measures offsetting against these increases.

Cheeverstown - Movement in Funding for CHO7 2015 v 2016			
Heading	**Comment**	**€000s**	**€000s**
Budget 2016	After SL funding retraction of €22k		23,181
Budget 2015	After removing once-off funding in 2015 with no relation to 2016 costs, i.e., partial supplementary & Pensions	22,802	
Increase in Core Funding			379
% Increase			1.66%

KARE has received an increase in allocation for 2016 of €588k over 2015 levels. The table below summarises the position per the National budgetary system (Rosetta). The 2016 budget is adjusted for a retraction of School Leavers funding of €147k, while the 2015 budget is adjusted for supplementary and one off funding of €140k received which was not carried into the 2016 allocation.

The budget increase of €588k (3.55%) relates mainly to additional LRA funding €277k & School leavers funding of €332k with a deduction of €23k for saving measures offsetting against these increases.

KARE - Movement in Funding for CHO7 2015 v 2016			
Heading	**Comment**	**€000s**	**€000s**
Budget 2016	After SL funding retraction of €147k		17,158
Budget 2015	After removing once-off funding not carried into 2016 of partial supplementary & SL Capital	16,571	
Increase in Core Funding			588
% Increase			3.55%

Peamount Disability services has received an increase in allocation for 2016 of €400k over 2015 levels. The table below summarises the position per the National budgetary system (Rosetta). The 2015 budget is adjusted for supplementary and once off funding of €695k received which was not carried into the 2016 allocation.
The budget increase of €400k (3.32%) relates mainly to additional LRA funding €417k, with a deduction of €15k for saving measures offsetting against these increases.

Peamount (Disabilities) - Movement in Funding for CHO7 2015 v 2016			
Heading	**Comment**	**€000s**	**€000s**
Budget 2016			12,456
Budget 2015	After removing once-off funding not carried into 2016 of partial supplementary	12,056	
Increase in Core Funding			400
% Increase			3.32%

Stewarts Disability services has received an increase in allocation for 2016 of €1,138k over 2015 levels. The table below summarises the position per the National budgetary system (Rosetta). The 2016 budget is adjusted for a retraction of School Leavers funding of €228k, while the 2015 budget is adjusted for supplementary 2015 funding of €301k received which was not carried into the 2016 allocation.

The budget increase of €1,138k (2.71%) relates mainly to additional LRA funding €702k & School leavers funding of €457k with a deduction of €56k for saving measures offsetting against these increases.

Stewarts - Movement in Funding for CHO7 2015 v 2016			
Heading	**Comment**	**€000s**	**€000s**
Budget 2016	After SL funding retraction of €228k		43,134
Budget 2015	After removing once-off funding not carried into 2016 of partial supplementary & SL Capital	41,995	
Increase in Core Funding			1,138
% Increase			2.71%

Older Persons Services & NHASS (Statutory)

When excluding Regional Contract & Subvention beds, funding for Older Persons services in 2016 has dropped against the 2015 base by approximately €2.3m on a gross basis, or by €568k when adjusting for sanctioned overspend in Home Helps/Home Care Packages.

The table below illustrates the net movement in Budget per the national Budgeting (Rosetta) system at January 2016:

Rosetta - Movement in Older Persons Funding for CHO7 2015 v 2016		
Excludes FD Billing & Comm & Transitional Beds		
	€000s	€000s
Budget 2016		52,413
Budget 2015	54,714	
Increase in Core Funding		(2,301)
% Increase		4.2%

The budget differences from 2015 to 2016 are explained as follows:

- loss of (€3.3m) in TCB Budget which assisted wider CHO7 SCOP services in 2015;
- reinstatement of Clinical Waste Budget of €275k, which will be matched against expenditure;
- additional Budget for safeguarding posts and Chairman's notes of €120k, again matched with expenditure;
- FD Cost of Care increased allocation of c. €1m;
- FD Income target reduction of c. €1.1m;
- reduction in Ancillary base budget of (€263k);
- combined cost reduction target of (€1.7m);
- additional Short Stay (Respite) monies of €374k;
- increase in HH/HCP budget of €169km, (excluding allowable overspend of €1.7m);
- other minor adjustments to reflect the gross decrease above.

As mentioned above, Social Care Division have advised a sanctioned overspend of €1,733k within Home Help/Home Care Package services to assist with the alleviation of overcrowding in Acute Hospitals. This does not appear within the base budget for 2016.

CHO7 are projecting a run rate issue of €7.9m for 2016, based on current expenditure levels, broadly summarised between:

- Home Support €4.80m;
- Net adjustments to Fair Deal Cost of Care €1.48m
- Ancillary Costs of 1.58m

There are a series of cost containments in place to deal with these issues, as shown in the table below:

Main Containment headings	Home Help/Home Care Packages (€k)	Fair Deal Cost of Care (€k)	Ancillary Costs (€k)	Total (€k)
Projected Run rate issue	4,800	1,761	1,584	8,145
Less Allowable overrun	(1,733)			(1,733)
Sub Total	3,067	1,761	1,584	6,412
Paybill Management		(433)	(200)	(633)
Additional Agency reduction		(591)		(591)
Office Expenses/ Rent & rates		(288)		(288)
Heat, Light & Power		(146)		(146)
Cleaning		(201)		(201)
Catering		(141)		(141)
Medical Cover Review			(200)	(200)
Pharmacy Cost Review			(250)	(250)
Cease AHP inputs			(150)	(150)
X Ray Cherry Orchard			(50)	(50)
Reduce Catering/Support services			(100)	(100)
Procurement			(100)	(100)
General Savings			(150)	(150)
Overall Total	3,067	(39)	384	3,412

Work is ongoing between this CHO and the Social Care Division to manage the run rate issues in Home Support on an agreed national basis to deliver services within allocation.

Older Persons Services (Voluntary)

The tables below illustrate the relative budget movement for CHO7 Section 38 (Voluntary) agencies. The overarching assumption taken by CHO7 management is that each Agency will break even against its' Budget, and the CHO will actively engage with each Agency in order to assist in doing so.

Peamount Hospital (Older Persons) has received an increase in allocation for 2016 of €222k over 2015 levels. The table below summarises the position per the National budgetary system (Rosetta). The 2016 budget is adjusted for a

retraction of School Leavers funding of €22k, while the 2015 budget is adjusted for supplementary and one off funding of €779k received which was not carried into the 2016 allocation.
The budget increase of €222k (2.88%) relates mainly to additional LRA funding €258k with net adjustments of €36k offsetting against these increases.

Peamount (Older Persons) - Movement in Funding for CHO7 2015 v 2016			
Heading	**Comment**	**€000s**	**€000s**
Budget 2016			7,934
Budget 2015	After retracting once-off monies of €c.€779k provided in 2015 for backdated Fair Deal	7,712	
Increase in Core Funding			222
% Increase			2.88%

Our Lady's Hospice (Older Persons) has received an increase in allocation for 2016 of €4k over 2015 levels. The table below summarises the position per the National budgetary system (Rosetta).

The budget increase of €4k (0.12%) relates mainly to ELS Pay pressures.

OLH (Older Persons) - Movement in Funding for CHO7 2015 v 2016			
Heading	**Comment**	**€000s**	**€000s**
Budget 2016			3,663
Budget 2015		3,659	
Increase in Core Funding			4
% Increase			0.12%

The Workforce Position

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. Staff are central to the improvement in patient care, productivity and performance. A culture of compassionate care and a sense of belonging among staff will create and embed an organisation-wide approach to delivering a high quality, effective and safe service to our patients and clients. 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.

CHO 7 expects to complete the establishment of its Management Team in Q1 2016. This will include the filling the post of Head of Human Resources (HR). The Head of HR will play a key role in leading work across all divisions to provide a workforce which is responsive, flexible and adaptable to meet the ever changing needs within the health services. The Head of HR will actively contribute to the delivery of patient/client centred services and will play a key role in supporting and directing the CHO towards the achievement of the service's objectives.

CHO 7 will further develop structures and processes related to Human Resource Management in line with current ongoing Divisional structural changes and the HSE People Strategy 2015-2018.

CHO 7 is committed to developing the competencies and skills of its entire workforce. In particular there will be a focus on the Leadership Development Programme and Performance as it will be critical to support new emerging senior teams and to build managerial capacity in the context of a rapidly changed and evolving health service with new structures and integration of statutory and voluntary agencies.

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

The workforce position in CHO 7 as at December 2015 is detailed in the table below:

CHO / Division	Medical/ Dental	Nursing	Health & Social Care Professionals	Management / Admin	General Support Staff	Patient & Client Care	Total	Change 2014 vs 2015
Mental Health	96.25	374.93	138.44	60.11	28.64	143.16	**841.53**	**-257.77**
Primary Care	112	493	352	305	145	262	***1669**	**+28**
Social Care							**2894**	**+123**
Total CHO 7	**247**	**1830**	**797**	**556**	**466**	**1841**	**5737**	**+225**

*figure as at September 2015.

Reducing Agency and Overtime Costs

Following on from a successful agency reduction programme in 2015 CHO 7 will continue to closely control and monitor agency usage across all services during 2016, ensuring that internal controls are in place to ensure best use of resources.

Service Developments in 2016 – Workforce Additions.

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.

Managing the Workforce: Pay and Staff Numbers Strategy

Government policy on public service numbers and costs is focused on ensuring that the numbers of people employed are within the pay budgets available. 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 management and pay costs will continue to be managed through funded workforce plans at divisional and service delivery unit level. 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.

Paybill Management

Pay and Staffing Controls will be enhanced in 2016. Service Delivery Units 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. Service managers will have to focus on stretching pay expenditure to deliver optimal hourly labour costs and optimising the capacity and capability of their workforce, while strictly adhering to the pay envelope. This requires an integrated approach, with service management being supported by HR and finance. It further requires finance and HR workforce data, monitoring, and reporting to be aligned.

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 by HBS.

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.

Attendance and Absence Management

This continues to be a key priority area for CHO 7 and robust attendance management programme is in place and will continue during 2016. The performance target for 2016 remains at < 3.5% staff absence rate.

Employee Engagement

CHO 7 Human Resources will develop a Staff Engagement Action Plan during 2016. CHO 7 will to develop mechanisms for more effective communications.

European Working Time Directive

CHO 7 is committed to maintaining and progressing compliance with the requirement of the European Working Time Directive for both NCHDs and staff in the social care sector. CHO 7 have established a local verification forum to achieve EWTD compliance.

Health and Safety at Work

CHO 7 will continue to comply with the Safety, Health and Welfare at Work Act, 2015, by continuing to work in partnership with HSE Occupational Health Department, HSE Health and Safety Advisors, HSE Employee Assistance Programme and HSE Employee Relations.

Health Services People Strategy 2015 – 2018 Leaders in People Services

CHO 7 welcomes the development of the Health Services People Strategy 2015 – 2018 Leaders in People Services and will endeavour to meet its objectives, within funded budget. The People Strategy will result in improved performance, workforce optimisation and a learning organisation delivering the overall goal of safer better healthcare system.

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

Accountability Framework.

Governance & Accountability.

The HSE is the statutory body tasked with the responsibility for the delivery of health and personal social care services in Ireland. 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 has a range of other accountability obligations to the Oireachtas and to its Regulators.

The HSE recognises the critical importance of good governance and of continually enhancing its accountability arrangements. In this regard, and in the context of the establishment of the Hospital Groups and Community Healthcare Organisations, the HSE is strengthening its accountability arrangements and is putting in place a new **Accountability Framework.**

In implementing the HSE's Accountability Framework 2016 the National Performance Oversight Group seeks assurance, on behalf of the Director General, that the National Directors of the Divisions are delivering against priorities and targets set out in the Service Plan and in the Performance Agreements 2016.

The performance indicators against which Divisional performance is monitored are set out in the Balance Score Cards grouped under Access, Quality, Finance and People. The key performance indicators are also included in the individual Performance Agreements between the Director General and the National Director.

Performance against the Balanced Scorecards is reported in the monthly published Performance Report. Where the data indicates underperformance in service delivery against targets and planned levels of activity, the National Performance Oversight Group explores this with the relevant National Director at the monthly performance meeting and seeks explanations and remedial actions where appropriate to resolve the issue.

As part of the Accountability Framework an Escalation and Intervention process has been developed and implemented. The Escalation and Intervention Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels.

Accountability Levels

The implementation of the new CHO structure and the development of CHO 7 within this structure will see significant reconfiguration in 2016 that will impact on governance and accountability across all services. CHO 7 has a governance and accountability structure that spans both the ISA structure and the new CHO structure:

- CHO 7 is managed by the Chief Officer, who has established an interim Management Team, to support the delivery of services across the CHO. This team meets monthly and is chaired by the Chief Officer;
- Dublin South West/Kildare West Wicklow and Dublin South Central ISA's are managed by an Area Manager and each has an Area Management Team which meets on a monthly basis chaired by the Area Manager;
- Each ISA operates reporting structures in the Area across all services, Primary Care, Social Care, Mental Health and Health and Wellbeing Services, with Managers of these services reporting to the Area Manager;
- Service Managers and Heads of Disciplines report to the Managers of our services, who in turn have service delivery teams within each service that report into them;

- Funded organisations are accountable under the Service Arrangements and are monitored through IMR and Service Arrangement meetings. Financial accounts and reports are submitted and reviewed.

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.

Performance Agreements

During 2016 the monitoring and management of these plans will be further strengthened through the formal Performance Agreements which explicitly link accountability for the delivery of the HSE's Plans to managers at each level of the organisation.

- The National Director Performance Agreement will be between the Director General and National Directors. (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service).

- The Hospital Group CEO Performance Agreement will be between the National Director Acute Hospitals and each Hospital Group CEO.

- A single CHO Chief Officer Performance Agreement (covering all community services Divisions) will be put in place between the four National Directors for Primary Care, Social Care, Mental Health and Health and Wellbeing and each of the 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 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.

CHO Chief Officers are accountable to each of the 4 National Directors for delivery of services within that Division, but will continue to have a single reporting relationship to the chair of the Executive Committee.

Performance reports

The HSE will also continue to retrospectively account for delivery of its services through the National Performance Report. This report is produced on a monthly basis by the HSE and submitted to the Department of Health. The Performance Report sets out the HSE's performance against its National Service Plan commitments.

The HSE also prepares an Annual Report which having been submitted to the Minister for Health is laid before the Houses of the Oireachtas.

Accountability Processes

CHO 7 will engage in the re-structuring process and development of the new accountability framework. As in previous years, all budget holders will focus on service delivery and expenditure control. The Health Service Code of Governance and the Financial, Procurement and Human Resource regulations apply across the organisation and set out the behaviours expected. Compliance with the code remains a key requirement. Once established, each Division will be accountable for the overall performance of services in that Division, in particular, the safe and cost effective delivery of services to a high standard. This will also apply to services delivered through Service Arrangements, as Health Service funding will be contingent on providers meeting agreed criteria as set out in Service Arrangements, including formalised compliance statements.

Escalation, Interventions and Sanctions

This section sets out the arrangements in place for 2016 between the National Performance Oversight Group (NPOG) and National Directors for identifying and responding to areas of underperformance in relation to service delivery, quality and safety of care, financial management and HR. Its objective is to support the Director General and the Directorate by ensuring that potentially serious issues and areas of underperformance are identified as early as possible and addressed effectively.

It reflects how information will be exchanged and used in a timely manner, the triggers and prompts for escalation and intervention, and where responsibility sits for each level of escalation.

This Framework is intended to be a dynamic process that will be reviewed on an ongoing basis in order to reflect any changes required as the system matures and develops.

Performance

One of the 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. Performance will be measured against the four quadrants of the Balanced Score Card of Quality and Safety, Access, Finance and Workforce

Underperformance

In the context of the Escalation and Intervention Framework underperformance includes performance that:

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

Where the measures and targets set out in these areas are not being achieved, this will be considered to be *'underperformance'*.

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. Each Divisional National Director 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 which are described below.

An issue that requires escalation can start in any part of the organisation and this process ensures that Service Managers, Hospital Group CEOs, Chief Officers of Community Healthcare Organisations and National Directors 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.

Escalation Process

Each National Director is responsible for maintaining appropriate governance arrangements for their Division to ensure that it is operating effectively and delivering quality and safe care to patients.

The objective of the National Performance Oversight Group is to co-ordinate their work programme on behalf of the Directorate to seek assurance on the safe, effective and efficient delivery of services. Issues arising will normally be dealt with by National Directors through their normal reporting channels of Hospital Groups and the Executive Management Committee.

The following sections describe the formal performance escalation process as part of the Accountability Framework 2016 and outline the process in terms of:

- Responsibilities at each level of performance and escalation
- The thresholds and tolerances for underperformance services for red escalation (to NPOG) for a number of priority measures
- The type of supports, interventions and sanctions to be taken at each escalation level

Escalation Levels

The National Performance Oversight Group has developed a 4 point Escalation Framework from Level 1 (Yellow) to Level 4 (Black) which will be used to escalate issues and incidents as required.

- **Level 1 (Yellow)** is at Hospital Group CEO or Chief Officer CHO level

- **Level 2 (Amber)** is at National Director level
- **Level 3 (Red)** is at National Performance Oversight Group level
- **Level 4 (Black)** is at Director General level.

Hospital Group CEO or Chief Officer CHO Level

Level 1 Yellow Escalation – Concern across several areas

Performance Trigger:	Continued failure to achieve or maintain one or more key deliverables.
Description:	Level 1 Yellow Escalation indicates a concern or concerns that require investigation by the CEO of the Hospital Group or the Chief Officer of the relevant Community Healthcare Organisation. It is likely that this level of escalation will be instigated following persistent performance issues of a material nature that may span one or more areas. It may also be where the CEO Hospital Group or Chief Officer CHO lacks confidence in recovery plan(s) of the service(s) in question.
Escalation Action	The CEO Hospital Group or Chief Officer CHO will be actively involved in determining the necessary supports and interventions in order to deliver the required outcomes / improvements.
Support:	Support focused on improvement on specific issues and recovery plans
Interventions:	Intervention is likely to be focused on supporting improvement in particular areas, but broader intervention can be deployed. Interventions are likely to include the development and implementation of remedial action plans.
Sanctions:	No sanctions are likely at this level of escalation
De-escalation	Sustained improvement of KPIs causes removal of escalation actions.
Accountability:	Accountability at this level of escalation is through the relevant Hospital Group CEO or the Chief Officer of the Community Healthcare Organisation. The involvement of the National Performance Oversight Group is not required

Thresholds and tolerances will be reviewed in light of the NSP2016 and agreed with National Directors

Operational Service Delivery – Corporate Goals Implementation

Health & Wellbeing Division

Figure 1 – Description of Health & Wellbeing functions.

Introduction:

Improving the health and wellbeing of Ireland's population is a national priority and a key element of healthcare reform. As part of this reform and in response to Ireland's changing health and wellbeing profile, the *Healthy Ireland (HI) Framework* was adopted by the Irish Government. This commitment is also reflected in the HSE's Corporate Plan, *Building a high quality health service for a healthier Ireland 2015-2017*, which identifies the promotion of 'health and wellbeing as part of everything we do' within its five over-arching Corporate Goals.

Within the HSE, the Health and Wellbeing Division is responsible for driving and coordinating the health service response to this agenda. Our work is focussed on helping people to stay healthy and well, reducing health inequalities and protecting people from threats to their health and wellbeing.

Whilst much of the day to day work of the division is discrete, we are driving a collaborative effort to:

- Ensure health system implementation of *Healthy Ireland* goals
- Reduce levels of chronic disease by addressing modifiable lifestyle risk factors
- Enhance and improve service delivery models for the health of the population
- Protect the population from threats to their health and wellbeing
- Create and better support cross-sectoral partnerships for improved health outcomes.

The enabling role of Health and Wellbeing in translating *the HI Framework* into tangible and impactful actions across the HSE remains a key priority for the Division this year. A major milestone in formulating the health services response to the *HI Framework* was achieved in 2015, with the publication of our *Healthy Ireland in the Health Services National Implementation Plan 2015-2017 (HI Implementation Plan)* which specifically focuses on the HSE, our workforce, our services and the people to whom we provide services.

This year will see the further embedding of these priorities across a greater number of service areas and within local plans and services, particularly Hospital Groups and Community Healthcare Organisations (CHOs). Staff delivering services within the Health and Wellbeing Division will have responsibility for driving this agenda on a partnership basis, building on the work already undertaken in 2014/15. The strengthening of the health service response to specific policy priority areas will be a key feature of 2016 and its areas of focus are set out in this Operational Plan.

Implementation of the actions set out in this plan will be commensurate with available funding, with some being prioritised and phased during 2016. Many are to be delivered on a partnership basis, with other Divisions, healthcare organisations and agencies, Local Authorities, Government Departments, statutory and voluntary organisations and academia. This reflects the joined up approach necessary to deliver on the Healthy Ireland vision.

Developments and Reform Priorities 2016

Improving the health and wellbeing of Ireland's population is a Government priority and is one of four pillars of healthcare reform outlined in *Future Health – A Strategic Framework for Reform of the Health Services 2012 – 2015*. 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

A significant programme of change is underway to enable and drive the establishment of Hospital Groups and CHOs with the aim of delivering integrated services and better outcomes for service users. The appointment of a Head of Health and Wellbeing to the Senior Management of each CHO in 2016 will be a significant enabler to the translation of the goals and actions set out in the *HI Implementation Plan* within communities.

The appointment of a Head of Health and Wellbeing to the Senior Management of CHO 7 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:

• The continued, phased implementation of the Breast Check age extension programme to women aged 65 to 69 within our National Screening Service

• Within the Child Health area, the augmentation of the current Primary Childhood Immunisation (PCI) schedule to address agreed public health priorities.

• The continued support for the development of care pathways for key chronic conditions

• Review of the governance of the National Emergency Management Function.

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. CHO7 will commence the implementation of Health Ireland in our local health services.

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. CHO 7 and the Dublin Midlands 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. We will aid to deliver services in a joined up way, placing people's 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.

Creating, improving and maintaining health and wellbeing for all is complex and requires an overall view of population health and an understanding of local communities and their specific needs. The updating, wider dissemination and use of published County Profiles developed in 2015 will help support this work locally within the HSE and more widely through our collaborative work on the Local Community Development Committees (LCDC) and Children and Young People's Services Committees (CYPSC).

Supporting Service Delivery

Health and Wellbeing is of critical importance in all aspects of the work of CHO7. 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.

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 CHO7 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.

Key Priorities and Actions to Deliver on Goals in 2016

Corporate Goal	Health and Wellbeing Strategic Priority	Actions 2016	Measure of Performance	End Qtr
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** 'Healthy Ireland in the Health Service' – National Implementation Plan 2015 - 2017	Support the development and implementation of CHO Healthy Ireland Plans as resources permit.	CHO Plan in place by year end.	Q1 – Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** 'Healthy Ireland in the Health Service' – National Implementation Plan 2015 - 2017	Develop Action plan to progress Breastfeeding in Ireland within HI Framework and across Primary Care and acute sector as with community and voluntary sector	Ongoing	Q1 – Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Immunisation	CHO 7 commits to augmenting the current primary immunisation schedule to address agreed public health priorities. CHO 7 commits to improve national immunisation update rates in partnership with Primary Care CHO 7 commits to implement changes to Primary Childhood Immunisation Programme and Schools Immunisation Programmes as resources allow. CHO 7 commits to implementation the recommendations from the review of models of delivery and governance of immunisation services. Community Medical Services will address BCG wait list challenges when supply issues are resolved.	Ongoing Ongoing Ongoing Ongoing Meet KPI Targets	Q1 – Q4 Q1 – Q4 Q1-Q4 Q1-Q4 Q1 – Q4

		Improve influenza uptake rates amongst staff in frontline (longer-term care in the community) and amongst persons aged 65 and over.	Ongoing	Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Tobacco Free Campus Policy and BISC training	Support the continued role out of the Tobacco Free Campus Policy in Social Care with set targets – *specific targets to be set* Continue to support the release of frontline staff to attend BISC training	Attain targets for new and existing sites to adhere to tobacco free campus policy 123	Q1 - Q4 Q1 - Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Protect the population from threats to their Health and Wellbeing	Ongoing engagement with Emergency Management Regional	Ongoing	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Protect the population from threats to their Health and Wellbeing	Promote the prevention and control of health care associated infection within all service areas	Development of Infection Control Team and implementation of Health Care Associated Infection Control Audit Programme Meet KPI Targets	Q1 – Q4 Q1 - Q4 Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority**: Infection Prevention and Control	Develop a plan in relation to HCAI/AMR with Primary Care services as resources allow.	Put Plan in place by year end.	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Protect the population from Threats to their Health and Wellbeing	Ongoing structured discharge planning to ensure there is a safe and coordinated discharge from the acute sector to community	Safer discharges, less re-admissions, better patient outcomes and satisfaction Reduction in complaints	Q1 – Q4 Q1-Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Priority**: Implement a uniform system for recording, collating and reporting Complaints and Compliments across Health and Wellbeing and its services	Continue to work with the National Complaints Governance & Learning Team to review complaints, analyze trends and put in place action plans to improve service	Measurable reduction in complaints	Q1 – Q4

Goal 4: Engage, Develop and value our workforce to deliver the best possible care and services to them	**Priority:** Provide training and support to staff to embed the concept of 'every contact counts' through the provision of training and support, improved data capture and the development of a framework and implementation plan for the National Brief Intervention Model	Practice Development Co-ordinators will identify gaps in training, audit practice, and community audit, developing and implementing required training programmes	Ongoing	Q1 – Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Embed Health and Wellbeing indicators within HSE reform programmes and projects	CHO 7 will support the introduction of the individual health Identifier.	Improved patient safety and more efficient service (national dependency on implementation)	Q1 – Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Embed Health and Wellbeing indicators within HSE reform programmes and projects	Develop and progress the priority work streams of the five Integrated Care Programmes to improve integration of services, access and outcomes for patients in collaboration with Clinical Strategy and Programmes	Ongoing Developments	Q1-Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Incorporate prevention and intervention requirements into existing and new clinical care programmes	Integrated Care Programme - Older People CHO 7 & Tallaght Hospital. Chronic Disease Management Programme.	Ongoing Developments Ongoing Developments	Q1-Q4 Q1-Q4

Primary Care

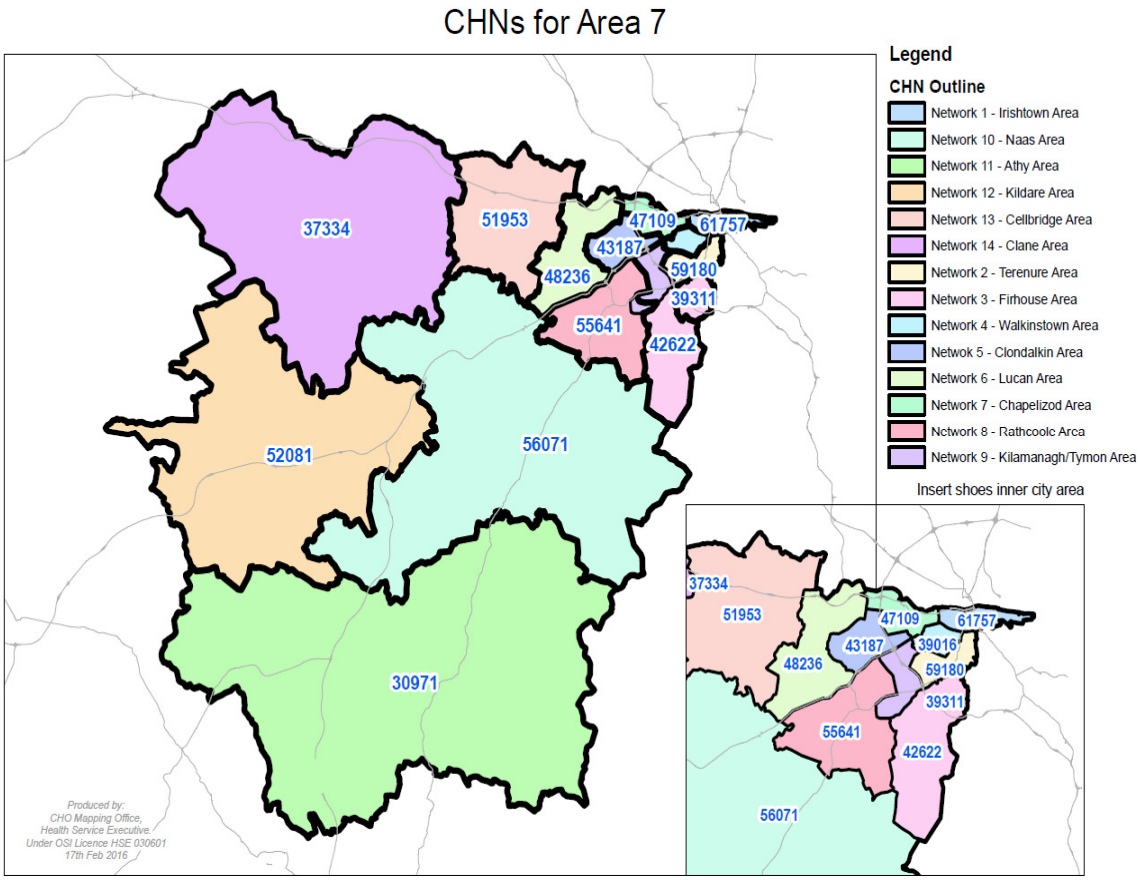
Introduction

The development of primary care services is a key element of the overall Health Reform programme. The core objective is to achieve a more balanced health service by ensuring that the vast majority of patients and clients who require *urgent or planned care are managed within primary and community based settings, while ensuring that services are:*

- *Safe and of the highest quality*
- *Responsive and accessible to patients and clients*
- *Highly efficient and represent good value for money*
- Well integrated and aligned with the relevant specialist services.

Primary Care services include primary care, primary care reimbursement, social inclusion, and palliative care services. A key priority for 2016 is the continued implementation of the recommendations of *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, 2014.* There will be a continued emphasis on enhanced control and accountability for primary care services. This will strengthen the accountability framework and outline explicit responsibilities for managers at all levels.

Primary Care services in CHO 7 will be provided from 14 Community Health Networks areas – see map below.



Primary Care

Over the last number of years work has been underway to realise the vision for primary care services whereby the health of the population is managed, as far as possible, within a primary care setting, with people very rarely requiring admission to a hospital. This approach is now aligned with the *Healthy Ireland* framework, noting the importance of primary care to the delivery of health improvement gains. Primary care will play a central role in co-ordinating and delivering a wide range of integrated services in collaboration with other service areas. The primary care team (PCT) is the central point for service delivery which actively engages to address the medical and social care needs of the population in conjunction with a wider range of Health and Social Care Network (HSCN) services.

PCRS

The Primary Care Schemes are the means through which the health system delivers a significant proportion of primary care services. Scheme services are delivered by primary care contractors e.g. general practitioners, pharmacists, dentists, optometrists and/or ophthalmologists.

Services are provided to 2.3 million people in the community through 7,061 Primary Care Contractors. The schemes include:

- General Medical Services (GMS) – Medical Card Scheme including GP Visit Cards.
- Drug Payment Scheme.
- Long Term Illness Scheme.
- Dental Treatment Services Scheme (DTSS).
- High Tech Drug Arrangements.
- Primary Childhood Immunisation Scheme.
- Community Ophthalmic Scheme.
- Services under *Health (Amendment) Act 1996*.
- Methadone Treatment Scheme.

Social Inclusion

The core objective of Social Inclusion is improvement of health outcomes for the most vulnerable in society. This includes provision of targeted interventions for people from traditionally marginalised groups who experience health inequalities, have difficulties accessing services and present with multiple, complex health and support needs. Vulnerable people and communities falling within the remit of Social Inclusion include Irish Travellers and Roma, Asylum seekers and refugees and LGBT service users. Issues of addiction, substance misuse, homelessness and domestic, sexual and gender based violence are overarching themes. The cross cutting nature of social inclusion, with intersection of a range of issues across service user groups demands a partnership approach across statutory and voluntary sectors where responses are flexible, sophisticated, coordinated and aimed at eventual integration of service users into mainstream services, where possible. At the same time, social inclusion works with mainstream services towards assuring accessibility to disadvantaged service users.

Socially excluded service users are often invisible in datasets or outcome frameworks and this presents a challenge to ongoing maintenance of a focus on the needs of such vulnerable people. It is incumbent on Social Inclusion services to continue working towards development and application of appropriate disaggregated data that accurately reflects health needs and outcomes of vulnerable groups; such efforts will continue to be progressed during 2016, aligned with objectives of the Healthy Ireland Implementation Plan.

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment and management of pain and other physical, psychosocial and spiritual problems. In recent years, the scope of palliative care has broadened and includes not only cancer related diseases but supporting people through non-malignant and chronic illness also. In 2015 the Health Service established a stakeholder representative working group to review existing national strategies and policies, most of which are more than 5 years old. A new plan, which will provide the direction for palliative care services for the next 3 years, will be published early in 2016. The *plan will be developed in collaboration with the* National Clinical Programme for Palliative Care.

In 2016 engagement will continue with voluntary service providers, the Irish Hospice Foundation, the All Island Institute for Hospice and Palliative Care and the voluntary hospice movement to ensure that emerging needs and solutions can be identified and addressed. The Integrated Care Programmes (ICPs) are core to operational delivery and reform. Palliative Care recognises the potential for the ICPs to improve integration of services, access and outcomes, and commits to actively supporting the development and implementation of the priority work streams of the five ICPs in 2015.

The vision for the future is that palliative care will be a gradual and natural increasing component of care from diagnosis to death. Palliative Care will ensure that people with a life-limiting condition, and their families, can easily access a level of high quality service that is appropriate to their needs, regardless of age, care setting, or diagnosis.

Developments and Challenges in 2016

The 2016 New National Funding Allocation of €13.5m will facilitate progress in relation to:

- Extension of free GP care to all children aged under 12 years (6 years to under 12 years) subject to negotiations under the Framework Agreement.
- Improved access to diagnostics (ultrasound and x-rays) for GPs.
- Expansion of the minor surgery initiative.
- Improved access to primary care psychology and counselling will be progressed.
- Improved access to primary care speech and language therapy services will be progressed.

The challenges for 2016 will be in the areas of:

- Provision of new drugs and cancer drugs.
- Provision of oral health prevention services.
- Provision of addiction services within the Primary Care setting in line with Government Policy.
- Provision of services to homeless people in line with Government Policy.
- The provision of enhanced care support planning for complex Homeless Service users.
- Provision of services in line with the requirements of the Refugee Protection Programme.
- The implementation of the National Traveller and Roma Inclusion Strategy.
- Participation within the LCDC – structures for Healthy Ireland and working with the National Children's Hospital Group to develop Health Children Programmes in the south inner city.

Key Priorities and Actions to Deliver on Goals in 2016

Corporate Goal	Primary Care Strategic Priority	Actions 2016	Measure of Performance	End Qtr
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority**: Implement, in collaboration with Health and Wellbeing child health programmes/initiative to improve health outcomes for children	**Child Health**: Work in partnership with the Health and Wellbeing Division in the achievement of compliance with KPI Targets.	Meet KPI targets	Q1 – Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority**: Implement, in collaboration with Health and Wellbeing child health programmes/initiative to improve health outcomes for children	Continue to work in collaboration initiatives to improve health outcomes for vulnerable populations	CHO 7 will continue to engage with local LCDSs.	Q1 – Q4
		Work in collaboration with Health & Wellbeing on Child Health Programmes and initiatives.	CHO 7 will continue to roll out Child Health programmes/Initiatives to improve health outcomes for children.	Q1 – Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Tobacco Free Campus Policy and BISC training	Support the continued role out of the Tobacco Free Campus Policy in Primary Care with set targets – *specific targets to be set*	CHO 7 is committed to a target of 5% of Primary Care staff attending BISC training in 2016.	Q1 - Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Support Health Promotion and improvement Initiatives in primary care.	Support the implementation of the Sexual Health Strategy.	CHO7 will seek guidance from H&WB division on implantation of identified, resourced actions.	Q1 – Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Improve national immunisation rates in partnership with Health and Wellbeing	Continue to provide primary and secondary school immunisation in accordance with the national immunisation schedule	Ongoing	Q1 – Q4

Due to shortage of Vaccines and no definite date confirmed that we will receive vaccine.		Community Medical Services will address BCG wait list challenges through provision of additional vaccination clinics/extension of existing clinics as necessary subject to funding	Meet KPI Targets	Q1 – Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Strengthen national supports and guidance to primary care providers in relation to Health Care Associated Infections	Continue the promotion of hand hygiene training and hygiene audit in keeping with national priorities	Ongoing	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Provide improved and additional services at primary care (PCT and Network) level	Continue to consolidate the delivery of primary care services through our Primary Care teams and our 14 CHNs when in place.	Meet KPI targets	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Provide improved and additional services at primary care (PCT and Network) level	Implement the recommendations from the GP Out of Hours Review Report once published	Implement recommendations (publication dependent)	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** National Standards for Safer Better health Care	Support the Implementation of National Standards for Safer Better Healthcare.	CHO 7 will identify Quality Improvement Plans and agree reporting mechanism to be adhered to.	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Provide improved and additional services at primary care (PCT and Network) level	Will continue to work with estates for minor and major capital to extend and reconfigure existing Health Centres, and development of new Primary Care initiatives	Upgraded centres	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Provide improved and additional services at primary care (PCT and Network) level	Extend the 2015 Minor Surgery Project to further practices and target activity transfer from acute hospitals of up to 10,000 procedures.	National dependency. Await direction from Minor Surgery Project Manager on further rollout of this initiative	Q1-Q4

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Provide improved and additional services at primary care (PCT and Network) level	Extend direct access for GPs to ultrasound and x-ray	National dependency. CHO 7 will participate as required.	Q1-Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Provide improved and additional services at primary care (PCT and Network) level	Extend GP Access under Framework Agreement -	National dependency. CHO 7 will participate as required.	Q1-Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Improve access to Oral Health and Orthodontics.	Work with Orthodontic Services to ensure governance of service meets CHO7 requirements. Dependent on National actions.	CHO 7 will participate as required.	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Strengthen Primary Care Psychology services.	National dependency.	CHO 7 will participate as required.	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Review access to SPLT services.	National dependency.	CHO 7 will participate as required.	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Improve Cross Division Service Integration	Implement the Primary Care Education, Pathways and Research in Dementia (PREPARED) Programme.	National dependency. CHO 7 will participate as required.	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Social Inclusion Priority:** Improve health outcomes for persons with addiction issues	Implement the New National Drugs Strategy when published in line with available resources.	National dependency. CHO 7 will participate as required.	On-going
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Social Inclusion Priority:** Improve health outcomes for persons with addiction issues	Provide additional supports for those presenting with multi substance addictions as resources allow.	Meet KPI targets	Q3

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Social Inclusion Priority:** Support the Implementation Plan to reduce Homelessness	Continue to work with Dublin Regional Homeless Executive (DRHE) and NGO's through the SLA process subject to resources.	Meet KPI targets	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Social Inclusion Priority:** Improve health outcomes for vulnerable groups - Traveller and Roma health	Continue to work with relevant NGOs to ensure agreed work plans are delivered	Meet KPI targets	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Social Inclusion Priority:** Improve health outcomes for vulnerable groups Domestic, Sexual and Gender based violence	Work with NGO's to ensure training is being carried out as per SLA's	Ongoing engagement with NGO's to review if training requirements being met	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Social Inclusion Priority:** Improve health outcomes for vulnerable groups Intercultural Health	Continue to work with NGO's and monitor health needs	Ongoing meetings during 2016	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Palliative Care Priority: Improve quality within palliative care service provision**	CHO 7 will participate as required by National Palliative Care Lead on National Actions.	National dependency. CHO 7 will participate as required.	Q1-Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Quality and Safety Priority:** collaborative with QID in reducing harm as part of the safety programme	Continue to support the Pressure Ulcers to Zero collaborative	CHO 7 will continue to prioritise the roll out the pressure ulcer to zero collaborative, and continue to roll out the programme across all PCTs.	Q1 – Q3
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Patient engagement and empowerment.	CHO 7 will establish a formal process to engage with patients and service users on their experience of primary care.	Results of service user experience process.	Q2 - Q4

		CHO7 will support the measurement of patient experience using a range of methods to obtain service user feedback	Primary Care Service User tool will be used to measure patient experience.	Q1-Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Management Quality Indicators	Strengthen Quality and Safety Accountability across CHO 7 subject to resource	Monthly assurance and measurement of quality and safety indications through the maintenance of the Primary Care Quality Dashboard	Q1 – Q4
		Monitor the performance of primary care services against agreed national indicators for quality and safety	Meet QS KPI targets	Q1 – Q4
		Collaborate with consumer affairs in the management and analysis of complaints	Ongoing Dashboard	Q1 – Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Quality and Safety Priority: Incident Management & Serious Incident Reporting	Continue to support the roll out of the National Incident Management System (NIMS) in Primary Care in conjunction with the National Quality Assurance and Verification Division and the State Claims Agency subject to resources.	Ongoing	Q1 – Q4
		Ensure systems and structures are in place within Primary Care for reporting and monitoring serious reportable events and other serious safety incidents in keeping with the HSE Safety Incident Management Policy 2014	Update and maintenance of SRE/SI Log	Q1 – Q4

Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Children First	Local implementation plans to be developed.	CHO 7 will develop a summary of local plans in relation to implementation of Children First in 2016.	Q1
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Serious Incident Reporting	Ensure systems and structures are in place within Primary Care for reporting and monitoring serious reportable events and other serious safety incidents in keeping with the HSE Safety Incident Management Policy 2014	Update and maintenance of SRE/SI Log	Q1 – Q4
		Continue to support the roll out of the National Incident Management System (NIMS) in Primary Care in conjunction with the /National Quality Assurance and Verification Division and the State Claims Agency	Ongoing	Q1 – Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Open Disclosure	Build capacity for roll out of Open Disclosure Policy	Participation of Senior Staff in the OD 'Train the Trainer' Programme	Q1 - Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Social Inclusion** Priority: Roll out of Brief Intervention Training	Continued roll out of brief intervention training to staff	Ongoing. Completion of training for all staff in the Drugs and Alcohol Services	Q1
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Palliative Care:** Priority: Encourage the on-going development of person-centred services	Continue to engage and work with palliative care providers in CHO 7 in the development of person-centred services	Ongoing process through SA/IMR	Q1 – Q4

Goal 4: Engage, Develop and value our workforce to deliver the best possible care and services to them	**Priority:** Quality and Safety Education & Training	Support participation of staff in training of Incident Management, Systems Analysis, Open Disclosure , Clinical Audit Training and the development of clinical audit tools	Ongoing	Q1 - Q4
Goal 4: Engage, Develop and value our workforce to deliver the best possible care and services to them	**Priority:** Quality and Safety Education & Training	Develop Clinical Audit structures and plans to develop a robust CHO wide clinical audit programme as resources allow.	Ongoing	Q1-Q4
Goal 4: Engage, Develop and value our workforce to deliver the best possible care and services to them	**Priority:** Staff Engagement	Work with HR and Quality Improvement Division to identify, use and share learning from staff engagement initiative	Participate in any working groups set up following the staff engagement survey.	Q1 – Q4
		Ongoing Performance Management and development with staff	Ongoing	Q1 –Q4
		Build capacity for the roll out of the Open Disclosure Policy	Participation in the Open Disclosure 'Train the Trainer' programme	Q1 – Q4
Goal 4: Engage, Develop and value our workforce to deliver the best possible care and services to them	**Social Inclusion priority: Provide LGBT health training/ intercultural health training to health service staff**	Continue to meet training requirements as resources allow.	Ongoing	Q1 – Q4
Goal 4: Engage, Develop and value our workforce to deliver the best possible care and services to them	**Palliative Care** Priority: Develop the capacity of healthcare professionals to better meet the needs of patients and their families	Collaboration with hospice and acute service providers to provide education and information to all first line clinical staff in relation to provision of services to palliative care clients in the community	Ongoing	Q1 – Q4

Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority: Quality and Safety**	Support and work with Primary Care Davison in further Development of the Primary Care Quality Dashboard.	Ongoing	Q1 - Q4
		Continue to gather submit accurate and timely quality & safety information for Monthly Performance reports subject to resources. Analyse the data in the Quality & Safety Committee for Primary care.	Ongoing	Q1 – Q4
		Continued rollout of Single Assessment Tool	Ongoing	Q1 – Q4

Mental Health Services CHO 7

Dublin South Central Mental Health Services
Kildare West Wicklow Mental Health Services

Area Description

The Dublin South Central Mental Health Service encapsulates the geographical areas of the former Dublin West/South West Mental Health Service (Lomans / Tallaght) and the Dublin South City Mental Health Service (St James's). While serving a total population of 406,441 in the South Central and South West parts of Dublin, the service now also includes Child and Adolescent Mental Health Services that were formerly provided by HSE Linn Dara service and the Lucena Clinical Services provided by St John of Gods. A number of service providers from Intellectual Disabilities are also included within the Mental Health Division and have responsibility for providing mental health services for people with Intellectual Disabilities. These several providers include Stewarts Hospital Palmerstown, Cheeverstown House Services, Dublin South City Intellectual Disability Service and St John of Gods.

A number of other key stakeholders are also based in the locality and it is planned that the Mental Health Directorate will formalise links and promote the integration agenda with these services as part of the emerging directorate requirements. These services include Addiction Services, Homeless services and EVE-Community Based Recovery Programmes. The Cloverhill/Wheatfield prison complex is also located within the catchment area.

Service Description

The general adult services in the former Dublin West/South West service are largely community-oriented with an emphasis on delivering care in the community and have well developed community mental health and homecare teams (CMHTs). Due to limited resources, the Dublin South City Service at St. James's lacks this level of community care capacity. The catchment area also has Psychiatry of Later Life (PLL) teams and a Rehabilitation team. The demands on the PLL team have increased year on year as the at risk population has increased in size and also according as the number of nursing home beds in the catchment area increases.

Psychological Medicine Liaison services are provided within the two acute hospitals in Tallaght and St James's. Child & Adolescent Mental Health Services are delivered in three Community centres for the catchment area.

The service budget includes funding for a number of National and Regional services such as externally provided assisted admissions service and the Alba National Counselling Services.

Funding for Child & Adolescent Mental Health Services (CAMHS) is inclusive of funding for services delivered in the neighbouring Areas of Dublin North, Kildare, West Wicklow and Midlands. The interim CAMHs Acute Inpatient unit based at St. Loman's Hospital was replaced by a 22 bed Unit which opened in December 2015. There is a service requirement to widen the access to the acute care programme including in-patient beds within the catchment area give the local demographics. This extended acute care programme will be dependent on sourcing sufficient and appropriately skilled staff.

The Kildare West Wicklow Mental Health Service is a Community Based Mental Health Service which started in 1992 with the opening of the 29 bed Lakeview Acute Admissions Unit in Naas General Hospital. The population of the area has grown from 135,000 in 1992 to 228,400 in 2011. Further population growth is expected due to the age structure in the area and its proximity to Dublin.

The mental health services in the area have been managed in a Supercatchment Area with the Laois/Offaly/Longford/ Westmeath services this is now changing to conform with the new Community Healthcare Organization boundaries.

Quality and Service User Safety

The CHO 7 mental health services will support the Division in providing high quality and safe services for our service users and staff. The service will engage with the Division to build the capacity of service users, families and carers to influence the design and delivery of Mental Health Services.

Dublin South Central Mental Health Services

Population			
General Adult Teams	**Population Served**	**CAMHS**	**Population served**
Tallaght	79,062	Ballyfermot/ St. James's	81,215
Clondalkin	57,846	Clondalkin	58,537
Ballyfermot	81,093	Lucan	44,487
Crumlin	49,845	Total	184,239
Owendoher	65,913	North Kildare	71,673
Drimnagh	27,384	Mid Kildare	71,679
Camac	45,298	South Kildare	66,960
Total	406,441 (inclusive of CAMHs)		

Spend and Budget		
(1) **2014 Actual Net Spend**	**(2)** **2015 Projected Net Spend**	**(5)** **2016 opening Budget**
53,994,681	55,613,777	57,268,493

Staffing	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Other Patient & Client Care	Total
Dec 2015	**75.45**	**268.6**	**116.48**	**54.28**	**25.52**	**132.79**	**673.12**

Services Provided

Service	**No. Provided**	**Service**	**No. Provided**
No of Adult Acute Inpatient Beds	103		
General Adult		Psychiatry of Old Age	
No. of non acute beds for adults	0	No. of Day Hospitals	2
No. of Day Hospitals	6	No. of Community Mental Health Teams	2
No. of Community Mental Health Teams	7	Number of Day Centres	0
Number of Day Centres	4	Specialist Mental Health Services	
No, of High Support Community	6	No. of Rehab and Recovery Teams	1

Residences			
No. of Low and Medium support Community Residences	12	No. of Liaison Psychiatry Teams	2
		No. of MHID Teams	2
CAMHS			
Number of Inpatient Beds	22		
No of Day Hospitals	1 (Cherry Orchard)		
No of Community Mental Health Teams	8*		

*Number of CMHT's includes teams for Dublin North, Kildare/ West Wicklow

Corporate Goal	Mental Health Strategic Priority	Actions 2016	Measure of Performance	End Qtr
Goal 1 – Promote health and wellbeing as part of everything we do so that people will be healthier:	**Priority 1** Greater availability of Rehabilitation Services.	Develop the Rehabilitation service to enhance individual recovery and ultimately reduce the pressures on the inpatient bed resource	*Dependent on resources being made available through service developments* *Monitor bed occupancy in acute unit.*	***Q1-4***
	Priority 2 Support the continued roll out of tobacco free campuses in line with national policy.	*Promote participation in smoking cessation programmes and provision of nicotine replacement therapy to those in residential settings*	*Increased participation in smoking cessation initiatives.*	***Q3***
	Priority 3 Roll out of pilot project with the three cancer screening programmes for mental health patients in Dublin South Central	*Staff participation in and promotion of screening programmes.*	*Increased uptake of screening by users of Mental Health Service.*	***Q1-4***
Goal 2 – Provide fair, equitable and timely access to quality, safe health services that people need:	**Priority 1** Further develop Clinical Care Programmes	Continued support of the 3 Clinical Care Programmes including the provision of a Community Based Eating disorder programme in CAMHS	*Dependent on resources being made available through service developments* *Monitor uptake of Early Intervention of Psychosis Programme.*	***Q3-4***
	Priority 2 Deliberate Self Harm Programme	Review and implement the Clinical Deliberate Self Harm programme in the Emergency Departments in	*Ensure programme is implemented. Reduction of*	***Q1-4***

		consultation with the National Office	*incidents of self harm. Submit data to National Office.*	
	Priority 3 Out of Hours Access.	Extend out of hours access to establish 24hr crisis response capacity in line with VFC.	*Dependant on resources being made available. Numbers seen out of hours.*	***Q4***
	Priority 4 CHO 7 Mental Health Governance.	Development of new local mental health governance structures in CHO 7 by planning for re-alignment of our sector boundaries to an average pop' of 50,000 in line with the development of the Primary Care Networks in the area.	Engage with colleagues in CHO 7 forum re: new structures. Monitor progress of development of structures.	***Q1-4***
		Appointment of Quality and Risk Manager Service User Rep to CHO	Ensure appointments are in place.	
	Priority 5 Reconfiguration of Community Mental Health Teams.	Continue with supporting the reconfiguration of all General Adult CMHTs & Develop and progress process for assigning team co-ordinators	Progress introduction of Team Coordinators to piloting with one CMHT and one MHID.	***Q1-4***
		Develop out of hours service for 16-17 year olds	Service provided.	
	Priority 6 Out of Hours Service for 16 to 17 year olds.	Continue to roll out local service developments in line with 2016 development monies and ensure anti ligature and capital works are completed	Approved developments commended and completed. Capital Works completed.	***Q1-2***
	Priority 7 Service Developments.	Further develop the infection control measure and prevention within the service and the inspection process.	Develop and	***Q1-3***

	Priority 8 Infection Control		infection control strategy in conjunction with National Office	***Q1***
		Continue with pilot project of ECT based in AMNCH. Seek approval as a development post for CNM11	Risk Management Division.	
	Priority 9 ECT		ECT Service operable.	
		Continue the roll out of programmes to support collaboration and partnership with service users, family members and carers.		***Q1***
			Number of family and Carers engaged.	
	Priority 1 Service User Engagement			
Goal 3 : Foster a Culture that is honest compassionate transparent and accountable.		Roll out open disclosure training.		***Q1-4***
			Numbers trained.	
	Priority 2 Open disclosure training.	Continue to support the roll of recently appointed Suicide Prevention Resource Officers in the community.	*No of facilitated sessions.*	***Q1-4***
	Priority 3 Reduction of stigma.			
		Implement the Peer Support Worker role within the Mental Health Services and continue with its development subject to resources.		***Q2-4***
	Priority 1 Peer Support			
Goal 4: Engage Develop and value our workforce who deliver the best possible care to the people who depend on them:				***Q2-4***
		Optimise the recruitment and retention of staff by engagement with NRS and Third Level Colleges to maximise the available skill sets.		
	Priority 2: Retention of staff.		*Increased retention of staff.*	
				Q1-4

Kildare West Wicklow Mental Health Service

Population	
228,410	**Kildare/West-Wicklow**
Clinical Teams	**Population**
North Kildare	72,161
Mid East Kildare	61,984
Mid West Kildare	54,070
South Kildare	**39,688**

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Spend and Budget		
(1) **2014 Actual Net Spend**	**(2)** **2015 Projected Net Spend**	**(5)** **2016 opening Budget**
14,563,105	15,725,003	15,611,429

Staffing	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Other Patient & Client Care	Total
Dec 2015	**20.80**	**106.33**	**21.96**	**5.83**	**3.12**	**10.37**	**168.41**

Services Provided

Services Provided				
Service	**No. Provided**		**Service**	**No. Provided**
No. of Adult Acute In Patient Beds	29+6 (Portlaoise)			
General Adult			Psychiatry of Old Age(To de developed in 2015)	
No. of non acute beds for adults	0		Number of Day Hospitals	0
No. of Day Hospitals	4		No. of Community Mental Health Teams	0
No. of Community Mental Health Teams	4		Number of Day Centres	0
Number of Day Centres	2.5		Specialist Mental Health Services	
No, of High Support Community Residences	2		No. of Rehab and Recovery Teams	0.5
No. of Low and Medium support Community Residences	4 (0 Med and 4 low)		No. of Liaison Psychiatry Teams	0
CAMHS			No. of MHID Teams	0
Number of In Patient Beds	0			
No. of Day Hospitals	0		Other – Training Centre	0

No. of Community Mental Health Teams	0			

Corporate Goal	Mental Health Strategic Priority	Actions 2016	Measure of Performance	End Qtr
Goal -1 **Promote health and wellbeing as part of everything we do so that people will be healthier.**	**Mental Health Strategic Priority 1: Promote the mental health of our population in collaboration with other services and agencies including reducing loss of life by suicide**	Engage with Connecting for Life Strategy as rolled out in Kildare	Kildare localised Connecting for Life Strategy	Q4
		Develop the Rehabilitation service in AMH KWW to enhance individual recovery and ultimately reduce the pressures on the inpatient bed resource	Increase in number of individuals engaging with rehab team	Q1-Q4
Goal -2 **Provide fair, equitable and timely access to quality, safe health services that people need.**	**Mental Health Strategic Priority 2:**	Plan realignment of our sector boundaries to an average population of 50,000 in line with the development of the Primary Care Networks in the area.	New aligned teams	Q2-4
		A plan has been developed based on identified needs of the area for 3 new 17 bed high support hostels. For submission to Estates planning meeting Feb 2016	Decreasing length of stay in acute unit. Decrease in institutionalisation of individuals.	Q2-4
		Plan to develop a High Obs unit within existing footprint in Lakeview unit		
		MOU to be agreed with Portlaoise in absence of new structure, Ongoing bed shortage now at crisis in KWW	Approval from Estates to proceed	
		Develop a model of care for DSH in ED		Q2-4
		Continued roll out of 3 national Clinical care		

		Programs	MOU in place	
		Support for Training and recruitment of staff in KWW	Initiate DSH capacity including SOP in NGH ED. CNS role in Place.	Q1 Q2
		Streamline process for purchasing assessment tools for normal day to day activities	Continued BFT, FEP and DTB training	Q2
Goal 4 – Engage, Develop and value our workforce to deliver the best possible care and services to the people who depend on them.	**Mental Health Strategic Priority 4**	In OT & Psychology service.	Continue the process of bringing MH staffing in KWW up to Vision for Change levels.	Q1-4
		Develop 3 Homecare teams in Kildare_ will allow people to be treated in the most appropriate setting.	Ease and speed of supply to service managers	Q2
Goal 5 Manage resources in a way that delivers best health outcomes, improves peoples experiences of using the service and demonstrates good value for money.	**Mental Health Strategic Priority 5**		Reduced risk in acute unit due to decrease in demand for beds	Q1

Social Care

Introduction

CHO 7 Social Care Services provides older persons and disability services to a population of 668,250. The population of people over 65 years within the area is 93,039. CHO 7 is committed to developing different models of service delivery to support older people to age positively.

Life expectancy for people with a disability is increasing and is welcome. CHO 7 is proactively implementing the recommendations of the key priorities nationally – such as Progressing Children's Disability Services, New Directions Report and De-congregation Settings in partnership with Voluntary Providers.

The increasing demand for services within the social care division will be a particular challenge within CHO 7 both from a financial and service delivery perspective. To remain within the financial allocation will require significant focus and cost containment measures with inherent risk to service delivery

Service Description

Social Care Services within CHO 7 are focused on:

- 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.
- 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 and improving services to meet their needs.
- 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.

Maximise Delivery of Social Care within Available Resources 2016

The social care allocation for CHO 7 for 2016 is €**226.75m** which indicates **a budgetary deficit** problem of €**19m**. **This assumes that the S38s will breakeven against budget by implementing cost containment measures as required**

Whilst continuing efforts will be made to reform and improve services based on existing values with service users at the centre of all decision making, there will also be a focus on the cost and sustainability of services while ensuring at all times that services are delivering best value for money for the public and service users.

The challenge for 2016 is social care's capacity to meet the increasing demand of an ageing population, together with changing needs and an increasing number of people with a disability with more complex service requirements. Demand for services continues to increase as the population of 65 years and over will increase by 3.1% nationally between 2015 and 2016 and the population 85 years and over (which places the largest pressure on services) is growing at a rate of 4.2% nationally between 2015 and 2016. Additionally, the Census 2011 reports that 13% of the national population report at least one disability and one in 10 adults of working age report a disability. To respond to the projected increase in the number of people living with a disability in conjunction with the age profile and increased life expectancy of those with a disability, it is necessary for a more affordable and sustainable model of services to be put in place.

Our operational plan for Social Care Services provides clarity as to the services we intend to provide over 2016, building on progress made over recent years. This plan details the many actions we will undertake over the year. Our actions and goals will be dependent primarily on financial and human resources available to us. We will endeavour to comply with the Pay-bill Management and Control Framework within CHO 7 in all our operational endeavours and all service provision will be subject to compliance with same. However, this creates a significant challenge for CHO 7 especially in terms of posts which require filling that are not in the run rate.

Introduction of the Single Assessment Tool (SAT)

Progress the implementation of the IT enabled standardised assessment of health and care needs of older people through the implementation of the Single Assessment Tool project. Phased implementation is planned with an initial focus on access to long term care, resulting in a minimum of 50% of NHSS application assessed using SAT by the end of 2016. Implementation for applications to home care services will follow resulting in a minimum of 25% of HCP applications assessed using SAT by the end of 2016.

Actions to Implement SAT	**Q**
Implementation of SAT initially in 4 Early Adopter sites (Beaumont, CUH, UHG & Tallaght hospitals and surrounding community locations)	Q1 – Q2
– Identification of SAT assessors & release for training and completion of Training and Assessor Competency Evaluation	Q1 – Q2
– Commencement of SAT assessments for 6 month period initially for older people seeking access to NHSS and thereafter HCP	Q1 – Q2
Evaluation of implementation in Early Adopter sites after 6 months	Q3
Phased implementation into remaining locations	Q3-Q4
CHO Specific Actions to Implement SAT	**Q**
CHO **Action**	
CHO 2, 4, 7, 9 Implementation in Early Adopter Hospital/Community Site – UGH and Galway, CUH & Cork City, Tallaght Hospital and Dublin SW, Beaumont & Dublin North	Q1- Q2
CHO 1, 3,5,6,8 Commence phased implementation following Early Adopter evaluation	Q3-Q4

The implementation of SAT will require the re-designation of a number of staff to carry out assessment s in the Community and in the acute hospital. This will impact on service provision elsewhere in the older persons' service.

Quality and Service User Safety

CHO 7 Social Care Services are committed to the continued implementation of a strong system of integrated corporate and clinical governance within our social care services. In 2016 we will continue, subject to resources, to:

- Further develop structures and processes relating to clinical governance and proactively promote service user involvement;
- Ensure quality standards and arrangements are enforced in accordance with statutory and organisational requirements;
- Monitor quality improvement and patient safety through use of key performance indicators;
- Promote the prevention and control of healthcare associated infection;
- Promote risk management as everyday practice across all services and enhance the way we manage and learn from incidents;

- Ensure compilation and regular review of risk registers for all services/service areas;
- Strengthen SA and GA review and management for all agencies, through an enhanced monitoring framework;
- Ensure the delivery of a high quality, patient centered service through the review of structures so as to meet the social/ physical/ medical needs of those accessing HSE services;
- Implement the Safeguarding Vulnerable Persons at risk of abuse – National Policy and Procedures

Staffing Levels in Social Care Division

CHO / Division	Medical/ Dental	Nursing	Health & Social Care Professionals	Management / Admin	General Support Staff	Patient & Client Care	Total	Change 2014 vs 2015
Social Care	22	757	266	176	280	1394	**2895**	**+123**

Services Provided
Older Persons Services
Home Support Services through Home Help, Home Care Packages and Intensive Home Care Packages
Day Care Services/Day Hospitals
Meals on Wheels Services through Voluntary Providers
Home Help Services through Voluntary Providers
Long stay Services through our Community Nursing Units and District Hospitals
Nursing Home Support Scheme
Short Stay Provision
Respite Services
Disability Services
Disability Services are mainly provided through Section 38 and 39 agencies on behalf of CHO 7, these consist of;
Residential Care
Day Care
Rehabilitation Training
Specialists Schools
Multidisciplinary Supports
Early Intervention Teams
Home Support Services

Service Reform Fund

The CHO will engage with the Disability service reform fund as appropriate to support decongregation of institutional settings with specific priority actions in relation to St John of God Services in Celbridge and significant progress to be made with other services regarding their plans for decongregation.

Children's' Disability Network Teams.

Work is underway in reconfiguring children's disability services into geographically based Children's Disability Network Teams (Early-Intervention and School-aged or 0–18 Teams), with 56 of the 129 teams reconfigured. The objective of the programme is to provide one clear referral pathway for all children (0–18s), irrespective of their disability, where they live or the school they attend. 2016 will see the completion of the full reconfiguration of 0–18s disability services into 129 Children's Disability Network Teams. Oversight of implementation will be provided through working group 2 of the Transforming Lives process.

In 2016 Social Care services will:

Complete the process of reconfiguration of 0–18s disability services into Children's Disability Network Teams, including the provision of 75 additional WTE therapy posts through new staff appointments to reconfigured multi-disciplinary geographic based teams and through using innovative approaches to achieve targeted reductions in waiting lists for therapies.

CHO 7 will implement National Access Policy in collaboration with primary care to ensure one clear pathway of access for all children with a disability into their local services.

New Directions* – reconfiguring day services including school leavers and rehabilitative training *(New Funding €7.25m)

In 2015, a national project group was established to develop and oversee a process to attend to the needs of school leavers and those existing rehabilitative training (RT) that require a HSE funded adult day service.

- In 2016, CHO7 will continue the implementation of *New Directions* which will progress an approach of individualised supports for all current users of HSE funded adult day services.
- Benchmark providers against standards framework developed in conjunction with NDA.
- Develop a CHO implementation structure to support *New Directions*.
- Develop a framework for person-centred planning.
- Support development of day places for 43 RT and 105 School leaver s in CHO 7.

National Guidelines on Accessible Health and Social Care Services

- Work with services to ensure that they are examining their services for accessibility, in line with the national guidelines.

Governance and communication

CHO 7 will bbuild capacity to effectively manage incidents and complaints.

Service User and Family Engagement within the Disability Sector

- CHO 7 will continue to work with the Confidential Recipient.

- CHO 7 will continue to improve Compliance with National Standards for Disability Residential Centres – Quality Improvement Enablement Programme / Quality Improvement Team

- CHO 7 staff will continue to participate in training to improve the quality and safety of our services.

Governance and Service Arrangements

- CHO 7 will develop a strong regional capability to ensure effective governance and accountability in respect of S38 and S39 Agencies.

Key Priorities & Actions to Deliver on Goals in 2016

Corporate Goal	Social Care Strategic Priority	Actions 2016	Measure of Performance	End Qtr
Older Persons Services				
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Promote Positive Ageing and Improve Physical Activity Levels	Engage with Health and Well Being Division in rolling out of National Positive Ageing Strategy and other Age Friendly initiatives with Local Authorities. Continue to work with Co. Councils promoting Health & Well Being through LCDCs	Implementation of strategies and Initiatives Continued cooperation with Co. Councils	Q1 - Q4 Q1 and ongoing
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Implement actions from the Dementia Strategy Implementation Programme	Develop a CHO wide Strategy to implement actions from the National Dementia Strategy	Development and implementation of strategy	Q2 and ongoing
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Implement Older Persons Remaining at Home (OPRAH)	Continue existing initiatives supporting OPRAH	Successful continuance of existing strategy	Q1 and ongoing
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Tobacco Free Campus Policy and BISC training	Support the continued role out of the Tobacco Free Campus Policy in Social Care with set targets – *100% of new and 75% of existing sites.*	Attain targets for new and existing sites to adhere to tobacco free campus policy	Q1 - Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Improve compliance with Safeguarding vulnerable persons at risk of abuse	Continue to improve services within the context of implementation of the Safeguarding Vulnerable Persons at Risk of Abuse Policy	Ensuring compliance with Strategy/Policy	Q1 and ongoing

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** NHSS (Fair Deal)	Continue to support Fair Deal Process	Streamlined processing of applications/Maintain 4 week waiting time for approval	Q1 and ongoing
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Home Care Packages (HCPs) Home Care improvement Plan	Standardise processes in relation to HCP's and Home Help provision. Ensure fair and equitable access to HCPs Participate as required in projects to implement HCP Improvement Plan	HCP applications to be dealt with in an efficient and timely manner Support the development of implementation group(s) and/or pilot projects as required to progress implementation in line with national plan	Q2 Q1
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Home Help Hours (HHHs)	Continue funding of Home Help Hours to funded levels	HH applications to be dealt with in an efficient and timely manner	Q1 and ongoing
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Transitional Care Funding	Continue implementation of Transitional Care Funding throughout CHO 7	Ensure Transitional Care Funding applications are dealt with in an efficient and timely manner and facilitate discharge	Q1 and ongoing
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Enhance Respite Care Provision	Review and determine Respite Care Requirements within CHO 7	Implementation of Care Requirements	Q1 - Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need.	**Priority:** Actions for Falls Prevention and Bone Health	Development of integrated care pathways for falls with division.	Support the division in identifying additional adapter sites in CHO 7	Q1 - Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Actions to Implement the Carers Strategy	Progress to support and monitor the CHO projects through the assistance of a national project team.	CHO will continue to work with Local authorities in Kildare West Wicklow, Dublin South West & Dublin South East to further promote the concepts of the Age Friendly Cities and Communities Strategy.	Q1 - Q4

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Actions to Implement Integrated Care Programme for Older Persons	Recruit 6.0 WTE Consultant Geriatrician and multidisciplinary team in conjunction with Tallaght Hospital to support development of enhancing care pathways for older persons.	Team in place	Q1 - Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Priority:** Service User Engagement	Increase engagement with key stakeholders, National and local advocacy groups and the voluntary sector to develop a strong user engagement and participation process Actions to Implement Improved Governance and Communication	Increase service user engagement Continue process of establishing Quality & Safety Structures in the CHO including reporting on CHO Q&S Committee, Social Care Q&S Committee and the development of HCAI/Infection Control Committee and Drugs & Therapeutics Committee	Q1 and ongoing Ongoing
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Open Disclosure	Phase II - roll out of Open Disclosure Training	Participation of all Staff in the Opening Disclosure Awareness Programme	Q1 - Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Improved Service User Engagement	Ensure that all service users and their families are aware of the role of the Confidential Recipient Progress the implementation of Residents Councils for older persons residential care services	Ensure that the poster for the Confidential Recipient is distributed to all older persons residential care services for display. Progress the implementation of Residents Councils for older persons residential care services	Q1 and ongoing Q1 and ongoing
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Actions in relation to Safeguarding Vulnerable Adults.	Continue the Implementation Process of the Safeguarding Vulnerable Adults Policy	Continue Front line staff – awareness briefings Support the development by National Division of the National database of safeguarding concerns	Q1 - Q4

Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Leadership Presence	Support the development of leaders at CHO level to provide direction and purpose and connect with all staff and teams through opened and ongoing communication and engagement as a core leadership activity.	Ongoing communication and engagement from leaders.	Q1 - Q4
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Staff Voice	Encourage feedback and value staff opinions	Service Improvements	Q1 - Q 4 and ongoing
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Staff Motivation	Foster a culture of partnership with staff	Improved staff morale and work ethic	Q1 and ongoing
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Learning and Development Approach	Encourage staff to engage and participate in online training programmes	Better educated and motivated staff	Q1 - Q4
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Public Residential Care Workforce Plan	Support the National Older Persons services in the development of a SMART action plan to implement the agreement reached at the Workplace Relations Commission regarding skill mix in the CHO's,	Service Improvements	Q1 - Q4

Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Improve compliance with HIQA residential standards	Continue working towards compliance with HIQA residential standards	Compliant with HIQA Standards	Q1 - Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Roll out of skill mix initiative to elderly residential units	Ensure skill mix is an integral component in the HR management of residential units	Appropriate skill mix present in residential units	Q2
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Continue to address cost of care challenge in public units	Review non pay costs in public residential units	Reduction in cost of care	Q1 –Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Introduction of the Single Assessment Tool (SAT)	Roll out SAT Programme in 2016	SAT to be fully implemented in CHO 7	Q4

Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Sign off of SA Part 2s for our Section 38/39 Voluntary & Private provider agencies.	Assign staff to target completion of SA with our Section 38/39 Voluntary Agencies and Private for Profit Agencies.	Sign off for Section 38/39 SA by 29th February 2016	Q1

Corporate Goal	Social Care Strategic Priority	Actions 2016	Measure of Performance	End Qtr
Disability Services				
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** "Time to Move on from Congregated Settings"	Continue to implement national policy on Congregated Settings - in 2 CHO 7 settings –	Complete transition of 8 clients from St. Raphael's Celbridge. Agree a CHO lead to implement the policy on de-congregation. Implementation of person centred models of care	Q1 - Q4 Q1 Q1 - Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Tobacco Free Campus Policy and BISC training	Support the continued role out of the Tobacco Free Campus Policy in Social Care with set targets – *specific targets to be set*	Attain target of 25% for new and existing sites to adhere to tobacco free campus policy	Q1 - Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	**Priority:** Improve compliance with safeguarding vulnerable persons at risk of abuse	Support National Implementation Task Force Team as appropriate	Effective monitoring through Service Arrangements and IMR Processes	Q1 - Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Progressing Disability Services for Children and Young People	All 5 KPI metrics to be completed by year end	Completion of metrics	Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** New Directions – reconfiguration of day services including school leavers and rehabilitative training	Work with National Structures and Service Providers to expand the implementation of New Directions locally through the development of the CHO implementation structure and within available resources.	Effective monitoring through Service Arrangements and IMR Processes	Q1 - Q4

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Rehabilitation Strategy and Integrated Care Programme	Commence planning for implementation of neuro rehabilitation strategy at CHO level	Successful completion of strategy with timelines outlining implementation phases	Q1 - Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Priority: Reconfiguring Disability services into Network Disability Teams.	Reconfigure into 4 x 0-18 teams in DSC and 2 x 0-18 Teams in DSW. KWW will be demonstration site for Outcomes for Children and their Families Framework	Delivery of Network Disability teams.	Q1 - Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	**Priority:** Demographic and Changing Need	Address emerging needs within available resources; notify national system of unmet needs and risks	Continue to monitor emerging needs at local level	Q1 and ongoing
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Priority:** Develop Improved Service User Engagement	Increase engagement with key stakeholders, advocacy groups and the voluntary sector to develop a strong user engagement and participation process	Positive feedback from service user forums	Q1 - Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Priority:** Service User Engagement	Increase engagement with key stakeholders, National and local advocacy groups and the voluntary sector to develop a strong user engagement and participation process Actions to Implement Improved Governance and Communication	Increase service user engagement Continue process of establishing Quality & Safety Structures in the CHO including reporting on CHO Q&S Committee, Social Care Q&S Committee and the development of HCAI/Infection Control Committee and Drugs & Therapeutics Committee	Q1 and ongoing Ongoing
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Improved Service User Engagement	Ensure that all service users and their families are aware of the role of the Confidential Recipient Progress the implementation of Residents Councils for older	Ensure that the poster for the Confidential Recipient is distributed to all residential care services for display. Progress the implementation of	Q1 and ongoing Q1 and

		persons residential care services	Residents Councils for in residential care services.	ongoing
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Quality and Safety Priority:** Actions in relation to Safeguarding Vulnerable Adults.	Continue the Implementation Process of the Safeguarding Vulnerable Adults Policy	Continue Front line staff – awareness briefings Support the development by National Division of the National database of safeguarding concerns	 Q1 - Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	**Priority:** Quality Enablement Programme.	Continue to support work to improve the implementation of the Quality Improvement Division enablement programme.	Take immediate, medium and longer term actions to respond to HIQA concerns and recommendations arising from inspection findings of disability residential services	Q1 - Q4
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Leadership Presence	Enhancement of leadership qualities though Future Leaders Programme	Ongoing communication and engagement from leaders	Q1 - Q4
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Staff Voice	Encourage feedback and value staff opinions	Development of a culture of learning and improvement	Q1 - Q 4
Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Staff Motivation	Foster a culture of partnership with staff	Improved staff morale and work ethic	Q1 and ongoing

Goal 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Priority:** Learning and Development Approach	Encourage staff to engage and participate in online training programmes	Better educated and motivated staff	Q1 - Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Improve compliance with HIQA standards in disability residential centres	Continue to support system wide residential services 6 step programme	National dependency with support from nominated CHO leads	Q1 - Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Service Improvement Team	Support Service Improvement Team in the provision of guidance and support across public residential facilities in a safe, equitable and cost effective manner	Identification and implementation of models of best practice in relation to the delivery of services	Q1 and ongoing
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority (Disabilities):** Ensure compliance with the Pay-Bill Management and Control Framework	Monitoring and control process at CHO Level	Management of services within control framework	Q1 - Q4
Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Continuation of the VFM Programme and Policy Review	Continue to engage with National Directorate projects/actions/priorities in accordance with timelines agreed with National Directorate	Implementation of initiatives /actions to be determined in accordance with national directorate targets	Q1 - Q4

Goal 5: Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money	**Priority:** Sign off of SA Part 2s for our Section 38/39 Voluntary & Private provider agencies.	Assign staff to target completion of SA with our Section 38/39 Voluntary Agencies and Private for Profit Agencies.	Sign off for Section 38/39 SA by 29th February 2016	Q1

Appendices

Appendix 1: Primary Care Financial Tables

2016 CHO Net Expenditure Allocations

CHO	Pay	Non Pay	Gross Budget	Income	Net Budget
	€m	€m	€m	€m	€m
Primary Care	54.0	25.0	79.0	-.3	78.7
Social Inclusion	17.7	28.1	45.8	-.1	45.7
Palliative Care	2.3	.5	2.9	.0	2.8
Core Services	**74.1**	**53.6**	**127.6**	**-.4**	**127.2**
Local DLS	.0	46.3	46.3	.0	46.3
Total	**74.1**	**99.9**	**173.9**	**-.4**	**173.5**
OLH					
Primary Care	.0	.0	.0	.0	.0
Social Inclusion	.0	.0	.0	.0	.0
Palliative Care	23.2	5.5	28.7	-8.2	20.5
Core Services	**23.2**	**5.5**	**28.7**	**-8.2**	**20.5**
Local DLS	.0	.0	.0	.0	.0
Total	**23.2**	**5.5**	**28.7**	**-8.2**	**20.5**
Total Area 7 (Incl. OLH)					
Primary Care	54.0	25.0	79.0	-.3	78.7
Social Inclusion	17.7	28.1	45.8	-.1	45.7
Palliative Care	25.6	6.0	31.6	-8.3	23.3
Core Services	**97.3**	**59.1**	**156.4**	**-8.6**	**147.7**
Local DLS	.0	46.3	46.3	.0	46.3
Total	**97.3**	**105.3**	**202.6**	**-8.6**	**194.0**

Appendix 2 – Balance Scorecard & Key Performance Indicators

Balance Scorecard – Quality and Access Indicators of Performance

Health & 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%		

Balance Scorecard - Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Primary Care **Service User Experience**	*System-wide*
• Complaints	
• % of PCTs by CHO that can evidence service user involvement.	100%
Safe Care	
• Serious Reportable Events	*System-wide*
• Safety Incident Reporting	
Healthcare Associated Infections: Medication Management	
• Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	< 21.7
Effective Care	
Community Intervention Teams (number of referrals)	**6,941**
• Admission Avoidance (includes OPAT)	141
• Hospital Avoidance	4,922
• Early discharge (includes OPAT)	1,878
• Unscheduled referrals from community sources	0
***Health Amendment Act*: Services to persons with state acquired Hepatitis C**	180
• Number of patients who were reviewed	
Primary Care Reimbursement Service **Effective Care**	
Medical Cards	
• % of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days – this is a national target	90%
• % of Medical Card / GP Visit Card applications which are accurately processed by national medical card unit staff	95%
Social Inclusion **Effective Care**	
Traveller Health	
• No. of people who received health information on type 2 diabetes and cardiovascular health	475
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%

Quality	Expected Activity / Target 2016
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	61,997
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%

Access	Expected Activity / Target 2016
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)	3,740
• 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	0
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	308
• No. of children in the care of the children's outreach nursing team / specialist palliative care team	140

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years
** These are National Targets for Medical Cards.

Balance Scorecard Mental Health

Quality and Access Indicators of Performance	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 Score Cards 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%**
Congregated Settings	
• Facilitate the movement of people from congregated to community settings	**8**
Serious Reportable Events	
• % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	**99%**
• % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	**90%**
Safety Incident Reporting	
• % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	**90%**
Complaints	
• % of complaints investigated within 30 working days of being acknowledged by the complaints officer	**75%**
Safeguarding	
• % of preliminary screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan	**100%**
• % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy	**100%**
• % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy	**100%**
• % compliance with inspected outcomes following HIQA inspection of Disability Residential Units	**75%**
Service Improvement Team Process	
• Deliver on Service Improvement priorities	**100%**
Transforming Lives - VfM Policy Review	
• Deliver on VfM Implementation priorities	**100%**
Quality	
• 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%**

Progressing Disability Services for Children and Young People (0-18s) Programme	
• No. of Childrens Disability Network Teams established	**100%** (9/9)
Disability Act Compliance	
• % of assessments completed within the timelines as provided for in the regulations	**100%**
Day Services	
• % of school leavers and RT graduates who have been provided with a placement	**100%**
Respite*	
• No. of day only respite sessions accessed by people with a disability	**4395**
• No. of overnights (with or without day respite0 access by people with a disability	**26,654**
Personal Assistance (PA)	
• No. of PA service hours delivered to adults with a disability	**17,382**
Home Support Service	
• No. of Home Support Hours delivered to persons with a disability	**376,758**

Finance

Human Resources

Budget Management including savings	
Net Expenditure variance from plan (budget)	
• Pay - Direct / Agency / Overtime	≤ .33 %
• Non-pay	
• Income	≤ .33 %
Service Arrangements/ Annual Compliance Statement	
• % of number of Service Arrangement signed	≤ .33 %
• % of the monetary value of Service Arrangements signed	
• % of Annual Compliance Statements signed	
Capital	
• Capital expenditure versus expenditure profile	100%
	100%
Governance and Compliance	100%
• % of internal audit recommendations implemented by due date	
• % of internal audit recommendations implemented, against total number of recommendations, within 12 months of	100%
•	
•	
•	
•	75%
• months of report being received	95%

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

*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

Balance Scorecard Older Persons Services

Quality and Safety

Service User Experience	
• % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Older Persons Services (Q3)	**100%**
Serious Reportable Events	
• % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	**99%**
• % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	**90%**
Safety Incident Reporting	
• % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	**90%**
Complaints	
• % of complaints investigated within 30 working days of being acknowledged by the complaints officer	**75%**
Safeguarding	
• % of preliminary screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan	**100%**
• % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy	**100%**
• % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy	**100%**
Service Improvement Team Process	
• Deliver on Service Improvement priorities	**100%**
Governance for Quality and Safety	
• Quality and Safety committees across all Divisions at Divisional, Hospital Group and Community Healthcare Organisation	**100%**

Access

Home Care Packages	
• Total no. of persons in receipt of a HCP including delayed discharge initiative HCPs	**1988**
• Intensive HCPs: Total no. of persons in receipt of an intensive HCP	**130**
Home Help	
• No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	**734,000**
• No. of people in receipt of home help hours (excluding provision from HCPs)	**5,200**
NHSS	
• No. of persons funded under NHSS in long term residential care	**23,450**
• No. of NHSS beds in Public Long Stay Units	**642**
• No. of short stay beds in Public Long Stay Units	**199**

Finance

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

Human Resources

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

Appendix 3 Key Performance Indicators (KPIs)

Health & Wellbeing KPIs

Health and Wellbeing				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Tobacco				
No. of smokers who received intensive cessation support from a cessation counsellor	M	123	11,000	11,500
No. of frontline staff trained in brief intervention smoking cessation	M	1,350	1,120	1,350
% 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		4,935
No. of frontline healthcare staff who have completed the physical activity e-learning module	M	New PI 2016		45
No. of people who have completed a structured patient education programme for diabetes	M	New PI 2016		200
% 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		900
% 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%
% 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%

Health and Wellbeing				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
% 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%

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

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016		
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	CHO 7
Community Intervention Teams (number of referrals)				26,355	18,600	24,202		6,941
Admission Avoidance (includes OPAT)	NSP	Quality	M	1,196	651	914	CHO	141
Hospital Avoidance	NSP	Quality	M	14,134	10,788	12,932	CHO	4,922
Early discharge (includes OPAT)	NSP	Quality	M	6,375	3,980	6,360	CHO	1,878
Unscheduled referrals from community sources	NSP	Quality	M	4,650	3,181	3,996	CHO	0
Outpatient parenteral Antimicrobial Therapy OPAT Re-admission rate %	DOP	Access /Activity	MQ2	New PI 2016	New PI 2016	≤5%	HG	≤5%
Community Intervention Teams Activity (by referral source)				26,355	18,600	24,202	CHO	6,941
ED / Hospital wards / Units	DOP	Access /Activity	M	17,038	11,272	13,956	CHO	5,274
GP Referral	DOP	Access /Activity	M	6,029	4,073	6,386	CHO	1,055
Community Referral	DOP	Access /Activity	M	1,455	1,823	2,226	CHO	211
OPAT Referral	DOP	Access /Activity	M	1,833	1,432	1,634	CHO	401
GP Out of Hours								
No. of contacts with GP Out of Hours Service	NSP	Access /Activity	M	959,455	964,770	964,770	National	

Tobacco Control								
% of primary care staff to undertake brief intervention training for smoking cessation	DOP	Quality	Q	New 2016	New 2016	5%	CHO	5%
Physiotherapy								
No of patient referrals	DOP	Activity	M	184,596	192,884	193,677	CHO	22,237
No of patients seen for a first time assessment	DOP	Activity	M	159,260	158,262	160,017	CHO	16,886
No of patients treated in the reporting month (monthly target)	DOP	Activity	M	34,993	35,291	36,430	CHO	4,171
No of face to face contacts/visits	DOP	Activity	M	770,878	767,109	775,864	CHO	85,229
Total No. of physiotherapy patients on the assessment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	28,527	CHO	2,791
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	80%	83% Data Gap	70%	CHO	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%
Occupational Therapy								
No of patient referrals	DOP	Activity	M	85,030	88,162	89,989	CHO	13,286
No of new patients seen for a first assessment	DOP	Activity	M	83,004	84,983	86,499	CHO	14,611
No of patients treated (direct and indirect) monthly target	DOP	Activity	M	19,811	20,070	20,291	CHO	2,835
Total No. of occupational therapy patients on the assessment waiting list at the end of the reporting period **	DOP	Access	M	New PI 2016	New PI 2016	19,932	CHO	2,329
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	80%	76% Data Gaps	70%	CHO	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%
Orthodontics								
No. of patients receiving active treatment at the end of the reporting period	DOP	Access	Q	21,050	16,887	16,887	National/ former region	
% of referrals seen for assessment within 6 months	NSP	Access	Q	75%	74%	75%	National/ former region	
% on waiting list for assessment ≤ 12 months	DOP	Access	Q	100%	99.80%	100%	National/ former region	
% of patients on the treatment waiting list less than 2 years	DOP	Access	Q	75%	60%	75%	National/ former region	
% of patients on treatment waiting list less than 4 years (grade 4 and 5)	DOP	Access	Q	95%	92%	95%	National/ former region	
No. of patients on the assessment waiting list at the	DOP	Access	Q	6,165	5,966	5,966	National/	

end of the reporting period							former region	
No. of patients on the treatment waiting list – grade 4 –at the end of the reporting period	DOP	Access /Activity	Q	9,444	9,912	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	7,562	8,194	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%	8%	<5%	National/ former region	
Oral Health (Primary Dental Care and Orthodontics)								
No. of new patients attending for Scheduled Assessment	DOP	Access /Activity	M	No Target 2015	Unavailable	Unavailable	CHO	Unavailable
No. of new patients attending for Unscheduled Assessment	DOP	Access /Activity	M	No Target 2015	Unavailable	Unavailable	CHO	Unavailable
% of new patients who commenced treatment within 3 months of assessment	NSP	Access	M	No Target 2015	Not Available	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	25.7	<21.7	National	
Primary Care – Psychology								
No. of patient referrals	DOP	Activity	M	New	12,250	12,261	CHO	1,467
Existing patients seen in the month	DOP	Activity	M	No Target 2015	2,601	2,626	CHO	194

New patients seen	DOP	Activity	M	No Target 2015	9,387	9,367	CHO	1,368
Total No. of psychology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	6,028	CHO	609
No. of psychology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%

% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	60%	CHO	60%
Primary Care – Podiatry								
No. of patient referrals	DOP	Activity	M	New	10,689	11,589	CHO	No direct service
Existing patients seen in the month	DOP	Activity	M	No Target 2015	5,095	5,210	CHO	No direct service
New patients seen	DOP	Activity	M	No Target 2015	7,279	8,887	CHO	No direct service
Total No. of podiatry patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	3,186	CHO	No direct service
No. of podiatry patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%

% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	75%	CHO	75%
No of patients with Diabetic Active Foot Disease treated in the reporting month	DOP	Quality	M Q3	New PI 2016	New PI 2016	133	CHO	0
No. of treatments for Diabetic Active Foot Disease in the reporting month	DOP	Access /Activity	M Q3	New PI 2016	New PI 2016	532	CHO	0
Primary Care – Ophthalmology								
No. of patient referrals	DOP	Activity	M	New	22,261	26,913	CHO	0
Existing patients seen in the month	DOP	Activity	M	No Target 2015	3,818	13,807	CHO	0
New patients seen	DOP	Activity	M	No Target 2015	10,091	16,524	CHO	0
Total No. of ophthalmology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	14,267	CHO	
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	60%	CHO	60%
Primary Care – Audiology								
No. of patient referrals	DOP	Activity	M	No Target 2015	18,317	18,317	CHO	3,100
Existing patients seen in the month	DOP	Activity	M	No Target 2015	2,822	2,850	CHO	331
New patients seen	DOP	Activity	M	No Target 2015	16,645	16,459	CHO	1,840
Total No. of audiology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	13,870	CHO	2,036
No. of audiology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	60%	CHO	60%
Primary Care – Dietetics								
No. of patient referrals	DOP	Activity	M	No Target 2015	25,138 (data gap)	27,858	CHO	2,613
Existing patients seen in the month	DOP	Activity	M	No Target 2015	3,393 (data gap)	5,209	CHO	220
New patients seen	DOP	Activity	M	No Target 2015	19,281 (data gap)	21,707	CHO	1,767
Total No. of dietetics patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New 2016	5,479	CHO	486
No. of dietetics patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	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	New PI 2016	New PI 2016	No target	CHO	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	85%	CHO	85%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	70%	CHO	70%
Primary Care – Nursing								
No. of patient referrals	DOP	Activity	M	No Target 2015	150,768	159,694	CHO	1,702 (Data gap)
Existing patients seen in the month	DOP	Activity	M	No Target 2015	63,724	64,660	CHO	1,800 (Data gap)
New patients seen	DOP	Activity	M	No Target 2015	115,785	123,024	CHO	1,884 (Data gap)
Number of new patients accepted on the caseload and waiting to be seen over 12 weeks	NSP	Access	M	New 2016	New 2016	0	CHO	0
Primary Care – Speech and Language Therapy* **								

No. of patient referrals	DOP	Activity	M	No Target 2015	50,863	50,863	CHO	5,769
Existing patients seen in the month	DOP	Activity	M Q2	New 2016	New PI 2016	New PI 2016	CHO	New PI 2016
New patients seen for initial assessment	DOP	Activity	M	No Target 2015	41,083	41,083	CHO	4,045
Total No. of speech and language patients waiting initial assessment at end of the reporting period ****	DOP	Access	M	New 2016	New PI 2016	13,050	CHO	3,057
Total No. of speech and language patients waiting initial therapy at end of the reporting period ****	DOP	Access	M	New 2016	New PI 2016	8,279	CHO	1,060
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%
Health Amendment Act - Services to persons with state acquired Hepatitis C								
No. of patient who were reviewed.	NSP	Quality	Q	820	22	798	National	180

Note: All waiting list targets reflect end of year target.

***Monthly average based on April – Oct 2015 submitted data.**

**** Monthly average based on July – Oct 2015 submitted data.**

***** Speech and Language Therapy Data includes all non – acute activity across the care groups.**

****** SLT Monthly average based on Jan – Oct. 2015 submitted data**

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

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016		
KPI Title	NSP / DOP	KPI Type Access / Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	CHO 7
Quality and Patient Safety								
Service User Experience								
% ratio of compliments to complaints by CHO	DOP	Quality	Q	New PI 2016	New PI 2016	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	System Wide	New PI 2016	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	System wide	New PI 2016	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	System wide	New PI 2016	99%	CHO	99%
% of investigations completed within 120 days of event occurrence)	NSP	Quality	M	System wide	New PI 2016	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	System wide	New PI 2016	90%	CHO	90%
% of claims received by State Claims Agency that were not reported previously as an incident	NSP	Quality	A	System wide	New PI 2016	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 – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	CHO 7
Total no. of clients in receipt of opioid substitution treatment (outside prisons)	NSP	Access	M 1 Mth in Arrears	9,400	9,413	9,515	CHO	3,740
No. of clients in opioid substitution treatment in Clinics	DOP	Access	M 1 Mth in arrears	5,400	5,392	5,470	CHO	2,170
No. of clients in opioid substitution treatment with level 2 GP's	DOP	Access	M 1 Mth in arrears	2,000	1,995	1,975	CHO	1,855
No. of clients in opioid substitution treatment with level 1 GP's	DOP	Access	M 1 Mth in Arrears	2,000	1,999	2,080	CHO	725
No. of clients transferred from clinics to level 1 GP's	DOP	Access	M 1 Mth in Arrears	300	238	300	CHO	61
No. of clients transferred from level 2 GP's	DOP	Access	M 1 Mth in Arrears	100	115	134	CHO	50
No. of clients transferred from level 2 to level 1 GPs)	DOP	Access	M 1 Mth in Arrears	120	94	119	CHO	50
Total no. of new clients in receipt of opioid substitution treatment (outside prisons)	DOP	Access	M 1 Mth in Arrears	500	588	617	CHO	170
Total no. of new clients in receipt of opioid substitution treatment (clinics)	DOP	Access	M 1 Mth in Arrears	400	482	498	CHO	151
Total no. of new clients in receipt of opioid substitution treatment (level 2 GP)	DOP	Access	M 1 Mth in Arrears	100	88	119	CHO	19
Average waiting time from referral to assessment for Opioid Substitution Treatment (days)	NSP	Access	M 1 Mth in Arrears	New 2016	New 2016	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	New 2016	New 2016	28 days	CHO	28 days

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	CHO 7
Number of people obtaining opioid substitution treatment from Pharmacies	DOP	Access	M 1 Mth in Arrears	6,430	6,421	6,463	CHO	2,110
No. of substance misusers who present for treatment	DOP	Access	Q 1 Q in arrears	1,274 per quarter	5,860 per annum	6,972	CHO	872
No. of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	Q 1 Mth in Arrears	797 per quarter	4,260 per annum	4,864	CHO	820
% of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	Q 1 Mth in Arrears	100%	71%	100%	CHO	100%
No. of substance misusers (over 18 years) for whom treatment has commenced following assessment	DOP	Quality	Q 1 Mth in Arrears	1,124 per quarter	4.658 per annum	5,584	CHO	468
No. of substance misusers (over 18) for whom treatment has commenced within one calendar month following assessment	DOP	Quality	Q 1 Mth in Arrears	1,100 per quarter	4590 per annum	5,024	CHO	468
% 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%	97%	100%	CHO	100%
No. of substance misusers (under 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Mth in Arrears	32 per quarter	302 per annum.	268	CHO	124
No. of substance misusers (under 18 years) for whom treatment has commenced within one week following	DOP	Access	Q 1 Mth in Arrears	30 per quarter	176 per annum	260	CHO	124

assessment								

Key Performance Indicators Service Planning 2016	NSP /			KPIs 2015		KPIs 2016		
KPI Title	DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	CHO 7
% 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%	79%	100%		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%	84%	100%		100%
No. of substance misusers (under 18 years) for whom treatment has commenced	DOP	Access	Q 1 Qtr in Arrears	32 per quarter	302 per annum.	268		124
% 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%	88%	100%		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%	88%	100%		100%
No. of problem alcohol users who present for treatment	DOP	Access	Q 1 Qtr in Arrears	699 per quarter	3,530 per annum	3540		400
No. of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	Q 1 Qtr in Arrears	414 per quarter	2,240 per annum	2,344		400
% of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	Q 1 Qtr in Arrears	100%	59%	100%		100%

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		CHO
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	7
No. of problem alcohol users (over 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Qtr in Arrears	636 per quarter	3,296 per annum	3228		380
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	635 per quarter	3,262 per annum	3228	CHO	380
% 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%	99%	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	5 per quarter	38 per annum	56	CHO	20
% of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1Qtr in Arrears	100%	57%	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%	75%	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%	86%	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%	86%	100%	CHO	100%

Key Performance Indicators Service Planning 2016	NSP /	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016		
KPI Title	DOP			2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	CHO 7
% 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%	71%	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	244	300	CHO	40
No. of pharmacies recruited to provide Needle Exchange Programme	DOP	Quality	TRI M 1 Qtr in Arrears	129	132	119	CHO	0
No. of unique individuals attending pharmacy needle exchange	NSP	Access	TRI M 1 Qtr in Arrears	1,200	1,731	1,731	CHO	0
No. of pharmacy needle exchange packs provided	DOP	Access	TRI M 1 Qtr in Arrears	3,200	3,628	3,433	CHO	0
Average No. of needle / syringe packs per person	DOP	Quality	TRI M 1 Qtr in Arrears	15	16	16	CHO	0
No. and % of needle / syringe packs returned	DOP	Quality	TRI M 1 Qtr in Arrears	930 (30%)	930 30%	1,032 (30%)	CHO	0
No. and % of individual service users admitted to homeless emergency accommodation hostels/ who have medical cards	DOP	Quality	Q	75%	1046 71%	1108 (75%)	CHO	98 (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	90%	324 75%	302 (70%)	CHO	25 (70%)

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016	Reported at National / CHO	CHO 7
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity		
% 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 2 weeks of admission	NSP	Quality	Q	85%	72%	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%	80%	80%	CHO	80%
Number of people who received health information on type 2 diabetes and cardiovascular health	NSP	Quality	Q	3,470 20% of the population in each Traveller Health Unit	2,228	3,470	CHO	475
Number of people who received awareness and participated in positive mental health initiatives	DOP	Quality	Q	3,470 20% of the population in each Traveller Health Unit	3,108	3470	CHO	475

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

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016		
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO7 Child-rens HG
Inpatient Palliative Care Services								
Access to specialist inpatient bed within 7 days (during the reporting month)	NSP	Access	M	98%	98%	98%	CHO	98%
Access to specialist palliative care inpatient bed from 8 to14 days (during the reporting month)	DOP	Access	M	New metric 2016	New metric 2016	New metric 2016	CHO	2%
Total number of referrals for specialist inpatient Palliative care services received	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for admission - cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for admission - non cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	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	445	429	474	CHO	82
No. of new patients seen or admitted to the specialist palliative care service (monthly cumulative)	DOP	Access /Activity	M	2,752	2,633	2,877	CHO	496
No. of admissions to specialist palliative care inpatient units (monthly cumulative)	DOP	Access /Activity	M	3,177	3,403	3,310	CHO	570

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016		
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO7 Childrens HG
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%	87%	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	New metric 2016	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	New metric 2016	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	New metric 2016	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for services - cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric
Total number of referrals deemed appropriate for services - non cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric
No. of patients in receipt of specialist palliative care in the community (monthly cumulative)	NSP	Access /Activity	M	3,248	3,178	3,309	CHO	308
No. of new patients seen or admitted to specialist palliative care services in the community	DOP	Access /Activity	M	8,907	9,089	9,353	CHO	941

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016		
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO7 Child-rens HG
No. of patients in receipt of specialist palliative day care services (during the reporting month)	DOP	Access /Activity	M	349	301	349	CHO	42
No. of new patients in receipt of specialist palliative day care services (monthly cumulative)	DOP	Access	M	962	1003	985	CHO	92
No. of patients in receipt of care in designated palliative care support beds (during the reporting month)	DOP	Access /Activity	M	165	142	165	CHO	40
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	320	359	370	CHO	140
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	New metric 2016	New metric 2016	CHO	115
No. of children in the care of the children's outreach nursing team / specialist palliative care team (community)	DOP	Access /Activity	M	n/a	n/a	New metric 2016	CHO	25
No. of new children in the care of the children's outreach nursing team / specialist palliative care team	DOP	Access /Activity	M	229	190	190	CHO	59
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	New metric 2016	New metric 2016	CHO	48
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	New metric 2016	New metric 2016	CHO	11

Key Performance Indicators Service Planning 2016 KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015 2015 National Target / Expected Activity	 2015 Projected outturn	KPIs 2016 2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO7 Childrens HG
Total number of new referrals for inpatient services seen by the specialist palliative care team	DOP	Access /Activity	M	n/a	486	Expected activity to be determined	CHO	
Specialist palliative care services provided in the acute setting for new patients and re referral within 2 days	DOP	Quality	M	n/a	93%	Target to be determined	CHO	
Bereavement Services								
Total number of family units who received bereavement services	DOP	Access /Activity	M	n/a	621	621	CHO	New metric
% patients triaged within 1 working day of referral (acute service)	NSP	Quality	M 2016 Q4 Reporting	New metric 2016	New metric 2016	90%	CHO	90%
% patients with a multidisciplinary care plan documented within 5 working days of initial review	NSP	Quality	M 2016 Q4 Reporting	New metric 2016	New metric 2016	90%	CHO	90%

Mental Health KPIs

Service Area Green = NSP 2015 KPI **Adult Mental Health Services**	New / Existing KPI	Data Timing	Area 7
% 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 seen within 12 weeks / 3 months by General Adult Community Mental Health Team	Existing	Monthly	> 75%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	New	Monthly	> 99%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	Existing	Monthly	> 95%
Child and Adolescent Community Mental Health Services			
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.	Existing	Monthly	
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	New	Monthly	>78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	Existing	Monthly	>72%
Adult Inpatient Services			
No. of admissions to adult acute inpatient units	Existing	Q (in arrears)	1,530
Median length of stay	Existing	Q (in arrears)	10.0
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	Existing	Q (in arrears)	59.7
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	Existing	Q (in arrears)	21.9
Acute re-admissions as % of admissions	Existing	Q (in arrears)	63%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area	Existing	Q (in arrears)	37.8
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	Existing	Q (in arrears)	21.5
No. of adult involuntary admissions	Existing	Q (in arrears)	160
Rate of adult involuntary admissions per 100,000 population in mental health catchment area	Existing	Q (in arrears)	6.2
General Adult Community Mental Health Teams			
% 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*	Existing	Quarterly	>50%
Number of General Adult Community Mental Health Teams	Existing	Monthly	14
Number of referrals (including re-referred)received by General Adult Community Mental Health Teams	Existing	Monthly	4,620
Number of Referrals (including re-referred) accepted by General Adult Community Mental Health Teams	Existing	Monthly	4,389
No. of new (including re-referred) General Adult Community Mental Health Team cases offered first appointment for the current month (seen and DNA below)	Existing	Monthly	6,549
No. of new (including re-referred) General Adult Community Mental Health Team cases seen in the current month	Existing	Monthly	5,638
No. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	Existing	Monthly	911
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	Existing	Monthly	14%
Number of cases closed/discharged by General Adult Community Mental Health Teams	Existing	Monthly	3,511
Psychiatry of Old Age Mental Health Teams			
Number of Psychiatry of Old Age Community Mental Health Teams	Existing	Monthly	2
Number of referrals (including re-referred)received by Psychiatry of Old Age Mental Health Teams	Existing	Monthly	1,182
Number of Referrals (including re-referred) accepted by Psychiatry of Old Age Community Mental Health Teams	Existing	Monthly	1,064
No. of new (including re-referred) Old Age Psychiatry Team cases offered first appointment for the current month	Existing	Monthly	

(seen and DNA below)			1,148
No. of new (including re-referred) Old Age Psychiatry Team cases seen in the current month	Existing	Monthly	1,148
No. of new (including re-referred) Old Age Psychiatry cases offered appointment and DNA in the current month	Existing	Monthly	-
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	Existing	Monthly	0%
Number of cases closed/discharged by Old Age Psychiatry Community Mental Health Teams	Existing	Monthly	851
Child and Adolescent			
No. of child and adolescent Community Mental Health Teams	Existing	Monthly	9
No. of child and adolescent Day Hospital Teams	Existing	Monthly	1
No. of Paediatric Liaison Teams	Existing	Monthly	2
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	Existing	Monthly	46
No. of children / adolescents admitted to adult HSE mental health inpatient units	Existing	Monthly	
i). <16 years	Existing	Monthly	
ii). <17 years	Existing	Monthly	
iii). <18 years	Existing	Monthly	
No. and % of involuntary admissions of children and adolescents	Existing	Monthly	
	Existing	Monthly	
No. of child / adolescent referrals (including re-referred**) received** by mental health services	Existing	Monthly	2,662
No. of child / adolescent referrals (including re-referred) **accepted** by mental health services	Existing	Monthly	2,130
No. of new (including re-referred) CAMHs Team cases offered first appointment for the current month (seen and DNA below)	Existing	Monthly	1,674
No. of new (including re-referred) child/adolescent referrals seen in the current month	Existing	Monthly	1,434
No. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	Existing	Monthly	240
%. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	Existing	Monthly	14%
No. and % of cases closed / discharged by CAMHS service	Existing	Monthly	1,704
			80%
Total no. on waiting list for first appointment at end of each quarter (reduce no. waiting by >5%)	Existing	Monthly	376
No. and % on waiting list for first appointment at end of each quarter by wait time			
i). < 3 months	Existing	Monthly	211
			56%
ii). 3-6 months	Existing	Monthly	69
			18%
iii). 6-9 months	Existing	Monthly	34
			9%
iv). 9-12 months	Existing	Monthly	61
			16%
v). > 12 months	Existing	Monthly	0
			0%

Social Care – KPIs

System-Wide				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Budget Management including savings **Net Expenditure variance from plan (within budget)** Pay – Direct / Agency / Overtime	M	≤ 0%	To be reported in Annual Financial Statements 2015	0.33%
Non-pay	M	≤0%		0.33%
Income	M	≤ 0%		0.33%
Acute Hospitals private charges – Debtor Days – Consultant Sign-off	M	New PI 2016	New PI 2016	90% @ 15 days by 31/12/16
Acute Hospitals private income receipts variance from Actual v Plan	M	New PI 2016	New PI 2016	≤ 5%
Capital Capital expenditure versus expenditure profile	Q	New PI 2016	New PI 2016	100%
Audit % of internal audit recommendations implemented by due date	Q	New PI 2016	New PI 2016	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received	Q	New PI 2016	New PI 2016	95%
Service Arrangements / Annual Compliance Statement % of number of Service Arrangements signed	M	100%	100%	100%
% of the monetary value of Service Arrangements signed	M	100%	100%	100%
% of Annual Compliance Statements signed	A	100%	100%	100%
HR % absence rates by staff category	M	3.50%	4.19%	≤ 3.5%
% variation from funded staffing thresholds	M	New PI 2016	To be reported in Annual Report 2015	≤ 0.5%
EWTD < 24 hour shift (Acute and Mental Health)	M	100%	96%	100%
< 48 hour working week (Acute and Mental Health)	M	100%	78%	95%
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	New PI 2016	New PI 2016	15% increase
Service User Experience				

% of complaints investigated within 30 working days of being acknowledged by the complaints officer	M	75%	75%	75%
Serious Reportable Events % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	M	New PI 2016	New PI 2016	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	62%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	New PI 2016	New PI 2016	90%
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	New PI 2016	To be set in 2016

Key Performance Indicators Service Planning 2016		
Disability KPI Title	2016 National Target / Expected Activity	CHO7
No. of requests for assessments received	5,539	1,355
% 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 Childrens Disability Network Teams established	100% (129/129)	100% (9/9)
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	206
No. of people with a disability in receipt of work / work-like activity services(ID/Autism and Physical and Sensory Disability)	3,253	284
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	2,048
No. of Rehabilitative Training places provided (all disabilities)	2,583	394
No. of people (all disabilities) in receipt of Rehabilitative Training (RT)	2,870	362
% 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	1,254
No. of new referrals accepted for people with a disability for respite services (ID/Autism and Physical and Sensory Disability)	1,023	140
No. of new people with a disability who commenced respite services (ID/Autism and Physical and Sensory Disability)	782	129
No. of existing people with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	5,964	626
No. of people with a disability formally discharged from respite services (ID/Autism and Physical and Sensory Disability)	591	22
No. of people with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	5,274	733
No. of overnights (with or without day respite) accessed by people with a disability (ID/Autism and Physical and Sensory Disability)	180,000	26,654
No. of day only respite sessions accessed by people with a disability (ID/Autism and Physical and Sensory Disability)	35,000	4,395
No. of people with a disability who are in receipt of more than 30 overnights continuous respite (ID/Autism and Physical and Sensory Disability)	51	6
No. of new referrals accepted for adults with a physical and / or sensory disability for a PA service	271	0
No. of new adults with a physical and / or sensory disability who commenced a PA service	223	0
No. of existing adults with a physical and / or sensory disability in receipt of a PA service	2,284	77
No. of adults with a physical or sensory disability formally discharged from a PA service	134	0
No. of adults with a physical and /or sensory disability in receipt of a PA service	2,186	123
Number of PA Service hours delivered to adults with a physical and / or sensory disability	1,318,819	17,382

No. of adults with a physical and / or sensory disability in receipt of 1 - 5 PA Hours per week	957	28
No. of adults with a physical and / or sensory disability in receipt of 6 - 10 PA hours per week	538	24
No. of adults with a physical and / or sensory disability in receipt of 11 - 20 PA hours per week	397	19
No. of adults with a physical and / or sensory disability in receipt of 21 - 40 PA hours per week	256	11
No. of adults with a physical and / or sensory disability in receipt of 41 - 60 PA hours per week	73	3
No. of adults with a physical and / or sensory disability in receipt of 60+ PA hours per week	83	1
No. of new referrals accepted for people with a disability for home support services (ID/Autism and Physical and Sensory Disability)	1,416	104
No. of new people with a disability who commenced a home support service (ID/Autism and Physical and Sensory Disability)	1,273	90
No. of existing people with a disability in receipt of home support services (ID/Autism and Physical and Sensory Disability)	6,380	714
No. of people with a disability formally discharged from home support services (ID/Autism and Physical and Sensory Disability)	466	27
No of people with a disability in receipt of Home Support Services (ID/Autism and Physical and Sensory Disability)	7,312	888
No of Home Support Hours delivered to persons with a disability (ID/Autism and Physical and Sensory Disability)	2,600,000	376,758
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	360
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	158
No. of people with a disability in receipt of 11 – 20 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	753	109
No. of people with a disability in receipt of 21- 40 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	402	54
No. of people with a disability in receipt of 41 – 60 Home Support hours per week (ID/Autism and Physical and Sensory Disability)	97	11
No. of people with a disability in receipt of 60 +Home Support hours per week (ID/Autism and Physical and Sensory Disability)	127	17
Facilitate the movement of people from congregated to community settings	8	
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 Older Persons Services 2016		
Older Persons KPI Title	2016 National Target / Expected Activity	CHO7
Total no. of persons in receipt of a HCP/DDI HCP(Monthly target)	15,450	1988
No. of new HCP clients, annually	6,000	825
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	734,000
No. of people in receipt of home help hours (excluding provision of hours from HCPs) (Monthly target)	47,800	5,200
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	19
No. of NHSS Beds in Public Long Stay Units.	5,255	642
No. of Short Stay Beds in Public Long Stay Units	2,005	199
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		
Total no. of preliminary screenings for adults aged 65 and over		
No. of staff trained in safeguarding policy		

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%

An online dashboard system is being developed to facilitate collection of these metrics at CHO level. It is expected that this will be in place by the end of Q2 2016.

Appendix 4 – Capital Projects Primary Care

CHO 7: Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West,									
Facility	Project Details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	2016 Capital Cost €m	Total	WTE	Revenue Costs €m
Kilnamanagh/Tymon, Dublin	Primary Care Centre, by lease agreement.	Q3 2016	Q4 2016	0	0	0	0	0	0
Springfield, Tallaght, Dublin	Primary Care Centre, by lease agreement.	Q3 2016	Q4 2016	0	0	0	0	0	0
Tus Nua, Kildare Town	Primary Care Centre, by lease agreement.	Q4 2015	Q1 2016	0	0	0	0	0	0
Celbridge, Co. Kildare	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0	0	0	0
Blessington, Co. Wicklow	Primary Care Centre, by lease agreement.	Q2 2016	Q2 2016	0	0	0	0	0	0