Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

St Mary's Community Nursing Unit

Ashlin Centre, Adult Mental Health

Phoenix Care Centre, Mental Health

Navan Road Primary Care Centre

Community Healthcare Organisation Plan 2016

Dublin North City & County

Contents

Introduction

Following on from the "Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group", CHO 9 Dublin North City and County (CHO DNCC) was established, bringing together two former ISA areas; Dublin North City and North Dublin. We are responsible for providing care services to a population of 581,486[1] within the geographical district of Dublin North City and County. This region is a mixed urban/rural area, and extends from the north city to the northern county boundary at Balbriggan. There are high growth areas located around the northern fringe and also areas towards the inner city of little or no growth. Some of these areas, for example, around Glasnevin have older population cohorts. There are also high levels of need within the inner-city for reasons of socio-economic making and ethnicity. Some Electoral Divisions in the inner city have over 50% foreign national constitution which brings its own opportunities and challenges. There are also pockets of affluence in the area. Fingal, which constitutes the main growth area of this CHO area, was responsible for 68% of growth (between 2002 -2006) and 40% of growth (between 2006 -2011) in the Dublin region. Population growth in CHO DNCC has been a significant factor in increasing demands for services in recent years.

A core value in CHO DNCC is patient centred care, ensuring high quality care and patient safety. This is being embedded into the work practices of the area, in line with the redesigned National Quality and Patient Safety Function, National HSE Policies and regulatory requirements. CHO DNCC has established clear pathways on integration across community and residential services to ensure clients receive quality care in the most appropriate setting with straightforward access. This will be a cornerstone in our progression of services for 2016.

In line with the implementation of the CHO Model, the responsibility of services will lie with the anticipated appointment of Heads of Service. The appointment of the Heads of Service, Heads of Business (Finance, Human Resources, and Corporate Support), GP Lead and Lead for Quality and Patient Development will be a driving force in the integration of services for the Health Service Reform. This will allow us to fully institute the direct line Accountability Framework which describes in detail the means by which the CHO is responsible for the efficiency and control of the provision of services, patient safety, finance and HR for our geographical area. This will also give rise to the reconfiguration of the structures and governance procedures of CHO DNCC.

The HSE National Service Plan 2016 (NSP) details the services to be provided by the HSE in 2016. The CHO DNCC Operational Plan serves the same purpose, specifically for the clients of our area. This is our first opportunity to present a cohesive overarching operational plan. This operational plan aims to provide clarity as to the services we intend to provide over 2016, building on progress made over recent years. Our four service headings are Primary Care, Social Care, Mental Health and Health and Wellbeing. 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 DNCC in all our operational endeavours, and all service provision will be subject to compliance with same.

CHO DNCC has seen an increase in staff of 39 WTE's (since September 2014) largely in progressing disabilities development posts. With this rise in staffing we must deliver on increasing capacity to provide services, reducing waiting times, and decreasing hospital delayed discharge. With the opening of additional primary care centres in 2016, this should further aid us in bringing further services to clients in a local setting. This culture of innovation is intended to inspire our staff to create new methods of care, to fully utilise already available assets and further increase partnerships between departments.

[1] Population based on 2011 Census figures (http://www.healthatlasireland.ie/internalfrontpage.html)

The measurement of the delivery of service in CHO DNCC is performed through a suite of Key Performance Indicators (KPI's), which are reported on monthly and published in the divisional Performance Reports. We will build on work undertaken last year and further develop our reporting capabilities, broaden our research and information base and build greater capacity to support a culture of high performance. This will be done in the context of the implementation of the overall Accountability Framework in place within the HSE. The CHO DNCC operational plan is an ambitious programme of work, and is highly dependent on the continued efforts, dedication and expertise of the Senior Management Team and all staff of CHO DNCC and the ongoing collaboration and co-operation of colleagues from across the HSE, wider health system and beyond. The resilience shown by staff is acknowledged and continues to enable the service to provide a high quality and safe service.

Quality Improvement and Quality Assurance

Quality improvement and patient safety is everybody's business and must be embedded in all work-practices across the Health Services. CHO DNCC is committed to establishing an integrated and consistent approach to Quality and Safety across the Divisions with the aim of developing and maintaining high quality, safe, effective and person centred care, in keeping with HSE Policies and regulatory requirements. CHO DNCC has prioritised the establishment of a Quality & Patient Safety Governance Committee to oversee and progress an integrated and consistent approach to Quality Improvement and Quality Assurance. This will contribute to the development of high quality, safe, effective and person centred care across the divisions within CHO DNCC.

Funding

CHO DNCC has received a total revenue allocation of €617.61m in 2016 to provide health and social care services within its catchment area, see Appendix 1, table 1. This is the budget allocated to CHO DNCC by Corporate Finance - it may differ from the level of funding set out in the National Division Operational Plans. Where this is the case, reconciliation is provided in the relevant divisional chapter of this Operational Plan. In addition, a summarised reconciliation, by division is also shown in Appendix 1, Table 2.

The total funding available for existing services represents a decrease of €7.1m (1.1%) on the final outturn for 2015. It is €19.07m (3.2%) above the opening base budget for 2016 (i.e. closing 2015 budget less once-off allocations) – see table below.

Movement in Funding for CHO DNCC 2015 v 2016		
	€000s	€000s
Budget 2016		617.61
Budget 2015	620.74	
Less 2015 Once-Off Funding	-22.19	
2016 Opening Base Budget		598.54
Increase in Core Funding		19.07

Of the 2015 once-off funding, a total of €10.35m related to the Supplementary Estimate.

The 2016 allocation includes funding for cost increases arising from the Lansdowne Road Agreement and the rollover of funded 2015 service developments in particular. It provides some funding to contribute towards cost pressures arising

from meeting regulatory compliance in the disability sector. However, there is no funding for increments or other pay pressures over which CHO DNCC has no control (e.g. national minimum wage increase), and these costs will have to be funded from existing resources.
CHO DNCC fully acknowledges the requirement to operate within the limits of the funding notified to it and will ensure that this receives significant management focus during the year. Nevertheless, given the scale of demographic, regulatory and other service pressures, it is prudent to disclose that there is a substantial financial risk within this Operational Plan.

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 DNCC 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 an interim CHO DNCC management team to report on the delivery of the key result areas in the balance scorecard.

Workforce

The staff of CHO DNCC 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 and in this regard CHO DNCC have developed a draft HR Strategy.

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 Community Health Organisation 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 DNCC in 2016 as services across former ISA's Dublin North City and Dublin North 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

- Continued or accelerated demographic pressures over and above those planned for delivery in 2016.
- Meeting of HIQA standards for both public long stay residential facilities and disability sector.
- Financial risks associated with statutory and regulatory compliance in a number of services.
- 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 provision of respite services to children with disabilities.
- The increased demand in 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 surrounding ED departments.
- CHO DNCC has identified a significant financial challenge in respect of maintaining existing levels of service within the net revenue allocation notified for 2016.

Conclusion

CHO DNCC 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 CHO DNCC, whilst ensuring equality of services across our organisation in an ever increasing demand led environment. While it is acknowledged the list of risks outlined above is not exhaustive, every effort will be made to mitigate the risks however it may not be possible to eliminate them in full within the current budgetary envelope.

Quality and Patient Safety

Introduction

Quality improvement and patient safety is everybody's business and must be embedded in all work-practices across all our services. CHO DNCC is committed to promoting a "quality and safety" culture by ensuring effective governance and clear accountability that will contribute to the development and maintenance of high quality, safe, effective and person centred care.

Strategic priorities in 2016 for quality and patient safety are defined across all services. In the restructuring of CHO DNCC, cognisance must also be taken of the on-going need for dedicated Quality & Safety expertise at local level and a need for a defined Quality and Patient Safety function across the CHO. The challenges and cost pressures in responding to the recommendations of HIQA inspection reports and statutory notices will continue to be a key focus of the quality and patient safety agenda in CHO DNCC.

Strategic Priorities for 2016

Leadership & Governance for Quality & Safety

- Continue to promote and protect the health and wellbeing of the population it serves across all services.
- Provide leadership, and clear lines of accountability for quality and safety.
- Support the clinical governance of Quality and Patient Safety through the consolidation of Quality and Patient Safety (QPS) committee structures across CHO DNCC, ensuring that quality standards and arrangements are enforced in accordance with statutory and organisational requirements.
- Strengthen accountability for quality and safety through assurance and performance arrangements in relation to quality and safety of care, monitoring quality improvement and patient safety through use of key performance indicators.
- Monitor the implementation of HIQA Quality Patient Standards compliance in the delivery of nursing care to the public.
- Strengthen Service Arrangement review and management for all agencies, through an enhanced monitoring framework.
- Continue to support and to build the capacity and capability of staff to lead on and to deliver quality assurance and improvement through education and training.

Safe Care

- Ensure ongoing maintenance and monitoring of the Divisional risk registers across CHO DNCC.
- Continue to work to embed the active use of risk registers including periodic review and updating of risks and the control actions being taken to mitigate risk, as a critical component of the service safety management programme across services in Dublin North City & County.
- Reinforce compliance with the HSE Safety Incident Management Policy across the Divisions.
- Continue to manage and to develop notification procedures for Serious Incidents/Serious Reportable Events.
- Prioritise the management and analysis of complaints in collaboration with Consumer Affairs.

- Continue to record complaints and use the information received to identify trends and opportunities for learning, risk reduction and quality improvement.
- Support and collaborate with the HCAI/AMR clinical care programmes in prioritising key infection prevention and control areas for development in 2016 i.e. promoting hand hygiene training.

Effective Care

- Support and promote quality improvement plans in line with the National Standards for Safer Better Health Care.
- Work in collaboration with the National Quality Improvement Division in supporting evidence based, quality initiatives, e.g. Pressure Ulcer Collaborative.
- Continued emphasis of Safeguarding Vulnerable Persons at risk of abuse in line with National Policy and Procedures.

Person Centred Care

- Promote person centred care through service user engagement in keeping with National and Divisional initiatives.
- Encourage and support staff engagement in keeping with National and Divisional initiatives.
- Support implementation of the National Open Disclosure Policy by rollout of staff training in CHO DNCC.

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%

Financial Framework

Introduction

The budget allocation for 2016 for CHO DNCC amounts to €617.61m. This represents a decrease of €3.13m (0.5%) on the final 2015 budget, and is €7.1m (1.1%) below the final 2015 outturn.

Included in the allocation is an amount of €3.19m relating to the implementation of the provisions of the Lansdowne Road Agreement (LRA) / Financial Emergency Measures in the Public Interest Act 2015. There is no funding for increments however, and this cost will have to be funded from existing resources – preliminary estimate €2.3m.

Incoming Deficit

For fiscal 2015, net expenditure in CHO DNCC amounted to €624.75m against an allocation of €620.74m. This resulted in a deficit of €4.02m for the year, which represents 0.65% of budget.

The 2015 deficit was driven by the following items in particular:

- Regulatory compliance, particularly in the disability sector.
- External placements in disability services and mental health.
- Home care packages, particularly in older persons services but also in disability services. The increase in home care packages for older persons was linked to a reduction in the levels of delayed discharges in acute hospitals in our catchment area.
- Agency costs arising from HIQA notices, staff attrition and duration of recruitment process. This is particularly evident in the voluntary (section 38) sector.
- GP Training Scheme which has been historically under-funded arising from a policy decision a number of years ago to provide an extra year's training as well as an increase in the number of trainees.

These factors will also be evident during 2016.

Existing Level of Service

Preliminary estimates indicate that in order to maintain existing levels of service, net spending in CHO DNCC is projected to increase by circa €20m (3.1%) to circa €644m. Examples of headings under which there will be cost increases include (i) the rollover costs of services which commenced during 2015; (ii) cost associated with LRA; and (iii) increments. The projected expenditure also takes account of embedded deficits, which were incurred in the provision of service levels in 2015.

While the 2016 allocation provides some funding for ELS, our analysis indicates it is not sufficient to fund the level of service provided in 2015. The majority of our financial challenge is expected to be in Social Care, i.e. older persons and disability services.

Cost Pressures

Increments are unfunded for 2016 and our preliminary estimate is that these will cost in the region of €2.3m. Aside from this, cost pressures are expected to be largely consistent with 2015. The significant cost pressures are therefore:

- Increments.
- Regulatory compliance, particularly in the disability sector.
- External / emergency placements in disability services and mental health.
- Home care packages, in older persons and disability sectors.
- Agency costs.
- GP Training Scheme

Savings and Extra Revenue Targets

Included within the allocation for CHO DNCC are savings in the sum of €1.64m which will have to be met through non-pay efficiencies. There have been budgetary measures in this vein over the past number of years and their cumulative impact has been significant. Therefore, the scope for achieving further savings is now extremely limited.

Approach to Financial Challenge

Under new EU fiscal rules, there will be no additional funding allocated by way of a Supplementary Estimate, (as has been the practice in the past), from 2016 onwards. As a consequence, financial performance in 2016 must continue to be tightly managed within the confines of the notified funding envelope.

In order to meet the requirement to operate within the limits of the funding notified, it will be necessary to identify and deliver additional savings in the order of €20m – see *Existing Level of Service* paragraph above. A process to identify cost reducing measures has already commenced with a view to allowing for their implementation sufficiently early in order that they have time to gain traction.

However, as previously stated, it will be a significant challenge to identify cost reducing measures which are non-service impacting and it is, therefore, prudent to disclose that there is a substantial financial risk within this service plan.

Pay and Pay Related Savings

There has been significant traction in the statutory services during 2015 in terms of savings on agency pay arising from a number of conversion programmes. Agency spend in the statutory sector was down 35% in 2015 to €7.2m. There is greater capacity to leverage savings on agency pay in the voluntary (i.e. section 38) sector and this will be targeted for 2016.

Financial Risk Areas

All services will need to operate within the 2016 budgetary allocation in order for CHO DNCC to deliver a breakeven position. Given the Divisional nature of budget allocation, there is no scope to address any over run in one area by compensating under spends in another area. A particular area of concern will be disability services, where there was a deficit of €3.85m after the allocation of additional funding from the Supplementary Estimate. Many of the underlying factors driving this deficit will rollover into 2016 – see below.

Some of the anticipated financial risk areas during 2016 in CHO DNCC include:

- Compliance with HIQA standards which may entail incremental expenditure on staffing and / or infrastructure.
- Provision of external / emergency placements, particularly in the disability and mental health sectors.

- School leavers in the ID sector, where *per capita* funding is insufficient to meet the individualised service requirements of many service users.
- Historical financial deficits in section 38 agencies, with consequential impact on cash flow.
- Demographic issues, with the 2016 census expected to show a further significant increase in population in CHO DNCC.

Workforce

Introduction

The HSE 2016 Service plan confirms that "the staff of the health services continues to be its most valuable resource." Staff are central to improvement in patient care, productivity and performance. A culture of compassionate care and a sense of belonging among staff will create and embed an organisation-wide approach to delivering a high quality, effective and safe service to our patients and clients.

Recruiting and retaining motivated and skilled staff is a key objective in 2016. This has to be delivered in an environment of significant reform and against a backdrop of significant reductions in the workforce over the past seven years, longer working hours, reductions in take-home pay and other changes in the terms and conditions of employment for staff.

The effective management of the health services' workforce will underpin the accountability framework in 2016. This requires that the HSE has the most appropriate workforce configuration to deliver health services in the most cost effective and efficient manner to maximum benefit.

CHO DNCC expects to complete the establishment of its Management Team in Q1 2016 which will include filling the post of Head of Human Resources. 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 services' objectives.

CHO DNCC 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 DNCC 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. 20 Senior Managers in CHO DNCC are currently engaged with the Future Leadership Programme.

The Workforce Position

The workforce position in CHO DNCC as at December 2015 is as follows:

CHO DNCC	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care	Total	Change 2014 - 2015
Mental Health	119.24	585.44	163.46	110.02	140.65	112.97	1231.78	46.08
Primary Care*	119.33	330.39	311.49	255.48	52.58	112.13	1181.4	84.54
Social Care	38.27	1084.89	852.05	258.04	394.61	1018.69	3646.55	67.71
Total	276.8	2,000.7	1,327.0	623.5	587.8	1,243.8	6,059.7	+198.3

*Please note the figures above may differ from a number of National / Divisional publications which are based on the CHO DNCC workforce position as at September 2015. The September figures are included under the section for Primary Care.

Reducing Agency and Overtime Costs

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

2016 New Service Developments and Other Workforce Additions

This plan provides for specific additional funding in 2016 for new improvements and additional demographic pressures as set out in Appendix 1, which is in addition to initial pay allocations. The planning, approval, notification, management, monitoring and filling of these new posts will be in line with the previous process for approved and funded new service developments specified in national service plans. Other workforce additions, not specifically funded, will be implemented only where offset by funding redirection within allocated pay envelopes.

Public Service Agreement

CHO DNCC will continue to formally engage with public sector unions and operate under the principles of the The Haddington Road Agreement (Public Service Stability agreement 2013-2016), now supported by the Landsdowne Road Agreement (2013-2018). CHO DNCC will also continue to support the achievement of significant cost reduction and extraction measures. The focus for 2016 and beyond will be to continue to maximise the flexibility provided by the enablers and provisions so as to reduce the overall cost base in health service delivery in the context of the reform and reorganisation of our Health Services as set out in The Corporate Plan 2015 – 2017. CHO Managers will continue to engage in practices that yield more effective management of their workforce through the flexibility measures the agreements provide such as workforce practice changes, reviews of rosters, skill-mix, increased use of productivity measures and use of redeployment mechanisms.

Workforce Planning

CHO DNCC management will support the work of the National Workforce Planning Group in order to develop an Integrated Strategic Workforce Planning Framework for the Health Sector

Paybill Management

Pay and staffing controls will be enhanced in 2016 and CHO DNCC managers and staff will continue to be compliant with the Pay Bill Management and Control – HSE National Framework 2015. CHO DNCC 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. However, this creates a significant challenge for CHO DNCC especially in terms of posts which require filling that are not in the run rate.

Attendance and Absence Management

Attendance and absence management continues to be a key priority area for CHO DNCC 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 DNCC Human Resources and CHO DNCC Managers will develop a Staff Engagement Action Plan as a result of the feedback from recent staff survey conducted in 2015 and focus group held in CHO DNCC. CHO DNCC will develop mechanisms for more effective communications.

European Working Time Directive

CHO DNCC 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 DNCC has established a local verification forum to oversee verification and implementation of measures to reduce NCHD hours, eliminate shifts in excess of 24 hours and achieve EWTD compliance.

Health and Safety at Work

CHO DNCC 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 DNCC 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.

Health Service Reform

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 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 Programme Management Office (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 National Care 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.

Accountability Framework

Introduction

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

- CHO DNCC 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 fortnightly and is chaired by the Chief Officer.
- Dublin North City and Dublin North 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 four National Directors for delivery of services within that Division, but have a reporting relationship to the Chair of the Executive Management 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 DNCC 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 Head of Division within CHO DNCC 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

Delivery of Services

Delivery of Services

Introduction

CHO DNCC Operational Plan for 2016 sets out the type and volume of services which will be provided across all Divisions within the funding allocated and taking into consideration:

- Quality improvement and patient safety.
- Overall reform of the health services.
- The Quantum of services to be provided.

We are continuing to change and reform in accordance with Future Health: A Strategic Framework for the Reform of the Health Service. Focusing on service improvement and ensuring that quality and patient safety is at the heart of service delivery is central to health service reform. This emphasis seeks to ensure that people's experience of the health service is not only safe and of high quality, but also caring and compassionate.

We are committed to fostering a culture of continuous learning and improvement, where patients' needs come first and where the value of patient centred care is communicated and understood at all levels. Fostering such a culture requires that patients and service users are put before other considerations, high standards are observed, noncompliance is not tolerated and all staff commit to full personal engagement to achieve this objective.

We recognise 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 Community Healthcare Organisations, the HSE is strengthening its accountability arrangements and is putting in place a new Accountability Framework. This enhanced governance and accountability framework will be implemented in a timely manner across CHO DNCC making explicit the responsibilities of all managers, to deliver targets set out in the National Service Plan and our Operational plans.

Health and Wellbeing

Introduction

CHO DNCC Health and Wellbeing services are provided to a population of 581,486, and are delivered by teams of public health nurses and community medical officers through the Primary Care Division. The teams are supported by ancillary physiotherapy, dietetic, speech and language therapy and other staff, and referrals of children requiring assessments are made to hospital, general practitioner and other health and well-being services as appropriate, ensuring that patient safety and quality of health care provision are the driving forces in our practices. The service has a broad remit with multiple client groups and the focus of care incorporates primary, secondary, tertiary and end of life care. CHO DNCC expects to complete the establishment of its Management Team in Q1 2016 which will include filling the post of Head of Health and Wellbeing. The Head of H&W will play a key role in leading the focus of the service in order to promote health and wellbeing, and provide clinical nursing care to the population through the delivery of high quality, evidence based nursing care.

Goal One of the HSE *Corporate Plan 2015–2017* is to 'promote Health and Wellbeing as part of everything we do'. It places the implementation of the *Healthy Ireland Framework* as a core pillar of our work in CHO DNCC and recognises the need to support staff and the wider community to look after their own Health and Wellbeing.

Within the HSE, the Health and Wellbeing National Division will continue to build capacity to implement evidence-based Health and Wellbeing objectives in 2016 and further develop research and policy capabilities. In addition, staff in Health and Wellbeing will continue to ensure new accountability mechanisms, models of care and funding reforms are realising corporate commitments to rebalance health system priorities toward, chronic disease prevention and management, strategies for earlier detection of disease and the scaling up of self-care and self-management supports for individuals living with chronic disease.

Implementation of all actions will be commensurate with available funding with some being prioritised and phased during 2016.

Health and Wellbeing Services are provided to the CHO DNCC population via:

- 12 Health and Social Care Networks
- 52 Primary Care Teams

Services provided:

- Child health screening
- National Blood Spot Screening/Breastfeeding promotion and support
- Mother and toddler groups
- "Ready Steady Grow"- Ballymun Child protection
- Immunisation
- School Screening Vision/Hearing
- 2nd Tier Audiometry Clinics
- Flu Vaccination Clinics
- Complaint Management, Documentation Audit , Child/Family Health Need Assessment Screening

- Collection and analysis of smoking patterns in the area through Public Health Information Tool
- PHIT street index updated regularly and circulated to all staff and acute sector
- Clinical nursing, referral, assessment of need. Caseload Analysis on all PHN caseloads
- Meeting KPI targets to include review and monitoring of KPI activity.

Quality and Service User Safety

Our service goal is to protect the wellbeing of the population by providing equitable access to a service that is responsive to, and meets the health and wellbeing needs, and clinical needs of individuals, families and communities.

The challenges faced in dealing with the increase in the amount and complexity of clinical nursing care required in community setting increases the requirement for ongoing professional development and education. The recent appointment of a Practice Development Coordinator to the area will be instrumental in monitoring the implementation of HIQA Quality Patient Standards compliance in the delivery of nursing care to the public.

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. Develop Action plan to progress Breastfeeding in Ireland within HI Framework and across Primary Care and acute sector as with community and voluntary sector Increase the numbers of Lactation Consultants in the area, whereby they are dedicated to increasing rates and promotion of breastfeeding	Meet KPI targets Increase rates	Q1 – Q4 Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	Priority: Immunisation	Continue to provide primary and secondary school immunisation in accordance with the national immunisation schedule Community Medical Services will address BCG wait list challenges through provision of additional vaccination clinics/extension of existing clinics as necessary Continue to provide Flu Vaccine in accordance with the national immunisation schedule	Ongoing Meet KPI Targets Ongoing	Q1 – Q4 Q1 – Q4 Q4

Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	Priority: Immunisation	Immunisation: Continue to implement recommendations from 2014 review of models of delivery and governance of immunisation services Further develop organisational response to influenza to improve influenza vaccine uptake rates amongst staff in frontline settings (acute and long term care facilities in the community) and among persons aged 65 and over	Ongoing Ongoing	Q1-Q4 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 Health & Wellbeing with set targets ; i.e. all new and 75% of existing sites for 2016 Promote and Support the implementation of BISC Training in CHO DNCC	Achieve targets for new and existing sites to adhere to tobacco free campus policy Ensure frontline staff attend BISC training (115)	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 Team chaired by CO of CHO DNCC	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 Recruitment of 2 vacant Clinical Nurse Specialist Posts for Infection Prevention and Control to enhance capacity	Q1 – Q4 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 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 Regional Consumer Affairs to review complaints, analyze trends and put in place action plans to improve service	Measurable reduction in complaints	Q1 – Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Priority: Develop, implement and disseminate a Quality Profile Framework for Health and Wellbeing Services	Further development of 'Test your Care' Audit tool to support nursing metrics and to be monitored against agreed standards and benchmarked.	QIP's improvement. Ongoing	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 DNCC 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	Extend the Respiratory Demonstrator Project to new sites	Recruitment of 2 x CNS and 1 x physiotherapist	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	Increase the proportion of patients utilising self-care and self-management supports (HI), XPERT in CHO DNCC for self management in Diabetes care.	Meet KPI Targets for XPERT	Q1 – Q4

Primary Care Services

Introduction

The Primary Care Strategy defined primary care as being 'an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social wellbeing'. 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 the population 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 plays a central role in co-ordinating and delivering a wide range of integrated services in collaboration with other divisions. The primary care team (PCT) is the central point for service delivery which actively engages to address the medical and social care needs of its defined population in conjunction with a wider range of Health and Social Care Network (HSCN) services. Building on the foundation work to date in primary care, the services will continue to work to realise the capacity to provide focused front line responses to patient needs.

Our operational plan for Primary 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 DNCC in all our operational endeavours and all service provision will be subject to compliance with same. However, this creates a significant challenge for CHO DNCC especially in terms of posts which require filling that are not in the run rate.

Demographics

Primary Care Services are provided to a population of 581,486 in this area via:

- 12 Health and Social Care Networks
- 52 Primary Care Teams.
- Access to CHO Audiology, Orthodontic, Addiction, Ophthalmology and GP Out of Hours Services.

Primary Care Services include:

- Public Health Nursing
- Physiotherapy Services
- Occupational Therapy
- Speech & Language Therapy
- Psychology Services
- Social Work Services
- GP Out of Hours Services (DDOC)
- Primary Care Unit & GP Training
- Palliative Care
- Community Intervention Teams
- Primary Care Counselling
- Community Schemes
- Ophthalmology
- Audiology
- Dental Services
- Orthodontics
- Area Medical Doctors

Community Health Networks in CHO DNCC

Network 1: Balbriggan Area
Network 2: Swords Area
Network 3: Coastal Area
Network 4: Coolock Area
Network 5: Kilbarrack Area
Network 6: Finglas Area
Network 7: Ballymun Area
Network 8: Cabra Area
Network 9: North Inner City Area
Network 10: Clontarf Area
Network 11: Blakestown
Network 12: Blanchardstown Area

Development of New Facilities and Revenue Costs

In 2016, Primary Care facilities will be further upgraded in Dublin North City & County (DNCC CHO) with the opening of three new Primary Care centres: Corduff PCC, Grangegorman PCC and Coolock PCC. Our experiences to date, following the opening of the Ballymun PCC, Blanchardstown PCC & the Navan Road PCC is that there is a substantial revenue cost associated with these developments, which is not funded within the Primary Care Budget. While there is a small reduction in costs for some of the smaller health centres, the increased costs in 2015 amounted to a budget deficit in non pay in DNC alone, of €295,000 for the Primary Care Centres. This amounted to a deficit against budget of €57,000 for Blanchardstown, €116,000 for Navan Road (no budget allocated) and €150,000 for Ballymun. The overall non pay deficit for Primary Care Centres in DNC was 6.8% in 2015. It is likely that a further similar deficit amounting to at least €600,000 would be recorded in a full year, however as the centres have operational dates of Quarter 3 at the earliest, the impact in 2016 will be €100,000. This has also been reflected in Appendix 4 “Capital Infrastructure” The full year impact, 2017 onwards will be in the region of a further €500,000 in extra revenue costs.

Social Inclusion Services

Social Inclusion plays a key role in supporting equity of access to services and provides targeted interventions to improve the health outcomes of minority groups which encompass Irish Travellers, Roma, and other members of diverse ethnic and cultural groups, such as asylum seekers, refugees and migrants, lesbian, gay, bisexual and transgender service users.

Specific interventions are provided to address addiction issues, homelessness and medical complexities. Members of these groups characteristically present with a complex range of health and support needs which require multi-agency and multi-faceted interventions. The Health Service promotes and leads on integrated approaches at different levels across statutory and voluntary sectors. A critical success factor is the continued development of integrated care planning and case management approaches between all relevant agencies and service providers.

Addiction Services

Addiction Services in CHO DNCC also work with five local drug task force areas and one Regional task force for the provision of services. Addiction services are provided via:

- 2,286 weekly treatments for substance misuse provided in 6 Treatment centres and Satellite clinics.
- 8 Stabilisation/Medical Detoxification beds in Beaumont Hospital.
- 6 Community based Detoxification beds in Cuan Dara.
- 14 Long Stay Residential Rehabilitation beds in Keltoi.
- Needle exchange / health promotion units across the Area.
- Under 18 service SASSY (counselling - preventative service).
- Stabilisation Centre (SOILSE) day service.
- Family Education Centre (TALBOT).
- Provision of 25 Service Level Agreements (mainstream) & 48 interim task force projects to voluntary groups.

The Addiction Service will continue to support the provision of an integrated range of preventative, therapeutic and rehabilitation services to meet the diverse health and social care needs of our service users in an accountable, accessible and equitable manner. The aim of the service is to improve the health outcomes for people with all substance addictions including alcohol.

Homeless Services

Homeless Services provide funding for the provision of the following range of Homeless Services via service level agreement with Voluntary providers:

- 895 emergency places;
- 149 long term places in supported accommodation including specialised mental health facilities.
- 8 outreach teams (includes medical/nursing as well as support services).

Quality and Service User Safety

Quality improvement and patient safety is everybody's business and must be embedded in all work-practices across primary care services. CHO DNCC Primary Care Services are committed to promoting a ""quality and safety" culture by ensuring effective governance and clear accountability that will contribute to the development and maintenance of high quality, safe, effective and person centred care.

The key priorities for Primary Care Quality and Service User Safety for 2016 are

- Supporting and promoting quality improvement plans in line with the National Standards for Safer Better Health Care.
- Encouraging person centred care through service user and staff engagement.
- Strengthen accountability for quality and safety through assurance and performance arrangements in relation to quality and safety of care

- Enhance the capacity and capability of staff in relation to quality and safety through targeted learning and support.
- To work in collaboration with the National Quality Improvement Division in supporting evidence based, quality initiatives, such as the Pressure Ulcer Collaborative.

Budget

Spend & Budget	2015 Actual Net Spend	2015 Actual Net Budget	2016 opening Budget
	€m	€m	€m
Primary Care (Core)	79.51	79.01	78.50
Local Schemes	48.75	48.63	50.83
Social Inclusion	35.51	34.95	34.54
Palliative Care	10.57	10.57	10.55
Total	174.34	173.16	174.42

The table below reconciles the 2016 Opening Budget to the funding for CHO DNCC as outlined in the Primary Care Operational Plan.

Reconciliation of National Division Plan to CHO DNCC Plan	
	€m
Per National Division Plan	174.40
Funding for GP Out of Hours held by Nat. Div.	-0.30
Social Inclusion - Other	0.20
Rounding	0.12
Per CHO9 Operational Plan	174.42

Workforce

The workforce position in CHO DNCC as at September 2015 is as follows:

Staffing	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Other Patient & Client Care	Total WTE Sept 2015	Total WTE Dec 2015
CHO DNCC	115	310	307	250	54	113	1,148	1,181

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 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 child health programmes/ initiative to improve health outcomes for children	Continue to work in collaboration initiatives with the Health and Wellbeing Division to improve health outcomes for vulnerable populations	Rotunda/HSE Collaborative to enhance the Antenatal Service for Darndale/Priorswood ongoing PCT in conjunction with the Preparing for Life Project ongoing Triple P Parenting Programme ongoing Infant Health and Wellbeing Programme ongoing	Q1 – Q4 Q1 – Q4 Q1 – Q4 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 –	Attain targets for new sites to adhere to tobacco free campus policy and release 5% of staff to attend brief intervention training for smoking cessation.	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	Continue to provide primary and secondary school immunisation in accordance with the national immunisation schedule in partnership with the Health and Wellbeing Division Community Medical Services will address BCG wait list challenges through provision of additional vaccination clinics/extension of existing clinics as necessary in partnership with the Health and Wellbeing Division	Ongoing Meet KPI Targets	Q1 – Q4 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 in partnership with the Health and Wellbeing Division	PHN Service: Commence second tier audiology screening clinics for children by PHNs	Commence a second tier advanced audiometry screen for children 7 months – 12 years in collaboration with the National Audiology Service	Q1
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	Dietetics: Work in collaboration with GP's and the Health and Wellbeing Division to implement national strategy for Dietetics	Develop a referral pathway with the Rotunda Hospital for overweight at risk antenatal mothers Roll out of programme to schools and clinics	Q1 – Q4 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	Work with the Health and Wellbeing Division and Clinical Programmes to integrate prevention, early detection and self management care into the Integrated Care Programmes	Continued roll out of Healthy Food made Easy Programme	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	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 Recruitment of 2 vacant Clinical Nurse Specialist Posts for Infection Prevention and Control to enhance capacity	Q1 – Q4 Q1 - Q4 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	Actively participate in the integrated CHO DNCC Infection Prevention and Control Committee Continue the promotion of hand hygiene training and hygiene audit in keeping with national priorities	Ongoing Ongoing	Q1 – Q4 Q1 – Q4
Goal 2: Provide fair, equitable and timely	Priority: Provide improved and additional services at primary care	Continue to consolidate the delivery of primary care services through 52 established PCTs and	Meet KPI targets	Q1 – Q4

access to quality, safe health services that people need	(PCT and Network) level	12 HSCNs		
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	Expand CIT/OPAT coverage and commence Infusion suite	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	Facilitate the transfer of appropriate complex paediatric cases to primary care, these cases will be supported by a Paediatric Ventilation service	Continue to progress application for CNS Paediatric post at CHO level	Q1
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	Strengthen primary care psychology services across CHO DNCC including primary care counselling services	Await national direction/resource dependent	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: Provide improved and additional services at primary care (PCT and Network) level	Implement the recommendations from the Primary Care Eye Services Review once published	Implement recommendations (publication dependent)	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to	Priority: Provide improved and additional services at primary care (PCT and Network) level	Undertake a review of model and provision of primary care SLT services including waiting list initiative	Work with Primary Care National Division on review and implementation	Q1 – Q4

quality, safe health services that people need				
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	Progress the review of GP contracts under the Framework Agreement	National dependency await direction	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. Await direction from the Ultrasound Project Manager on the further roll out of the ultrasound project in 2016 to CHO DNCC.	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 access to free GP care to children aged up to 12 years subject to negotiations under the Framework Agreement. This service development will be implemented in the context of the new contractual framework with GPs.	National dependency Await direction	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 CHO DNCC requirements	Ongoing	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	Implement HIQA infection control standards and continue to develop and implement standardized processes of infection control across CHO DNCC	Use of self assessment tools to monitor and upgrade processes against standards Ongoing internal control through auditing of infection control processes Ongoing staff training	Q1 – Q4 Q1 – Q4 Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Priority: Improve Cross Division Service Integration	Continue to provide and develop Cross Division Service Integration	Complete recruitment of Case Manager posts Progress discharge Co-ordinator role between acute hospitals and community Engage with the Local Implementation Groups on the Progressing Disability Services for Children and Young People (0-18 years) Programme in order to ensure integrated pathways for Primary Care and Network Disability Teams	Q1 – Q4 Q1 – Q4 Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Priority: Improve Cross Division Service Integration	Continue to develop Primary Care counselling services, including CIPC in collaboration with Mental Health	Improved governance of Laragh Service to meet CHO DNCC requirements	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Priority: Develop and progress the priority work streams of the five Integrated Care Programmes which will improve integration of services, access and outcomes for patients in collaboration with Clinical Strategy and Programmes	Continue to develop and align the existing primary care diabetes care initiatives to the nationally agreed model of care with the support of the Diabetes Clinical Programme.	Roll out of diabetes cycle of care	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services	Priority: Develop and progress the priority work streams of the five Integrated Care Programmes which will improve integration of	Extend the Respiratory Demonstrator Project to new sites	Recruitment of 2 x CNS and 1 x physiotherapist	Q1 – Q4

that people need	services, access and outcomes for patients in collaboration with Clinical Strategy and Programmes			
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	Continue to focus on the implementation of the Addiction Service external Review to reconfigure methadone services to expand and include poly-drug use and alcohol treatment options	Merge with alcohol services Stanhope/Barrymore House	Q2
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	Meet KPI targets	Q3
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	Further develop the recovery model to include additional detoxification, rehabilitation and stabilization programmes in North Dublin	Ongoing development of client care plans	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	Develop a standardised evaluation tool for all SLA funded projects in North Dublin. The tool will be used to measure outcomes and capture data on service user satisfaction.	Gain approval from National Division on agreed template submitted in relation to logic model project review template Complete pilot evaluation using common standardised assessment template	Q1 Q3
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	Reconfigure outreach service focusing on a broader harm reduction programme. This programme will continue to maintain needle exchange services	Expand Harm Reduction Model to include outreach service for alcohol and polydrug users, meeting KPI targets Expand role to include key worker responsibilities Care plans developed and tracked through ICT programme	Q1 Q4 Q4
Goal 2: Provide fair, equitable	Social Inclusion Priority: Improve health	Develop a new step down facility in North Dublin to assist drug free	Open step-down facility in North Dublin	Q2

and timely access to quality, safe health services that people need	outcomes for persons with addiction issues	individuals maintain sobriety until housing can be sourced	Provide Service Reports	Q2
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 DRHE and the NGO's through the SLA process	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	Support ongoing efforts in relation to the Asthma Education Programme for Traveller Healthcare Workers Support rollout of *Small Changes – Big Difference* Training Manual: Traveller Preventative Education Programme for Heart Disease and Diabetes	Continue to work with Traveller Health Unit, Pavee Point, St. Margaret's, Blanchardstown Travellers Development Group and St. Margaret's Traveller Group to ensure agreed work plans are delivered	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	Increase knowledge, skills, capacity and confidence of Traveller and Roma organizations and communities to combat and prevent domestic and sexual violence Increase information and access to domestic and sexual violence supports and protections for Traveller and Roma women	Promote awareness raising activities, training and campaigning Develop culturally appropriate and accessible awareness raising materials	Q1-Q4 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 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 Participate in action aimed at implementing ethnic equality monitoring across all disciplines in an agreed identified PCT	Ongoing meetings during 2016 Pending support in relation to ICT system	Q1 – Q4 Q1 – Q4

		(Blanchardstown), with associated reporting / analysis of finding Provide support, as necessary, to carrying out actions related to the Irish Refugee Protection Programme and addressing health needs of people seeking asylum	Ongoing	Q1-Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Social Inclusion Priority: Roll out of National Patient Safety Programmes	Commence self assessments and develop QIPs against NS SBHC, QuADs and Homeless Standards in selected pilot sites	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 access to adult palliative care services	Continue to engage with St. Francis Hospice Dublin seeking to maximize resources within existing capacity thresholds and by expanding access to Home Care and Day Care Services.	Enhanced inpatient bed utilisation and expanded Home and Day Care Services performance managed through KPIs	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 DNCC will ensure a quality and patient centred approach is at the heart of service provision with partner agencies and in this regard will seek to provide agencies with requisite resources in the attainment of quality service provision.	Meet KPI Targets	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	1 PCT participating in PUC	Q1 – Q3
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Quality and Safety Priority: Implement the National Standards for Safer Better Health Care in Primary Care	Continuation of multi-disciplinary approach to self assessments and development of quality improvement plans (QIPs) for the National Standards for Safer Better Health Care	Evidence of assessment and QIPs	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 DNCC	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	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: 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	Quality and Safety Priority: Service User Involvement	Engage with patients and service uses on their experience of Primary Care, collecting and analysing service user feedback using focus groups and client experience questionnaires	File audit compliance rate, focus groups results, service user feedback report	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	Social Inclusion Priority: Enhance community approaches to addressing HIV/AIDS	Continue to work with HIV Ireland (Formerly Dublin Aids Alliance) Develop and Pilot a HIV, Hepatitis and STI community testing service within community Addiction and Homeless Services	Ongoing Funding dependent	Q1 – Q4 Q1 – Q4
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 DNCC in the development of person-centred services	Ongoing process through SLA/IMR	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: 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 the people who depend on them	Priority: Restructure the provision of GP training	To continue to work with the local GP Training Scheme and the ICGP	Ongoing	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 Engagement	Work with HR and Quality Improvement Division to identify, use and share learning from staff engagement initiative Ongoing Performance Management and development with staff	Participate in any working groups set up following the staff engagement survey. Ongoing	Q1 – Q4 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: Quality and Safety	Provide ongoing training for staff on Incident Management Training, Systems Analysis Training, Open Disclosure, Clinical Audit Training and the development of clinical audit tools Work with HR and Quality Improvement Division to identify,	Ongoing Participate in any working groups set up following the	Q1 - Q4 Q1 – Q4

		use and share learning from staff engagement initiative Ongoing Performance Management and development with staff Build capacity for the roll out of the Open Disclosure Policy	staff engagement survey. Ongoing Participation in the Open Disclosure 'Train the Trainer' programme	 Q1 –Q4 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	Children First Priority: Implement Children First	Continue to Promote the Implementation of Children First in CHO DNCC Source Children First training for all Designated officers.	Implementation of Child Protection and Welfare Policy Committee Designated Liaison Officers in place Engage with National training programme (National Division dependent)	Q3 Q1 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	Social Inclusion priority: Provide LGBT health training/ intercultural health training to health service staff	Continue to meet training requirements as needed	Ongoing	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	Palliative Care Priority: Develop the capacity of healthcare professionals to better meet the needs of patients and their families	Continue to train interdisciplinary Health Care teams in addiction to manage end of life care	Ongoing	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	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	Continue to maintain Risk Registers and continued development of the risk register process in line with the National Division requirements Enhance the capacity and capability of staff in relation to the management of risk through the development and delivery of education and training Continue to support the Pressure Ulcers to Zero collaborative Continued rollout of Single Assessment Tool	Quarterly updates of Risk Register Ongoing 1 PCT participating in PUC	Q1 - Q4 Q1 – Q4 Q1 – Q3
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	Social Inclusion Priority: Promote implementation of a model around interpreting provision for service users who are deaf or not proficient in English	Continue with interpretation services at CHO and GP level	Ongoing	Q1 – Q4

Social Care

Introduction

Area Description

CHO DNCC Social Care Services provides older persons and disability services to a population of 581,486. The population of people over 65 years within the area is 61,110 and this is projected to increase by 3.1% in 2016 and the population of people over 85 years is projected to increase by 4.2 %[2]. CHO DNCC 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 DNCC is proactively implementing the recommendations of the key priorities nationally – such as Progressing Children's Disability Services, New Directions Report and Decongregation Settings in partnership with Voluntary Providers

The increasing demand for services within the social care division will be a particular challenge within CHO DNCC 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 DNCC 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 DNCC for 2016 is €336.56m representing a decrease of €7.73m on the 2015 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 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

[2] Trends and Priorities to inform Health Service Planning 2016

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 DNCC in all our operational endeavours and all service provision will be subject to compliance with same. However, this creates a significant challenge for CHO DNCC especially in terms of posts which require filling that are not in the run rate.

Quality and Service User Safety

CHO DNCC 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 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 SLA review and management for all agencies, through an enhanced monitoring framework.
- Ensuring 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.
- Implementation of Safeguarding Vulnerable Persons at risk of abuse – National Policy and Procedures
- Regional Training and Guidance Services to continue to visit Rehabilitation Training centres to ensure compliance with Standard QA 00/01 “Training and Development for People with Disabilities”.

Budget

Spend & Budget	2015 Actual Net Spend	2015 Actual Net Budget	2016 Opening Budget
	€m	€m	€m
Statutory (Older Persons)	82.22	82.36	77.44
Clontarf Orthopaedic	9.80	9.80	9.99
Sub-Total (Older Persons)	*92.02*	*92.16*	*87.43*
Statutory (Disabilities)	105.99	104.16	104.43
St. Michaels House	73.82	72.05	72.54
Daughters of Charity	59.10	58.84	58.06
Central Remedial Clinic	13.36	13.35	14.11
Sub-Total (Disabilities)	*252.26*	*248.41*	*249.12*
Total	344.29	340.57	336.56

The table below reconciles the 2016 Opening Budget to the funding for CHO DNCC as outlined in the Social Care Operational Plan.

Reconciliation of National Division Plan to CHO DNCC Plan	
Older Persons	€m
Per National Division Plan	84.19
Sanctioned HCP Overspend not in allocation	-2.48
Contract & Subvented Beds / Section 39	5.73
Per CHO9 Operational Plan	87.43
Reconciliation of National Division Plan to CHO DNCC Plan	
Disabilities	
Per National Division Plan	248.82
Recurring Allocations - November/December 2015	0.27
Rounding	0.03
Per CHO9 Operational Plan	249.12

Workforce

The workforce position in CHO DNCC as at December 2015 is as follows:

Staffing	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Other Patient & Client Care	Total
CHO DNCC	38	1,085	852	258	395	1,019	3,647

Services Provided

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
St. Marys Hospital, Lusk Community Unit, Claremont Complex, Cuan Ros - long stay, respite and rehabilitation services.
Nursing Home Support Scheme
Short Stay Provision
Day hospital and Healthy Ageing Clinic on site St. Mary's Hospital
Disability Services
Disability Services are mainly provided through Section 38 and 39 agencies on behalf of CHO DNCC, these consist of;
Residential Care
Day Care
Rehabilitation Training
Specialists Schools
Multidisciplinary Supports
Early Intervention Teams
Home Support Services

Key Priorities and 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. Development of a community based medicine for the elderly anti coagulation service Continue to work with Co. Councils promoting Health & Well Being through LCDCs Continue supporting Alzheimer cafes	Implementation of strategies and Initiatives Continued cooperation with Co. Councils Awareness of this initiative throughout CHO DNCC	Q1 - Q4 Q1 and ongoing 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 Establish consortia in CHO DNCC to coordinate the delivery of Intensive HCP's for people with dementia	Development and implementation of strategy Implementation plan with key timelines agreed and implemented	Q2 Q2- Q4
Goal 1: Promote health and wellbeing as part of everything we do so that people will be healthier	Priority: Implement the recommendations of the National Carer Strategy	Establish a CHO DNCC Divisional review group	Implementation plan with key timelines agreed and implemented	Q2- Q4
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: Develop an ICP for falls prevention and bone health	Roll out of Falls Project though Primary Care Networks	Reduction in reported incidents of fall	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; i.e. all new and 75% of existing sites for 2016	Achieve targets for new and existing sites to adhere to tobacco free campus policy BISC Training (31 people)	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 Safeguarding and Protection Committee convened in CHO DNCC	Q1 and ongoing 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: Integrated Care Programme for Older Persons	Recruit 6.0 WTE	2 wte Consultant Geriatrician posts and multidisciplinary team in conjunction with North side Dublin hospitals	Q1-Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Priority: Home Care Resources	Standardize processes in relation to Home Care Ensure fair and equitable access to Home Care	Home Care applications to be dealt with in an efficient and timely manner Participate at National Level in National Home Care forum	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 DNCC	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 DNCC	Implementation of Care Requirements	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	1 Older Persons Residential Team participating in PUC	Q1 - Q3
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Priority: Service User Engagement	Increase engagement with key stakeholders, advocacy groups and the voluntary sector to develop a strong user engagement and participation process	Increase service user engagement by currently reviewing and developing further the current residents Councils in residential settings Review current carer/ family fora.	Q1 and ongoing Q1 and ongoing
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Priority: Quality and Safety; Committee Structure	Establish Quality &Safety Committee within Social Care which will report to the CHO DNCC Quality & Safety Committee	The following CHO wide committees have been established in 2015: • CHO Quality and Patient Safety Governance Committee • Infection Prevention and Control Committee • Social Care Quality and Safely Committee	Ongoing Q3
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 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	Service Improvements	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 Development of Academic links with universities	Better educated and motivated staff Continue to establish Memorandums of Understanding with Universities	Q1 - Q4 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: Governance & Service Arrangements	Continue to engage with voluntary and private providers through Service Arrangement process All part 2's of SLA's to be signed by 29th February 2016	Ongoing Ongoing	Q1 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: 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 in Beaumont Hospital and North Dublin as the pilot sites	SAT to be fully implemented in CHO DNCC.	Q1-Q4
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 8 individuals to transition from Daughter's of Charity and 3 from St Michael's House to community living CHO Nominee identified for Implementation of Congregated Settings Policy	Implementation of person centred models of care Implementation plan to be developed and progressed to achieve target timeline Ongoing	Q1 - Q4 Q4 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 i.e. for all new and 25% of existing sites for 2016 Develop a CHO implementation structure to support new directions	Attain targets for new and existing sites to adhere to tobacco free campus policy	Q1 - Q4 Q3

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	Progress actions outlined in Social Care Divisional Operation Plan	Ongoing	Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Priority: New Directions – reconfiguring day services including school leavers and rehabilitative training	Work with National Structures and Service Providers to expand the implementation of New Directions locally 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: Respite with Host Families in Community Settings	CHO DNCC to develop action plan in line with National Social Care Operational Plan	Implementation of actions to be determined in accordance with national directorate targets	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: Social Care Division –Quality Improvement Enablement Project	Work with SC-QID Team to improve compliance with National Standards for Disability Residential Centres	Level of Compliance achieved	Q1 – Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Priority: Improve compliance with safeguarding vulnerable persons at risk of abuse	CHO DNCC safeguarding to be established reporting to the Head of Social Care	Establish committee with appropriate terms of reference and appropriate representation Effective monitoring through Service Arrangements and IMR Processes	Q1 - Q4
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 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 4: Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	Priority: Governance & Service Arrangements	Continue to engage with voluntary and private providers through Service Arrangement process All part 2's of SLA's to be signed by 29th February 2016	Ongoing Ongoing	Q1 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: 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: Continuation of the Transforming Lives 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 (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

Mental Health

Introduction

Mental Health Services in CHO Dublin North City & County (CHO DNCC) are provided to a population of 581,362* via a comprehensive General Adult Service, Child and Adolescent Mental Health Service (CAMHS), Mental Health Intellectual Disability (MHID) Service and Psychiatry of Old Age (POA) Service based on "A Vision for Change". The focus is on providing assessment and treatment at the least complex level and as close as possible to the patient's home by way of community mental health teams throughout the service. The General Adult and CAMHS Service provides assessment and treatment at out-patient, homecare and day hospital levels. POA is a home or clinic based first assessment service and treatment is augmented by day hospital and out-patient services when recommended.

There are sub-specialist services in Rehabilitation Psychiatry and Liaison Psychiatry in the general hospitals (Beaumont, Connolly and Mater).

Acute General Adult, Child and Adolescent, and Psychiatry of Old Age acute in-patient care is provided in four locations (Ashlin Centre - Beaumont, Connolly Hospital, Mater Hospital and St. Vincent's Hospital, Fairview). Two of these sites, Mater and St. Vincent's, provide the service by way of service arrangements.

The Mental Health Intellectual Disability service is provided by a mix of statutory services (St. Joseph's Intellectual Disability Service) and funded agencies that provide assessment and treatment to clients attending their services. The Mental Health of Intellectual Disability - St. Joseph's Intellectual Disability Service includes an Approved Centre under the Mental Health Act, 2001 and community residential and outreach services.

A Regional Psychiatric Intensive Care Service is provided in the purpose built mental health facility in the Phoenix Care Centre, North Circular Road and provides a highly specialised psychiatric intensive care service for the entire Dublin North East Region, South Dublin and Wicklow.

Our operational plan for Mental Health 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 DNCC in all our operational endeavours and all service provision will be subject to compliance with same. However, this creates a significant challenge for CHO DNCC especially in terms of posts which require filling that are not in the run rate.

Quality and Service User Safety

A key element of the culture and accountability within the mental health service is the need to continue to develop the measurement and management around quality and patient safety with the same focus as applied to measurement and management around resources. CHO Dublin North City & County Mental Health Service is committed to promoting and protecting the mental health and mental wellbeing of the population it serves to the maximum extent possible within the limits of the resources provided.

Work is progressing towards implementing the HSE Safety Incident Management Policy (May 2014). An Area risk register is in place together with site specific risk registers. The active use of these risk registers, including periodic review and updating of risks and the control actions being taken to mitigate them, is a critical component of the service

safety management programme. We will continue to work to embed the active use of risk registers including periodic review and updating of risks and the control actions being taken to mitigate them.

The changes in notification procedures for Serious Incidents/Serious Reportable Events are embedded in CHO DNCC Mental Health Services. Identified risks to further develop and implement standardised incident management include the need to recruit a dedicated Quality & Safety Advisor for CHO DNCC Mental Health Services and to enhance the capacity to release staff to participate in serious incident review teams for the Area.

All complaints are recorded and used to identify trends and opportunities for learning, risk reduction and quality improvement. All staff are required to report accidents, dangerous occurrences and 'near-miss situations' to their immediate supervisor via the standard incident report form. These forms are available in each department. All accidents, incidents and near miss reports are entered on the NIMS Web System. CHO Dublin North City & County's Mental Health Service commitment to the development of quality services will also be delivered through increasing participation by service users and carers to build their capacity to influence the design and delivery of services.

CHO Dublin North City & County Mental Health Quality and Safety Committees are established and meet on a monthly basis.
Quality and Patient Safety Objectives 2016 are:

- To support the clinical governance of Quality & Patient Safety through the established committee structures in all areas of the service
- To continue to implement the HSE Safety Incident management policy 2014.
- To continue to use the risk register as a system for the monitoring, managing and reporting of risk in CHO DNCC Mental Health Services.
- To support quality initiatives that enhances the involvement of service users and carers.

Population	
581,486	Population served by CHO DNCC Mental Health Service
61,100[3]	Over 65's population Served by CHO DNCC Mental Health Service

Budget

Spend & Budget	2015 Actual Spend €m	2015 Budget €m	2016 Opening Budget €m
Statutory	90.60	90.80	89.76
St Vincents Hospital	13.49	13.43	13.46
Total	104.09	104.23	103.22
Less: Minor Works	*1.02*	*1.02*	*0.11*
Total (Adjusted)	**103.07**	**103.21**	**103.11**

To allow for better comparability, the analysis above includes adjustments in respect of the cost (and associated budget) of minor works in 2015 and 2016, as these items are once-off in nature.

[3] Population based on 2011 Census figures (http://www.healthatlasireland.ie/internalfrontpage.html)

The table below reconciles the 2016 Opening Budget to the funding for CHO DNCC as outlined in the Mental Health Operational Plan.

Reconciliation of National Division Plan to CHO DNCC Plan	
	€m
Per National Division Plan	103.90
Recurring Allocations - November/December 2015	0.14
Development Posts held by Nat. Div.	-1.51
Regional Monies not in Nat. Div. Plan	0.17
2016 Other Funding not in Nat. Div. Plan	0.25
2016 Once Offs Restored	0.27
Per CHO9 Operational Plan	103.23

Workforce

The workforce position in CHO DNCC as at December 2015 is as follows:

Staffing	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Other Patient & Client Care	Total
CHO DNCC	119	585	163	110	141	113	1,232

Services Provided

Service	No. Provided Dublin North City	No. Provided Dublin North	Service	No. Provided Dublin North City	No. Provided Dublin North
No. of Adult Acute In Patient Beds			Psychiatry of Old Age		
General Adult	87	38	Number of POA Acute In Patient Beds	6	
			Number of Day Hospitals	2	6
No. of non acute beds for adults	63 (of which 34 are POA long stay)	99 (of which 25 are long stay)	No. of Community Mental Health Teams	1 Triple Team	0
No. of Rehabilitation beds	10		Number of Day Centres		0
No. of Day Hospitals	5	3	Specialist Mental Health Services		
No. of Community Mental Health Teams	13	7	No. of Rehab and Recovery Teams	3	1
Number of Day Centres	1	0	No. of Liaison Psychiatry Teams	2 (not full teams)	1 (Beaumont Hospital)

No, of High Support Community Residences	6 (107 places)	4	No. of MHID Teams	0	Community Service provided by St. Joseph's IDS. No complete team.
No. of Low and Medium support Community Residences	10 (78 places)	4 medium and 1 low	Homeless Specialist Team	1	
No. of Regional Psychiatric Intensive Care Beds	24		Homeless Day Hospital	1	
CAMHS			Other – Training Centre		
Number of In Patient Beds	12	0			
No. of Day Hospitals	1	0			
No. of Community Mental Health Teams	5	0			

Key Priorities and Actions to Deliver on Goals in 2016

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	Support the development of a Suicide Prevention Action Plan in line with the new National Strategy "Connecting for Life"	PET improved Patient experience improved 70% of Clinical staff on CMHTs provided with suicide prevention and assessment training programmes	Q1 – Q4 Q4
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	Develop a CHO strategy, in partnership with Primary Care, to promote the health and well being of service users and staff, inclusive of healthy eating, exercise, alcohol reduction and smoking cessation	Strategy developed and implemented Monitor compliance of the Tobacco Free Campus Policy BISC Training (44 people)	Q1 – Q4 Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 2: Design integrated, evidence based and recovery focused mental health services	Complete the recruitment and training requirements to facilitate implementation of the existing clinical programmes	Secure approved development posts under NSP 2015 and 2016 initiative (National Dependency)	Q3

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Reconfigure acute bed capacity to meet service need	Reconfiguration complete	Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Monitor the Balance Score Card in particular the waiting times in all services across CHO DNCC	Ongoing	Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Continue strategic and operational engagement with acute hospitals	Ongoing engagement	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Realign the CMHT and CAMHS teams with the development of PCNs across CHO DNCC	Ongoing implementation	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Implement in full the Access Protocol for 17 year olds to CAMHS	Full implementation	Q1 – Q2

Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Work with Chief Officer CHO DNCC in amalgamating all Mental Health services to ensure the continued delivery of an efficient and safe service	Ongoing	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Establish new Dialectical Behaviour Teams to increase service capacity to provide interventions	Teams established and service provided	Q1 – Q4
Goal 2: Provide fair, equitable and timely access to quality, safe health services that people need	Mental Health Strategy Priority 3: Deliver timely, clinically effective and standardized safe mental health services in adherence to statutory requirements	Appropriate management of delayed discharges from all acute units	Minimisation of delayed discharges	Q1
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Mental Health Strategy Priority 4: Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services	Establish Structures and mechanisms for engagement with service users, family members and carers, in line with the National reference Group Recommendations and Implementation Plan	Continued engagement between the Management Teams and the existing Service users Forum Appointment of an Area Head for Service User engagement and their inclusion as a member of the Area Management Team Continue capacity building training for service users, families and carers Continue the roll out of recovery orientated programmes such as Eolas/ARI for service users, carers and family members Facilitate the establishment of an Advocacy Service for CAMHS	Q1 – Q4 Q4 Q1 Q1 – Q4 Q1 – Q4

			Slan Abhaile Genio Project will continue throughout 2016	Q1 – Q4
Goal 3: Foster a culture that is honest, compassionate, transparent and accountable	Mental Health Strategy Priority 4: Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services	Work with the Mental Health National Division Management Team in the roll out of the introduction of Peer Support workers	Appointment of Peer Support Workers	Q4
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 Strategy Priority 5: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure	Undertake a consultation process, with relevant stakeholders, in the development of a staff training strategy, to reflect the service user and carers perspective	Strategy developed and implemented	Q4
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 Strategy Priority 5: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure	Develop a communication Strategy for engagement with staff through a series of events and visits over the year	Strategy developed and communicated	Q1
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 Strategy Priority 5: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure	Development of a consultation liaison psychiatry POA service to acute hospitals	Appointment of Consultants	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	Mental Health Strategy Priority 2: Design integrated, evidence based and recovery focused mental health services	Develop plan for the introduction of Employment Specialists to a number of MDTs	Appointment of Specialists	Q3
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	Mental Health Strategy Priority 6: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure	Continue engagement with Estates Management to progress initiatives to address shortages of clinical and office space	Regular meetings with CHO and Estates	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	Mental Health Strategy Priority 6: Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure	Engage with the progression of the National Mental Health Records Project to include ICT infrastructure, E Rostering and E Mental Health Record.	Ongoing	Q1 – Q4

Appendices

Appendix 1: Financial Tables

Table 1 :2016 Financial Allocation by Division - CHO9

Division	Outturn 2015 €m	Budget 2015 €m	2015 Once-Off Funding Returned €m	2016 Opening Base Budget €m	Existing Level of Service Funding €m	Funded Cost Pressures €m	Other Funding €m	Savings Measures €m	Budget 2016 €m	Change vs Opening Base Budget 2016 %	Change vs 2015 Outturn %
Palliative Care	10.57	10.57	-	10.57	-	-	-	-0.02	10.55	-0.2%	-0.1%
Primary Care	79.51	79.01	-0.60	78.41	0.40	0.21	-	-0.52	78.51	0.1%	-1.3%
Social Inclusion	35.51	34.95	-0.37	34.58	0.02	-	-	-0.06	34.54	-0.1%	-2.7%
Local Schemes	48.75	48.63	-1.23	47.40	-	3.43	-	-	50.83	7.2%	4.3%
Primary Care	***174.35***	***173.16***	***-2.19***	***170.97***	***0.42***	***3.64***	***-***	***-0.60***	***174.43***	***2.0%***	***0.0%***
Older Persons	92.02	92.16	-10.58	81.59	6.13	-	0.22	-0.51	87.43	7.2%	-5.0%
Disability Services	252.26	248.41	-8.43	239.98	5.17	4.16	0.13	-0.31	249.12	3.8%	-1.2%
Social Care	***344.29***	***340.57***	***-19.01***	***321.56***	***11.30***	***4.16***	***0.35***	***-0.81***	***336.56***	***4.7%***	***-2.2%***
Mental Health	***104.09***	***104.24***	***-1.67***	***102.57***	0.83	-	0.05	-0.22	***103.23***	***0.6%***	***-0.8%***
Corporate / Other	***2.03***	***2.77***	***0.68***	***3.44***	***-***	***-***	***-***	***-0.04***	***3.40***	***-1.2%***	***67.3%***
Totals:	**624.75**	**620.74**	**-22.19**	**598.54**	**12.54**	**7.80**	**0.40**	**-1.67**	**617.61**	**3.2%**	**-1.1%**

Table 2:

Reconciliation of Budgets in National Division Plan to CHO DNCC Plan						
	Primary Care	Older Persons	Disability Services	Mental Health	Corporate / Other	Total
	€m	€m	€m	€m	€m	€m
Per National Division Plan	174.41	84.19	248.82	103.90	3.40	614.72
Once Offs Restored		5.73		0.27		6.00
Recurring Allocations - November/December 2015			0.27	0.14		0.40
Regional Monies not in National Division Plan				0.17		0.17
Funding held by National Division	- 0.28			- 1.51		- 1.79
Sanctioned HCP Overspend not in allocation		- 2.48				- 2.48
Other / Rounding	0.30		0.04	0.25		0.58
Per CHO DNCC Operational Plan	174.43	87.43	249.12	103.23	3.40	617.61

Appendix 2: HR Information

CHO DNCC	WTE Dec 14	WTE Dec 15	% Change	Change 2014 - 2015
Mental Health	985.6	1,026.5	+4.2%	+40.9
Primary Care	1,096.9	1,181.4	+7.7%	+84.5
Social Care	1,170.0	1,165.3	-0.4%	-4.8
Health Service Executive	3,252.5	3,373.2	+3.7%	+120.7
Mental Health	200.1	205.3	+2.6%	+5.2
Social Care	2,408.8	2,481.3	+3.0%	+72.5
Section 38	2,608.9	2,686.6	+3.0%	+77.7
Total	5,861.4	6,059.7	+3.4%	+198.3

- Please note that as at September 2015 the Primary Care HR data was 1148 as per published NSP.

CHO DNCC	WTE Dec 14	WTE Dec 15	% Change	Change 2014 - 2015
Mental Health	1,185.7	1,231.8	+3.9%	+46.1
Primary Care	1,096.9	1,181.4	+7.7%	+84.5
Social Care	3,578.8	3,646.6	+1.9%	+67.7
Total	5,861.4	6,059.7	+3.4%	+198.3

CHO DNCC WTE Dec 2015	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care	Total	Change 2014 - 2015
Mental Health	119.24	585.44	163.46	110.02	140.65	112.97	1231.78	46.08
Primary Care	119.33	330.39	311.49	255.48	52.58	112.13	1181.4	84.54
Social Care	38.27	1084.89	852.05	258.04	394.61	1018.69	3646.55	67.71
Total	276.8	2,000.7	1,327.0	623.5	587.8	1,243.8	6,059.7	+198.3

Appendix 3: Performance Indicator Suite & Balance Scorecard

Performance Indicator Suite

System-Wide

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

System-Wide				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
% 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

Health and Wellbeing

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	9,000	11,000	11,500
No. of frontline staff trained in Brief Intervention Smoking Cessation	M	1,350	1,120	115
% of smokers on cessation programmes who were quit at one month	Q	New PI 2016	New PI 2016	45%
Healthy Eating Active Living				
No. of 5km Parkruns completed by the general public in community settings	M	New PI 2016		43,105
No. of fronline Healthcare staff who have completed the physical activity E-learning module	M	New PI 2016		82
No. of people who have completed a structured patient education programme for diabetes	M	New PI 2016	New PI 2016	80
No. of people attending a structure community based healthy cooking programme	M	New PI 2016		650
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%
Immunisations and Vaccines				
% children aged 24 months who have received 3 doses of the 6in1 vaccine	Q	95%	95.0%	95%
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	Q	95%	92.7%	95%
% of first year girls who have received two doses of HPV vaccine	A	80%	85%	85%
% 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%	75%
Public Health				
No. of infectious disease (ID) outbreaks notified under the national ID reporting schedule	Q	614	680	660

Primary Care

Primary Care					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Community Intervention Teams (no. of referrals)	M	26,355	18,600	24,202	4,898
Admission avoidance (includes OPAT)		1,196	651	914	192
Hospital Avoidance	M	14,134	10,788	12,932	1658
Early discharge (includes OPAT)	M	6,375	3,980	6,360	938
Unscheduled referrals from community sources	M	4,650	3,181	3,996	2110
Health Amendment Act: Services to persons with state acquired Hepatitis C					
No. of patients who were reviewed	Q	820	22	798	121
Healthcare Associated Infections: Medication Management					
Consumption of antibiotics in community settings (defined daily doses per 1,000 population)		< 21.7	25.7	< 21.7	National
Service User Experience					
% of PCTs by CHO, that can evidence service user involvement as required by Action 19 of the Primary Care Strategy – A New Direction (2001)	Q	New PI 2016	New PI 2016	100%	100%
GP Activity					
No. of contacts with GP Out of Hours Service	M	959,455	964,770	964,770	National
Nursing					
No. of new patients accepted on the caseload and waiting to be seen over 12 weeks	M	New PI 2016	New PI 2016	0	0
Physiotherapy					
% of new patients seen for assessment within 12 weeks	M	80%	83%	70%	70%
% on waiting list for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
Occupational Therapy					
% of new patients seen for assessment within 12 weeks	M	80%	76%	70%	70%
% on waiting list for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
Speech and Language Therapy					
% on waiting lists for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
Podiatry, Ophthalmology, Audiology, Dietetics and Psychology					
Podiatry					
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	75%	75%
Ophthalmology					
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
% on waiting lists for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%	60%
Audiology					
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI	New PI	60%	60%

Primary Care					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target 2016	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Dietetics % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
% on waiting list for treatment less ≤ 12 weeks	M	New PI 2016	New PI 2016	70%	70%
Psychology % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%	60%
Oral Health % of new patients care who commenced treatment within 3 months of assessment	M	New PI 2016	New PI 2016	80%	80%
Orthodontics % of referrals seen for assessment within 6 months	Q	75%	74%	75%	75%
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	Q	< 5%	8%	< 5%	<5%

Primary Care Reimbursement Service					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
% of completed Medical Card / GP Visit Card applications processed within the 15 days	M	90%	90%	95%	National
% of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	M	90%	90%	90%	National
% of Medical Card applications which are accurately processed by national medical card unit staff	M	New PI 2016	New PI 2016	95%	National
No. of persons covered by Medical Cards as at 31st December	M	1,722,395	1,725,767	1,675,767	National
No. of persons covered by GP Visit Cards as at 31st December	M	412,588	435,785	485,192*	National

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Social Inclusion					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Substance Misuse % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q	100%	97%	100%	100%
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	M	100%	89%	100%	100%
No. of clients in receipt of opioid substitution treatment (outside prisons)	M	9,400	9,413	9,515	2,955
Average waiting time from referral to assessment for Opioid Substitution Treatment	M	New PI 2016	New PI 2016	14 days	14 days
Average waiting time from Opioid Substitution assessment to exit from waiting list or treatment commenced	M	New PI 2016	New PI 2016	28 days	28 days

Social Inclusion					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Needle Exchange No. of unique individuals attending pharmacy needle exchange	Q	1,200	1,731	1,731	0
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	Q	85%	72%	85%	85%
Traveller Health No. of people who received health information on type 2 diabetes and cardiovascular health	Q	3,470	2,228	3,470	275

Palliative Care					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Inpatient Units – Waiting Times Access to specialist inpatient bed within 7 days	M	98%	98%	98%	98%
Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital)	M	95%	87%	95%	95%
No. of patients in receipt of specialist palliative care in the community	M	3,248	3,178	3,309	297
No. of children in the care of the children's outreach nursing team / specialist palliative care team	M	320	359	370	46
% patients triaged within 1 working day of referral	M	New PI 2016	New PI 2016	90%	90%
% of patients with a multi-disciplinary care plan documented within 5 working days of initial review	M	New PI 2016	New PI 2016	90%	90%

Mental Health

Mental Health					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
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	M	90%	92%	90%	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Team	M	75%	74%	75%	75%
% of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	M	18%	22%	18%	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	M	99%	98%	98%	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	M	95%	94%	95%	95%
%. of new (including re-referred) Old Age Psychiatry Team cases offered appointment and DNA in the current month	M	2%	3%	3%	3%

Mental Health					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
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.	M	95%	71%	95%	National
% 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	M	New PI 2016	New PI 2016	95%	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	M	78%	78%	78%	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	M	72%	72%	72%	72%
%. of new (including re-referred) child / adolescent referrals offered appointment and DNA in the current month	M	10%	12%	10%	10%
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.	M	2,632	2,509	2,449	191
Total no. to be seen 0-3 months	M	1,153	1,138	1,308	107
Total no. on waiting list for a first appointment waiting > 3 months	M	1,479	1,371	1,141	84
Total no. on waiting list for a first appointment waiting > 12 months	M	0	203	0	0

Social Care

Social Care					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Disability Services Progressing Disability Services for Children and Young People (0-18s) Programme No. of Children's Disability Network Teams established	M	New PI 2016	New PI 2016	100% (129 of 129)	100% (12 of 12)
Quality % 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	Q	New PI 2016	New PI 2016	100%	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	Q	New PI 2016	New PI 2016	100%	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	Q	New PI 2016	New PI 2016	100%	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	Q	New PI 2016	New PI 2016	100%	100%
% compliance with inspected outcomes following HIQA inspection of Disability Residential Units	Q	New PI 2016	New PI 2016	75%	75%
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	Bi-annual	100%	100%	100%	100%

Social Care					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
Disability Act Compliance % of assessments completed within the timelines as provided for in the regulations	Q	100%	34%	100%	100%
Day Services % of school leavers and RT graduates who have been provided with a placement	Q3	100%	100%	100%	100%
Respite Services * No. of day only respite sessions accessed by people with a disability	Q	New PI 2016	New PI 2016	35,000	3,392
No. of overnights (with or without day respite) accessed by people with a disability	Q	190,000	182,710	180,000	21,276
Personal Assistance (PA) No. of PA Service hours delivered to adults with a physical and / or sensory disability	Q	1.3m	1.4m	1.3m	288,104
Home Support Service No. of Home Support Hours delivered to persons with a disability	Q	2.6m	2.7m	2.6m	427,911
Congregated Settings Facilitate the movement of people from congregated to community settings	Q	150	112	160	11
Transforming Lives - VfM Policy Review Deliver on VfM Implementation priorities.	Bi-annual	New PI 2016	New PI 2016	100%	100%
Service Improvement Team Process Deliver on Service Improvement priorities.	Bi-annual	New PI 2016	New PI 2016	100%	100%
Older Persons Services Quality % 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.	Q	New PI 2016	New PI 2016	100%	National
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	Q	New PI 2016	New PI 2016	100%	National
% 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	Q	New PI 2016	New PI 2016	100%	National
% 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	Q	New PI 2016	New PI 2016	100%	National
Service Improvement Team Process Deliver on Service Improvement priorities.	Bi-annual	New PI 2016	New PI 2016	100%	
Home Care Packages Total no. of persons in receipt of a HCP including delayed discharge initiative HCPs	M	13,800	15,450	15,450	4,050
Intensive HCPs: Total no. of persons in receipt of an Intensive HCP	M	190	130	130	National
No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	M	10.3m	10.4m	10.4m	1,140,000
No. of people in receipt of home help hours (excluding provision of hours from HCPs)	M	50,000	47,795	47,800	4,900
No. of persons funded under NHSS in long term residential care	M	22,361	23,450	23,450	National

Social Care					
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016	Expected Activity/Target 2016 CHO DNCC
No. of NHSS beds in Public Long Stay Units.	M	5,287	5,288	5,255	507
No. of short stay beds in Public Long Stay Units	M	1,840	2,005	2,005	101
Average length of stay for NHSS clients in Public, Private and Saver Long Stay Units	M	3.2 years	3.1 years	3.2 years	3.2
% of population over 65 years in NHSS funded beds (based on 2011 Census figures)	M	4%	4%	4%	4%

*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

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 DNCC
Community Intervention Teams (number of referrals)				26,355	18,600	24,202		4,898
Admission Avoidance (includes OPAT)	NSP	Quality	M	1,196	651	914	CHO	192
Hospital Avoidance	NSP	Quality	M	14,134	10,788	12,932	CHO	1,658
Early discharge (includes OPAT)	NSP	Quality	M	6,375	3,980	6,360	CHO	938
Unscheduled referrals from community sources	NSP	Quality	M	4,650	3,181	3,996	CHO	2,110
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	4,898
ED / Hospital wards / Units	DOP	Access /Activity	M	17,038	11,272	13,956	CHO	2,483
GP Referral	DOP	Access /Activity	M	6,029	4,073	6,386	CHO	1,864
Community Referral	DOP	Access /Activity	M	1,455	1,823	2,226	CHO	279
OPAT Referral	DOP	Access /Activity	M	1,833	1,432	1,634	CHO	272
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	17,335
No of patients seen for a first time assessment	DOP	Activity	M	159,260	158,262	160,017	CHO	13,526
No of patients treated in the reporting month (monthly target)	DOP	Activity	M	34,993	35,291	36,430	CHO	2,933
No of face to face contacts/visits	DOP	Activity	M	770,878	767,109	775,864	CHO	62,288
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	3,263
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%

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 DNCC
% 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	10,806
No of new patients seen for a first assessment	DOP	Activity	M	83,004	84,983	86,499	CHO	9,178
No of patients treated (direct and indirect) monthly target	DOP	Activity	M	19,811	20,070	20,291	CHO	2,753
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	2,187
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%	99.8%	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 end of the reporting period	DOP	Access	Q	6,165	5,966	5,966	National/ former region	
No. of patients on the treatment waiting list – grade 4 –at the end of the reporting period	DOP	Access /Activity	Q	9,444	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	

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 DNCC
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	
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	1,356
Existing patients seen in the month	DOP	Activity	M	No Target 2015	2,601	2,626	CHO	126
New patients seen	DOP	Activity	M	No Target 2015	9,387	9,367	CHO	611
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	119
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

Key Performance Indicators Service Planning 2016 KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	KPIs 2015 2015 National Target / Expected Activity	KPIs 2015 2015 Projected outturn	KPIs 2016 2016 National Target / Expected Activity	KPIs 2016 Reported at National/ CHO	KPIs 2016 CHO DNCC
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	2,446
Existing patients seen in the month	DOP	Activity	M	No Target 2015	3,818	13,807	CHO	435
New patients seen	DOP	Activity	M	No Target 2015	10,091	16,524	CHO	1,243
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	2,143
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%

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 DNCC
% 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	3,062
Existing patients seen in the month	DOP	Activity	M	No Target 2015	2,822	2,850	CHO	434
New patients seen	DOP	Activity	M	No Target 2015	16,645	16,459	CHO	1,761
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	824
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	1,948
Existing patients seen in the month	DOP	Activity	M	No Target 2015	3,393 (data gap)	5,209	CHO	152
New patients seen	DOP	Activity	M	No Target 2015	19,281 (data gap)	21,707	CHO	1,254
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	360
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

Key Performance Indicators Service Planning 2016 KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	KPIs 2015 2015 National Target / Expected Activity	KPIs 2015 2015 Projected outturn	KPIs 2016 2016 National Target / Expected Activity	KPIs 2016 Reported at National/ CHO	KPIs 2016 CHO DNCC
% 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	21,216
Existing patients seen in the month	DOP	Activity	M	No Target 2015	63,724	64,660	CHO	3,805
New patients seen	DOP	Activity	M	No Target 2015	115,785	123,024	CHO	21,088
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	7,624
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	6,147
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	2,138
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	942
% 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	121

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

Balanced Scorecard

Balanced Scorecard for Health and Wellbeing

Quality	Expected Activity / Target 2016	Access	Expected Activity / Target 2016
Service User Experience • % of complaints investigated within 30 working days of being acknowledged by the complaints officer	75%	National Screening Service • BreastCheck: % BreastCheck screening uptake rate	> 70%
Safe Care • % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	99%	• CervicalCheck: % eligible women with at least one satisfactory CervicalCheck screening in a 5 year period	> 80%
• % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	90%	• BowelScreen: % of client uptake rate in the BowelScreen programme	> 45%
National Screening Service • BreastCheck: % women offered hospital admission for treatment within 3 weeks of diagnosis of breast cancer	> 90%	• Diabetic RetinaScreen: % Diabetic RetinaScreen uptake rate	> 56%
• CervicalCheck: % urgent cases offered a Colposcopy appointment within 2 weeks of receipt of letter in the clinic	> 90%	Health Promotion and Improvement – Tobacco • No. of smokers who received intensive cessation support from a cessation counsellor	11,500
Public Health – Immunisation • % of healthcare workers who have received seasonal Flu vaccine in the 2015-2016 influenza season (acute hospitals and long term care facilities in the com • • munity)	40%	Environmental Health Service – Food Safety • No. of official food control planned, and planned surveillance inspections of food businesses	33,000
• % children aged 24 months who have received 3 doses of the 6 in1 vaccine	95%		
• % children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	95%		
Effective Care Health Promotion and Improvement • Tobacco: % of smokers on cessation programmes who were quit at one month	45%		
Public Health • Child Health: % of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age	95%		
• Immunisation: % uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	75%		
• Child Health: % of newborn babies visited by a PHN within 72 hours of discharge from maternity services	97%		

Finance	Expected Activity / Target 2016	HR	Expected Activity / Target 2016
Budget Management including savings Net Expenditure variance from plan (within budget) • Pay – Direct / Agency / Overtime	0.33%	Absence • % of absence rates by staff category	≤3.5%
• Non-pay	0.33%	Staffing Levels and Costs • % variance from funded staffing thresholds	≤ 0.5%
• Income	0.33%	Health and Safety • No. of calls that were received by the National Health and Safety Helpdesk during the quarter	15% increase
Service Arrangements / Annual Compliance Statement • % of number of Service Arrangements signed	100%		
• % of the monetary value of Service Arrangements signed	100%		
• % of Annual Compliance Statements signed	100%		
Capital • Capital expenditure versus expenditure profile	100%		
Key Result Areas – Governance and Compliance (Development focus in 2015) Audit • % of internal audit recommendations implemented by due date	75%		
• % of internal audit recommendations implemented, against total number of recommendations, within 12 months of report being received	95%		

Balanced Scorecard for Primary Care

Quality	Expected Activity / Target 2016
Primary Care Service User Experience • Complaints	*System-wide*
• % 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)	4,898
• Admission Avoidance (includes OPAT)	192

Quality	Expected Activity / Target 2016
• Hospital Avoidance	1,658
• Early discharge (includes OPAT)	938
• Unscheduled referrals from community sources	2,110
Health Amendment Act: Services to persons with state acquired Hepatitis C • Number of patients who were reviewed	121
Primary Care Reimbursement Service Effective Care Medical Cards • % of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	90%
• % of Medical Card / GP Visit Card applications which are accurately processed by national medical card unit staff	95%
Social Inclusion Effective Care Traveller Health • No. of people who received health information on type 2 diabetes and cardiovascular health	275
Homeless Services • % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	85%
Palliative Care Effective Care • % of patients triaged within 1 working day of referral	90%
• % 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	(National) 964,770
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	

Access	Expected Activity / Target 2016
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	70%
Psychology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Oral Health	
• % of new patients who commenced treatment within 3 months of assessment	80%
Orthodontics	
• % of referrals seen for assessment within 6 months	75%
• Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	< 5%
Primary Care Reimbursement Service	
Medical Cards	
• % of completed Medical Card / GP Visit Card applications processed within 15 days	95%
• No. of persons covered by Medical Cards as at 31st December	(National) 1,675,767
• No. of persons covered by GP Visit Cards as at 31st December	(National) 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)	2,955
• 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	297
• No. of children in the care of the children's outreach nursing team / specialist palliative care team	46

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

Balanced Scorecard for Mental Health

Quality	Expected Activity / Target 2016
Service User Experience*	
• Complaints	
Safe Care	*System-wide.*
• 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.	191
• Total no. to be seen 0–3 months	107
• Total no. on waiting list for a first appointment waiting > 3 months	84
• 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	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	Expected Activity / Target 2016
Absence	
• % of absence rates by staff category	≤ 3.5%
Staffing Levels and Costs	
• % variation from funded staffing thresholds	≤ 0.5%
Compliance with European Working Time Directive (EWTD)	
• < 24 hour shift (Acute and Mental Health)	100%
• < 48 hour working week (Acute and Mental Health)	95%
Health and Safety	
• No. of calls that were received by the National Health and Safety Helpdesk during the quarter	15% increase

Balanced Scorecard for Social Care

Disability Services

Quality and Safety		Access	
Service User Experience • % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Disability Services (from Q3)	100%	Progressing Disability Services for Children and Young People (0-18s) Programme • No. of Children's Disability Network Teams established	100% (12/12)
Congregated Settings • Facilitate the movement of people from congregated to community settings	160	Disability Act Compliance • % of assessments completed within the timelines as provided for in the regulations	100%
Serious Reportable Events • % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS) • % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	99% 90%	Day Services • % of school leavers and RT graduates who have been provided with a placement	100%
Safety Incident Reporting • % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	90%	Respite* • No. of day only respite sessions accessed by people with a disability • No. of overnights (with or without day respite0 access by people with a disability	3,392 21,276
Complaints • % of complaints investigated within 30 working days of being acknowledged by the complaints officer	75%	Personal Assistance (PA) • No. of PA service hours delivered to adults with a disability	288,104
Safeguarding • % of preliminary screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan • % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy (from Q2) • % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy (from Q2) • % compliance with inspected outcomes following HIQA inspection of Disability Residential Units	100% 100% 100% 75%	Home Support Service • No. of Home Support Hours delivered to persons with a disability	427,911
Service Improvement Team Process • Deliver on Service Improvement priorities	100%		
Transforming Lives - VFM Policy Review • Deliver on VFM Implementation priorities	100%		
Quality • In respect of agencies in receipt of €3m or more in public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL or CARF	100%		
Governance for Quality and Safety • Quality and Safety committees across all Divisions at Divisional, Hospital Group and Community Healthcare Organisation	100%		

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

Older Persons Services

Quality and Safety		Access	
Service User Experience • % of CHOs who have a plan in place on how they will implement their approach to the establishment of a Residents Council / Family Forum/ Service User Panel or equivalent for Older Persons Services (Q3)	100%	Home Care Packages • Total no. of persons in receipt of a HCP including delayed discharge initiative HCPs • Intensive HCPs: Total no. of persons in receipt of an intensive HCP	4,050 130 (National)
Serious Reportable Events • % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS) • % of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	99% 90%	Home Help • No. of home help hours provided for all care groups (excluding provision of hours from HCPs) • No. of people in receipt of home help hours (excluding provision from HCPs)	1,140,000 4,900
Safety Incident Reporting • % of safety incidents being entered onto NIMS within 30 days of occurrence by CHO	90%	NHSS • No. of persons funded under NHSS in long term residential care • No. of NHSS beds in Public Long Stay Units • No. of short stay beds in Public Long Stay Units	23,450 (National) 507 101
Complaints • % of complaints investigated within 30 working days of being acknowledged by the complaints officer	75%		
Safeguarding • % of preliminary screenings with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan • % of CHO Heads of Social Care who can evidence implementation of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy throughout the CHO as set out in Section 4 of the policy (from Q2) • % of CHO Heads of Social Care that have established CHO wide organisational arrangements required by the HSE's Safeguarding Vulnerable Persons at Risk of Abuse Policy as set out in Section 9.2 of the policy (from Q2)	100% 100% 100%		
Service Improvement Team Process • Deliver on Service Improvement priorities	100%		
Governance for Quality and Safety • Quality and Safety committees across all Divisions at Divisional, Hospital Group and Community Healthcare Organisation	100%		

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

Appendix 4: Capital Infrastructure

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

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
	PRIMARY CARE[i]								
Corduff, Co. Dublin	Primary Care Centre, to be developed on HSE owned site.	Q1 2016	Q2 2016	0	0	2.58	7.36	0	0.00
Blanchardstown, Co. Dublin	Refurbishment of Roselawn Health Centre to complete the provision of primary care services in the Corduff/Blanchardstown network.	Q4 2016	Q4 2016	0	0	0.25	0.25	0	0.00
Balbriggan, Co. Dublin	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Grangegorman, Dublin	Primary Care Centre, to be developed on site in Grangegorman.	Q3 2016	Q4 2016	0	0	6.50	12.00	0	0.00
	Relocation of Eve Holdings to Grangegorman Villas (1-5).	Q4 2016	Q4 2016	0	0	0.25	0.75	0	0.00
St. Ita's Hospital, Portrane	Upgrade and refurbishment of 123 Block. This will facilitate the provision of Coolock Primary Care Centre, a European Institute of Innovation and Technology Centre and accommodate services currently in rented accommodation and accommodate staff currently in Coolock Health Centre.	Q2 2016	Q2 2016	0	0	2.00	4.30	0	0.00
	MENTAL HEALTH								
St. Ita's Hospital, Portrane, Co. Dublin	Stabilisation work to listed building, including repairs to roofs, windows, paraphet walls and heating systems (*will not impact on operational status)	Q3 2016	*N/A	0	0	0.680	2.20	0	0.00
	SOCIAL CARE – Services for OIder People								
Seancara	Refurbishment	Q3 2016	Q3 2016			.89	.99		

[i] The following updated information relating to the Primary Care developments at Corduff and Roselawn has been furnished by the Assistant National Director for Estates, Dublin North East (as at mid-February.2016). It also reflects the anticipated incremental revenue costs associated with Corduff (see page 29).

Facility	Project Completion	Fully Operational	Capital Cost €m		2016 Implications	
			2016	Total	WTE	Rev Costs €m
Corduff, Co. Dublin	Q2 2016	Q3 2016	3.56	7.65	0	0.10
Blanchardstown, Co. Dublin	Q1 2017	Q2 2017	0.73	1.00	0	0.00
Grangegorman, Dublin						
• Primary Care Centre, to be developed on site in Grangegorman.	Q3 2016	Q4 2016	8.50	12.20	0	0.00
• Relocation of Eve Holdings to Grangegorman Villas (1-5).	Q1 2017	Q2 2017	0.25	0.75	0	0.00
St. Ita's Hospital, Portrane, Co. Dublin	Q3 2016	Q4 2016	4.00	4.80	0	0.00