Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

# Dublin Midlands Hospital Group

# Operational Plan 2016

## Vision

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

## Mission

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

## Values

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

- Care
- Compassion
- Trust
- Learning

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

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

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

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

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

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# Executive Summary

# Executive Summary

## Introduction

Dublin Midlands Hospital Group (DMHG) Chief Executive has full legal authority to manage the group delegated to her under the *Health Act 2004* in line with NSP 2016 and allocated Group budget. In this context DMHG operational plan for 2016 is aligned with the Acute Hospitals Division overarching Operational Plan. Services delivered under the auspices of DMHG Operational Plan are in accordance with the funding allocation received for 2016.

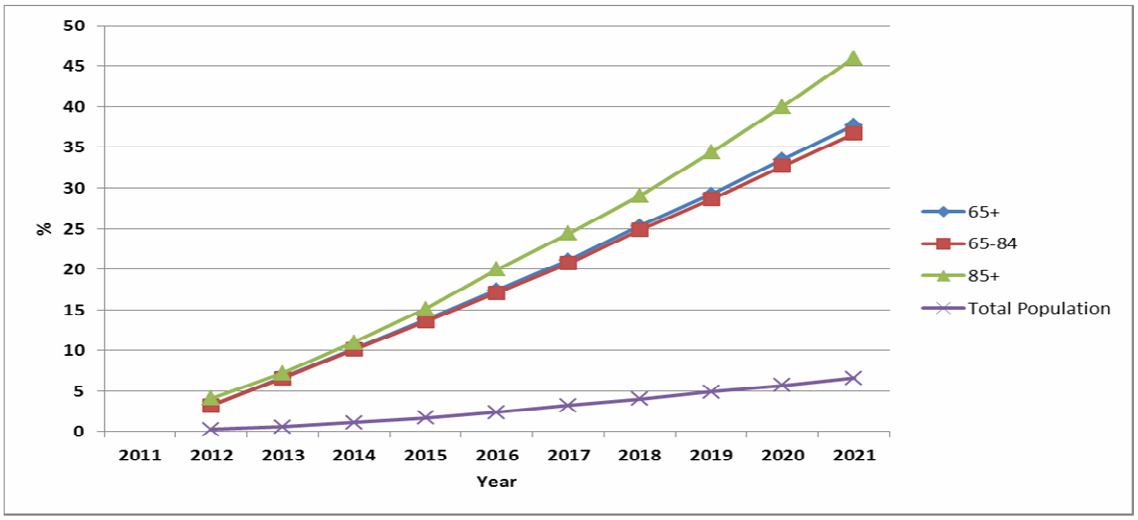
DMHG Chief Executive has a matrixed reporting relationship which includes the Chair of the Hospital Group Board. The Group CEO is accountable to the National Director for Acute Services for planning and performance under the accountability framework of the Health Services Executive (HSE). All targets and performance criteria adopted in the Operational Plan will be reported through this framework.

| | 2016 Available Budget €m | 2015 Outturn €m | Final Net Allocation 2015 including Supplementary €m | Original Net Allocation 2015 €m |
|---|---|---|---|---|
| St James's | 315,513 | 323,210 | 319,598 | 317,246 |
| Tallaght | 167,925 | 174,142 | 173,590 | 164,642 |
| Naas | 56,547 | 58,391 | 58,015 | 54,902 |
| Tullamore | 84,484 | 88,055 | 87,216 | 83,859 |
| Portlaoise | 51,676 | 54,132 | 52,282 | 49,418 |
| Coombe | 50,434 | 54,072 | 54,069 | 48,442 |
| St Luke's Radiation Oncology Network | 39,869 | 40,889 | 40,892 | 40,931 |
| **TOTAL DMHG** | **766,448** | **792,891** | **785,662** | **759,440** |

## Impact of Demographics on Hospitals

The demand for acute hospital services nationally continues to increase in line with a growing and ageing population.

The overall population growth year on year is in the order of 1%. However, the growth of the age group that is over 65 years is at a steeper rate, in the order of 3-4% per year. In 2016 we can expect a projected increase of 32,500 persons in our population with 19,400 aged 65 years and over and 2,900 85 years and over. The graph below demonstrates the projected cumulative percentage change in 65 years and older population versus total population 2011 – 2021. A steep increase in the older age cohorts is evident.




*Source: CSO*

The *Health Information Paper 2015/2016 Trends and Priorities to Assist Service Planning 2016* outlines the impact of the changing age profile of our population with respect to Inpatients, Daycases and Emergency Departments, some key points include:

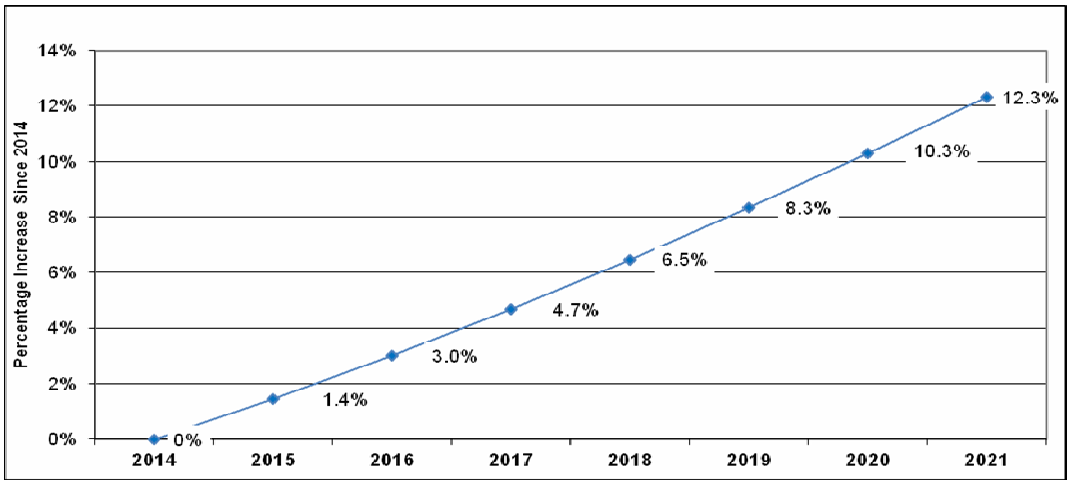
- In 2014, adults 65 years and over made up 12.7% of our population but used 53.3% of total hospital in-patient care and approximately 36% of day case care, and this trend is likely to continue.
- Adults 85 years and over currently represent 1.4% of our total population but use 13.5% of the in-patient beds.
- The five leading medical and surgical in-patient specialities in adults over 65 years include general medicine 37.2%, general surgery 11.9%, orthopaedic surgery 8.4% geriatric medicine 8.2% and cardiology 5.6%. General Medicine and Geriatric Medicine combined represent over 45% of all admissions in adults greater than 65 years.
- In adults over 65 it is projected, from 2014 to 2016, that there will be an increase of 3,846 discharges in General Medicine, 1,228 in General Surgery, 875 in Orthopaedics, 853 in Geriatric Medicine and 584 in Cardiology.
- The trend in projected in-patient costs for those over the age of 65 is an increase of 3.4% from 2015 to 2016.
- The likelihood of admission to the ward following an Emergency Department attendance increases with increasing age. 2014 data indicates that 57% of over 85s who attended require admission, compared with 44% of 65-84s and 20% of the 17-64 age group.
- It is predicted that in 2016 Emergency Department attendances will increase for adults aged 65-84 by 6% and for the 85+ group by 8%. There will be a corresponding drop in the 17-64 age group in the region of 10%.

The increase in the population and the higher increase in the population over 65 is putting increasing pressure on hospital resources. Combining in-patient and day case discharges provides a view of total cost pressures facing publicly funded acute hospitals in managing their in-patient workloads over the period to 2021. This shows average annual demographically driven pressures of around 1.7% for the years from 2014 to 2021 with a rising rate reflecting the acceleration in population ageing over the period.

From 2015 to 2016, which is the focus of this plan, cost pressures of 1.6% are predicted nationally. This Figure represents total in-patient and day case cost pressures, 2014 to 2021. This equates to €64m of the net 2015 allocation to keep up with the demographic pressure. Clearly model of care changes relating to the frail elderly area and chronic conditions are key to addressing this challenge. However in 2016 the pressure will continue to fall directly upon hospitals with limited additional financial provision.

The graph below shows the trend line in costs in the acute sector based upon CSO data and the use of Hospital Pricing Office (HPO) cost data adjusting for the impact of ageing.

**Total in-patient and day case cost pressures, 2014 to 2021**




- *Source: HPO and CSO.*

In the context of developing ABF as the funding model for the HSE the plan is also seeking to align activity with cost. Hospital services will be analysed on a diagnosis related groups (DRG) basis which will provide a truer assessment of real performance in 2016. This form of analysis is used internationally to understand the complexity and cost of hospital inpatient and day case activity. The budgets of each group and their hospitals will reflect the affordable activity level to be provided and the cost associated there with. This will be presented using the DRG tools available to the HSE.

## Developments and Challenges 2016

The 2016 net allocation to hospitals in the Dublin Midlands Hospital Group (DMHG) amounts to €766.448m, inclusive of national pay awards. 2016 is the first year when the funding model is migrating from the historic block budget approach towards the full implementation of Activity Based Funding (ABF), in line with Government policy on the reform of the health services.

The financial framework of the 2016 National Service Plan contains "stretched" targets in relation to cost containment and income generation. DMHG are required to apply our full management capability in delivering on those targets, and, that our efforts must be evidential. The 2016 allocation to the DMHG is therefore not without its challenges. DMHG will ensure that appropriate management effort and attention is applied to maximising its share in the delivery of the savings measures required under the divisional financial plans and in the overall budgetary performance of its hospitals.

### *Risks to the delivery of the Operational Plan*

In identifying the risks to the delivery of this Operational Plan within funding available, it is acknowledged that while every effort will be made to mitigate these risks, it may not be possible to eliminate them in full. Identified risks include:

- The impact of increased demand for services beyond the planned and funded levels arising from changes in demographics and consumer expectations.
- Capacity to control activity volumes to the targeted level under ABF.
- Ability to contain activity to 2015 levels for emergency care and urgent and routine elective treatments.

- Capacity to achieve pay and non-pay cost control at the level required with increasing demand for services.
- Capacity to maintain and collect income.
- Financial risks associated with the approval of new drugs and the control of existing drugs at or below 2015 funded levels.
- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task.
- Risks associated with the delivery of targeted procurement savings.
- The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce.
- Management of the scale of reform and change required to support new evolving models of service delivery and drive innovation.
- The limitations of our clinical, business information, financial and HR systems.

## Clinical Strategy and Programmes

One of the most significant areas of reform is the development of integrated care across all services. This is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in our care. Provision of care, which is provided by all Hospital Group and CHOs and the National Ambulance Service must be integrated by providing better and easier access to services which are close to where people live.

Services are being re-organised to ensure they are delivered in the most appropriate and effective way as part of the HSE reform programme. In this context DMHG will work with Clinical Strategy and Programmes to progress the establishment, enablement and delivery of integrated care programmes.

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Tallaght Hospital is one of the pioneer sites for implementation of the Integrated Care Programme for Older Persons in 2016 in partnership with the Social Care Division together with other agencies and Divisions as appropriate. The purpose of the Integrated Care Programme for Older Persons is to augment primary and secondary care services for older people in the community enabling a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older person. Given the ageing demographics there is an urgent need to build capacity in the provision of healthcare services that can meet this change in the model in both community and acute services.

## Conclusion

Dublin Midlands Hospital Group will work with colleagues across the Group together with all other internal and external stakeholders to deliver optimum services for our patients within the resources available whilst at the same time ensuring that quality and patient safety remains a key priority.

**Dr Susan O'Reilly**
**MB, Bch, BAO, FRCPC, FRCPI,**
**Chief Executive Officer Dublin Midlands Hospital Group**

# Improving Quality and Reforming Service Delivery

# Improving Quality and Reforming Service Delivery

## Strategic Priorities for 2016

Dublin Midlands Hospital Group (DMHG) places a significant emphasis on the quality of services delivered and on the safety of those who use them. In line with the national quality programme DMHG will work with the Acute Hospital Division (AHD), Quality Improvement Division (QID) and Quality Assurance and Verification Division (QAV) to improve the overall quality and safety of services with measurable benefits for patients and service users.

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

- The DMHG will put quality of care at the centre of all that they do by implementing the HSE Quality Enablement Programme (April 2015) and the HSE 'Framework for Improving Quality' (2016).
- Implementation of the National Clinical Effectiveness Committee (NCEC) guidelines (Department of Health 2014 – 2016).
- Improve access and responsiveness of services to meet individual patient and service user needs.
- Empower patients and service users to enhance interaction and experience with the service delivery system.
- Place a strong focus on ensuring quality and safety is improved through the use of approved quality improvement programmes.

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

In this context the objectives for 2016 include:

**Leadership and Governance for Quality and Safety**

- Provide assurance that the governance, authority and accountability structures necessary to deliver quality and safe services to patients in the DMHG are robust. Ensure that there is continual development and enhancement of the structures in line with development of clinical networks across the Group or intra other Groups/ Community Health Organisations.
- **Govern for Quality**; Put in place structures and processes to oversee the quality and safety of care being provided (as part of the reform process) by having clear lines of accountability on quality and safety matters at all levels of your service.
- Establish a Quality & Patient Safety Council for the Dublin Midlands Hospital Group.
- Enhance the current capacity for development of quality assurance & verification by sharing good practice developments from individual specialties/ Hospitals to other specialties / Hospitals within the Group (for e.g. Managing of Serious Reportable Events (St James's Hospital/ Listening to Service Users, (Tallaght Hospital)).
- Invest in the existing quality assurance & verification programmes of work within specialties/ Hospitals (for e.g. Systems Analysis Training)
- Build on the core values of the Corporate Plan (Care, Compassion, Trust & Learning) by supporting the elements of "Preventing Harm" (for e.g. Serious Adverse Events & Safety Incident Management, Serious Reportable Events)
- Further develop the quality & safety assurance systems to include measurement, healthcare audit and reviews that seek evidence that quality and safety is prioritised and committed to at all levels across DMHG delivery system.

- **Lead for Improvement:** Build capacity in ' leadership for improving quality of care' including participation on Leadership programme for executive management teams, and further support your staff trained in QI to network and build on their improvement skills.
- Enhance the current capacity for development of quality improvement by sharing good practice developments from individual specialties/ Hospitals to other specialties / Hospitals within the Group (for e.g. Productive Series Midland Regional Hospital Tullamore)
- Invest in the existing quality improvement resources within specialties/ Hospitals (for e.g. QI Programmes led & funded programmes delivered through professional colleges)
- Ensure compliance with the HIQA National standards (Safer Better Healthcare) and standards and regulations for service delivery and staff development.
- Engage in the strengthening of the HSE's governance arrangements under the health service Accountability Framework by measuring, monitoring and reporting on the performance of the health service in relation to the quality and safety of care. Focus on identifying and addressing areas of under-performance by recommending appropriate and proportionate action to ensure the improvement of services.
- Develop open and effective staff engagement as corner stone of quality improvement and person centred care.

**Safe Care**

- Ensure the reduction of risk to the patients, public, staff and healthcare services by adopting a risk based approach to predicting, identifying and responding to service areas where significant performance, quality and safety concerns may exist
- Improve monitoring, investigation and learning processes from serious incidents across all service areas.
- Progress the implementation of recommendations from major reports and serious incidents across all service in our Group.
- Provide continuous leadership and support for the development, implementation, monitoring and review of the National Clinical Effectiveness Committee (NCEC) Guidelines (for e.g. Early Warning Systems, Clinical Handover, HCAIs and Sepsis).
- Continue the implementation of the National standards for Health Care Associated Infection (HCAI) (for e.g. Compliance with standards for antimicrobial resistance (AMR)/ decontamination standards).
- Support and enhance current programmes of work relating to Medication Management ( for e.g. Medication management, medication reconciliation & reduction in medication errors).
- Support and enhance current programmes of work relating to the roll out of Nursing and Midwifery Metrics to include Patient Observations (NEWS/ IMEWS/ PEWS), Patient Assessment (Pressure Ulcers / Falls Programme) Patient Experience & Medication Management.
- Implement the recommendations of Nationally commissioned reports on safe staffing (Birthrate Plus Report ( HSE 2015) & Interim Report & Recommendations of Nursing Staffing Taskforce DoH 2016)
- Implement the recommendations of the Children First: National Guidance for the Protection & Welfare of Children (2011) and Children First Act (2015)

**Effective Care**

- **Measure for Improvement**: develop a profile of the quality of our services based on robust process and outcome indicators, and use this information to demonstrate and drive service improvement (Use of Nursing & Midwifery Metrics/ further development of Quality Profiles for Services/ Hospitals and at Hospital Group level)
- **Use Improvement Science**: Identify how the aspects of the following safety programmes and initiatives can be implemented within your services.

- HCAI prevention: Hand Hygiene; antimicrobial stewardship (Stop campaign); Safe use of devices/lines and decontamination
- Medication safety: National network of safer meds leaders
- Nutrition and hydration: Support Nourish programme
- Pressure Ulcers to Zero collaborative
- Promote the use of repository of nationally mandated Policies Procedures Protocols and Guidelines
- Implementation of NECE Guidelines e.g. Sepsis programme and early warning scores
- Support and act on national audits carried out under NOCA
- Support and act on the Specialty QI programmes in Histopathology, GI Endoscopy and Radiology

- Implement the recommendations of the National Maternity Strategy and prioritise improvements for Women & Children's services in line with National strategy.
- Implement the recommendations of core National Clinical Programmes (for e.g. HCAI Clinical Programme, Acute Medicine Programme - Pathway Tallaght Hospital)
- Implement the NCEC *Standards for Clinical Practice Guidance,* 2015.
- Promote clinical excellence through the further development of academic and clinical appointments in prioritised specialties.

**Service User Experience**

- **Engage patients**: Establish structures and processes to listen to and engage service users and patients; test new ways of promoting personalized compassionate care
- Conduct a service user and patient experience survey in each hospital (in conjunction with HIQA).
- Continue to develop access to advocacy services for all patients and service users within DMHG.
- Participation in the national person-centred programme (including listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals).
- **Engage staff**: Listen to staff and adopt new ways of working with staff to ensure opportunities for them to make and implement solutions for improving quality and their work environment and enhance their ability to do so.
- Continue implementation of the open disclosure policy in DMHG.

## Health Service Reform

Supporting the goals of the *Corporate Plan 2015-2017*, the reform programme within DMHG will drive the delivery of person-centred, integrated care across all services and 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. Services are being re-organised to ensure they are delivered in the most appropriate way.

DMHG began development in early 2015. The CEO, Dr Susan O'Reilly was appointed in November 2014 with the Senior Management Team being established in Q2 2015. Additional appointments for leadership in Quality and Safety and Information Technology are to be finalised.

The Group will finalise its Strategic Plan for 2016 – 2018 in Q2 2016 with the focus on improving clinical performance in scheduled and unscheduled care and in the development of clinical networks and delivery systems to improve access to excellent care in accordance with the HIQA National Standards for Safer Better Healthcare and in alignment with the National Committee on Clinical Excellence, the National Clinical Programmes and the National Cancer Control Programme Guidelines.

Trinity College Dublin (TCD) is the Academic Partner for the Group. Arrangements between the Groups and TCD will be further consolidated in 2016.

# Operational Framework – Financial Plan

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| Hospital | Budget 2016 €m | Out – turn 2015 €m | Final Net Allocation 2015 Including Supplementary €m | Original Net Allocation 2015 €m |
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| **SLRON** | 39,869 | 40,889 | 40,892 | 40,931 |
| **Total** | **766,448** | **792,891** | **785,662** | **759,440** |

## Introduction

The 2016 net allocation to hospitals in the Dublin Midlands Hospital Group amounts to €766.448m, inclusive of national pay awards.

2016 is the first year when the funding model is migrating from the historic block budget approach towards the full implementation of Activity Based Funding (ABF), in line with Government policy on the reform of the health services.

The introduction of ABF is a significant change in the funding process as it funds episodes of care delivered by hospitals rather than the former block grant. ABF is calculated on the gross cost of services and is a price and volume based model that applies to both inpatient and day-case services. For 2016, other services such as ED and Outpatients will remain funded by a block grant.

In order to deliver the same volume of service as 2015 the offered prices to hospitals has been discounted by 2% compared with their existing cost level for 2015. This discount applies before any incremental costs related to 2016 are factored in.

## Approach to ABF

The overarching management approach to ABF within a hospital is to deliver "efficiency within the financial cap". The Irish health system operates with a financial cap so ABF cannot fund unlimited increases in volume. What it can do, and is doing, commencing in 2016, is reward those hospitals which clearly have unit costs below the national average.

## 2016 Allocation

The breakdown of the ABF Allocation by Hospital Group as well as related activity and weighted units is outlined in Appendix 1.

***The constituent elements of the 2016 allocation are summarised as follows:***

- ABF Revenue – Based on the national average DRG Price and associated hospital activity levels.
- Transition Adjustment – This is to reflect the difference between hospital costs and the national average cost.
- Block Grant – Relates to services provided a hospital that are not included in ABF e.g. Outpatients and ED
- Impact of LRA and Increments
- Stretched Income Generation Target
- Activity Target for both Inpatient and Day-case Services.

Please note that Winter Bed Initiative monies are held centrally, and, where relevant, will be allocated additionally in 2016 as “Special Purpose Payments”.

## New Service Developments

Establish the Coombe/MRH Portlaoise maternity network and recruit appropriate specialty staff as funded. In addition prioritise recruitment of staff midwives to ensure compliance with Birthrate Plus 2015 and support delivery of the maternity strategy.

## Financial Framework

The financial framework of the 2016 National Service Plan contains “stretched” targets in relation to cost containment and income generation. Dublin Midlands Hospital Group we are required to apply our full management capability in delivering on those targets, and, that our efforts must be evidential. The 2016 allocation to the Dublin Midlands Hospital Group is therefore not without its challenges. DMHG will ensure that appropriate management effort and attention is applied to maximising its share in the delivery of the savings measures required under the divisional financial plans and in the overall budgetary performance of its hospitals.

The Financial Control framework for 2016 will consist of four major components:-

1. **Headcount and other pay controls**
   Following a number of years of economic recession, the hospital system did fill a range of risk-related posts in 2015 which had been vacant due to the recruitment moratorium. The strategy to deliver the EWTD and efforts to reduce agency premium also involved increases in headcount. It is

clear that the financial envelope which is available in 2016 does not allow for any further recovery of vacant posts, and indeed efforts will have to be made in some circumstances to carefully manage staff numbers in line with savings targets - particularly in hospitals which filled significant posts in 2015.

DMHG has received a pay framework for 2016 which will require it to improve the governance of headcount, further specific agency conversion where appropriate and manage expenditure on variable pay at 2015 levels - particularly through controlling activity volumes.

Payroll is a significant cost in the delivery of acute services and therefore requires robust emphasis in relation to the management of headcount and rosters. The 2016 allocation does not allow for additional staff to be recruited except for approved developments and the conversion of agency staff.

Any additional staff being put on payroll must be as a result of a clear management decision that can be tracked and verified and must reference available pay budget. Any overtime to be worked must also be as a result of a management decision and be evidenced and must reference available pay budget.

With regard to the engagement of agency staff, no additional agency staff above 2015 levels are to be engaged in the current year without prior Group approval. Conversion of agency staff, where appropriate, should be progressed as a cost reduction priority in order to reduce agency expenditure compared to last year while also reducing the reliance on such staff.

Growth in headcount and agency staff that is not approved through the Dublin Midlands Hospital Group cannot be funded by the Group and will require a separate funding stream to fund the cost.

**2. Management of activity volume and clinical non-pay expenditure**

The three critical components of clinical non-pay expenditure are:-

1. Activity volume
2. New drugs and increased volume of existing drugs due to treatment regimes
3. Improved medical technologies

- Increases in workload involve expenditure on consumables, medical and surgical devices, bloods, laboratory etc. The prices which have been offered to hospitals for 2016 under ABF are already discounted by 2% which means that hospitals cannot afford the levels of expenditure already being incurred and must make savings on these. Critically, there is no scope to increase clinical non-pay expenditure by growing volume. To the greatest extent practical and consistent with the safe delivery of services hospitals will deliver services at 2015 levels.

- New drugs are an intrinsic element of hospital systems and good progress has been made in recent years in the area of high-cost cancer drugs supported by the National Cancer Control Program and their protocol-driven reimbursement system. So called 'orphan' drugs such as enzyme replacement therapy can increase expenditure steeply and are among some of the most expensive drugs in the system. Additional funding has been provided in the service plan for this aspect of hospital expenditure.

Increased volume of drugs is a more difficult issue and can arise due to volume of patients and/or changes in treatment regimes which require more frequent administration of certain chemotherapy drugs. These types of cost will have to be managed carefully in the context of savings targets.

Improved medical technologies such as the capacity to deliver thrombectomy in stoke care or transcatheter aortic valve implantation (TAVI) can suddenly bring considerable additional cost to the system and these items will have to be isolated and monitored during 2016 given the funding available.

3. **System-wide Approach to Clinical Non-pay**
   Working with colleagues in other Divisions of the HSE, the Acute Hospital Division will review all areas of non-clinical expenditure to achieve savings.

4. **Maximising Delivery of Income Targets**
   The changes in legislation in relation to bed designation have allowed the hospital system to increase its income generation. Private patient billing and other income-generation is now supporting service costs to the level of €987m. This is a significant income target and is a considerable increase on the 2015 outturn. The €50m accelerated income target is a part of the increased target together with other factors such as an expected 4.55% growth in the private patient market.

   Some hospitals grew their income billing quite significantly in 2015 and the targets build in a level of this expectation for those which did not. Work is already taking place to assess the resources and systems available to maximise billing and to share processes and apply resources to assist hospitals to achieve these very stretched targets.

   Within the 2016 allocation to the Dublin Midlands Hospital Group there is a stretched target in relation to income generation. In that context, hospitals are required to develop their strategies to maximise patient income in 2016. There are two main priorities contained in this income target. Firstly, all hospitals should ensure that all relevant patients are appropriately charged for services delivered and secondly that they have a robust billing process plan to ensure approval of charges by Consultants in their hospitals. It is an imperative that the debt outstanding due to slowness in the process of having Consultants sign-off on bills is significantly improved in 2016.

# Operational Framework – Workforce Plan

# Operational Framework – Workforce Plan

## Introduction

Dublin Midland Hospital Group (DMHG) recognises and acknowledges its people as its most valuable resource and key to service delivery. Recruiting and retaining motivated and skilled staff remains paramount for the delivery of quality focussed services in an increasing and changing demographic population.

2016 will see a focus on the "The People Strategy" which has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. This strategy is underpinned by a commitment to engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them – evidence shows that staff who are valued, supported in their development and treated well improve patient care and overall performance. DMHG will support the implementation of The People Strategy throughout the hospitals within our Group.

## Staff Engagement

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

## The Workforce Position

Government policy on public service numbers and costs is focused on ensuring that the numbers of people employed are within the pay budgets available. The management of funding for human resources in 2016 will continue to be based on the Pay bill Management and Control Framework. Compliance with the framework and the requirement for hospitals within the Group to operate within the funded pay envelope and related workforce plans is a key priority.

The whole time equivalent numbers employed in DMHG at end of October 2016 will be 9,583 across the following disciplines:-

- Medical/Dental 1,193
- Nursing 3,503
- Health and Social Care Professionals 1,492
- Management/Admin 1,428
- General Support Staff 860
- Patient and Client Care 1,107.

## Reducing Agency and Overtime Costs

DMHG will continue to focus on further reductions in the cost and reliance on agency staff and overtime during 2016. Hospitals will develop appropriate plans for agency conversion and reduction in overtime expenditure across all services and staff categories to deliver appropriate and cost effective services while ensuring quality and safe patient care.

## 2016 Developments

The planning, approval, notification, management, monitoring and filling of service development posts will be in line with the existing process for approved and funded new service developments as specified in National Service Plan. Other workforce additions, not specifically funded at the outset of the year, will be implemented only where offset by funding redirection within the allocated pay envelope. In 2016 new service developments will focus primarily on further development of the Coombe/MRH Portlaoise Maternity Network and increased capacity at St Luke's Radiation Oncology Network.

## Public Service Stability Agreements 2013- 2018

The *Lansdowne Road Agreement 2015* builds upon the agreement set out in the Haddington Road Agreement (HRA) until 2018. This includes enablers, such as additional working hours, workforce practice changes, reviews of rosters, skill-mix and staffing levels, increased use of productivity measures, use of redeployment mechanisms and greater use of shared services and combined services focused on cost effectiveness and cost efficiencies.

DMHG will implement actions agreed under the Public Service Agreements 2013–2018 through which change is achieved and is a central element of the strategy for recovery and a sustainable future for acute hospital services.

## Workforce Planning

In DMHG workforce planning will address the impact of skills shortages, support improved capacity within acute hospitals by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals. There will also be a focus on workforce design based on service design and delivery, driven by clinical care pathways and efficient and effective staff deployment alongside the development of leadership and management competencies.

## European Working Time Directive (EWTD)

DMHG is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for non-consultant hospital doctors (NCHDs). DMHG will continue to work with Acute Hospitals Services Division and National Human Resources to develop a comprehensive framework plan to support the achievement of full compliance.

## Recruitment

DMHG will continue to work with national HR to recruit and retain highly skilled clinical staff to approved positions in line with service need. This will include international recruitment for staffing for scarce grades.

## Attendance and Absence Management

DMHG will continue to maintain and build upon the progress achieved during the past year in improving attendance levels through the consistent implementation of the Managing Attendance Policy and Procedures. The performance target for 2016, remains at less than or equal to 3.5% staff absence rate.

## Health and Safety at Work

In 2016 there will be a corporate emphasis on: reviewing and revising the Corporate Safety Statement, developing key performance indicators (KPIs) in Health and Safety Management and Performance, launching a new statutory Occupational Safety and Health training policy, and developing and commencing a national proactive audit and inspection programme. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established. DMHG will work in partnership with occupational health and safety in the rollout of new initiatives.

# Accountability Framework

# Accountability Framework

## Introduction

The HSE is the statutory body tasked with responsibility for the delivery of health and personal social care services in Ireland. In discharging its public accountabilities, it has in place a Governance Framework covering corporate, clinical and financial governance.

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

The key components of the Performance Accountability Framework for the Health Services 2016 as they relate to Hospital Groups are as follows:

- Continued strengthening of the performance management arrangements between the National Director Acute Hospital Services and the newly appointed Hospital Group CEOs.
- Completion of Formal Performance Agreements between the National Director Acute Hospital Services and the Hospital Group CEOs.
- A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance.

## Accountability Framework

In the second half of 2015 a review of the operation, effectiveness and application of the Accountability Framework was commissioned and completed. Recommendations from the review including the changes that are required to improve the accountability, intervention and support processes to address areas of underperformance will be taken on board during 2016. This includes an enhanced Escalation and Intervention Framework which will be implemented during 2016.

One of the important elements of the HSEs 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. 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.

The HSE's Escalation and Intervention Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation across four levels from Hospital Group CEO to National Director to National Performance Oversight Group to Director General level. Where escalation occurs, the accountability arrangements in place will require the relevant senior manager to ensure that appropriate interventions are commissioned and implemented.

## Accountability Levels - Acute Hospital Services and Hospital Groups

The Group CEO has a matrixed reporting relationship which includes the Chair of the Hospital Group Board.

Hospital Group Chief Executives are accountable to the National Director for Acute Hospital Services for their planning and performance under the accountability framework of the HSE. All targets and performance criteria adopted in the service plan will be reported through this framework.

The five levels of accountability (i.e. who is calling who to account) set out in the Framework are described below.

**Level 1 Accountability:**
- The HSE's accountability through the Directorate to the Minister for Health

**Level 2 Accountability:**
- The Director General's accountability to the Directorate

**Level 3 Accountability:**
- National Director accountability to the Director General

**Level 4 Accountability:**
- Hospital Group CEOs accountability to National Director Acute Hospitals.

**Level 5 Accountability:**
- Section 38 and Section 39 funded agencies / Service Managers accountability to the relevant Hospital Group CEO.

Accountability arrangements are in place for each level of accountability. The Operational Plan for the Hospital Group will continue to be the basis against which the performance of the Group will be measured and reported. Delivery of DMHG Operational Plan will be measured, monitored and performance managed in 2016 through a formal Performance Agreement between the Acute Hospital Services National Director and the DMHG CEO. Performance Agreements will set out the integration arrangements between hospital and community services.

The Hospital Group Operational Plan will continue to be the basis against which the performance of each individual service is measured and reported on by the Hospital Group CEO.

## Accountability Processes - Hospital Group CEO and Hospitals within the Group

The National Director for Acute Hospital Services will formally review the delivery of the Hospital Group CEO Performance Agreement at monthly Performance Review Meetings with the Group CEO and members of their core teams. These will continue to be the principal accountability meetings at which progress against the Hospital Group CEO Performance Agreement and the DMHG Operational Plan are reviewed.

DMHG CEO will continue to hold a formal monthly performance management process with hospitals within the Group. It is expected that any deviation from planned performance will be addressed at this level in advance of the Hospital Group Performance Management meetings with the Acute Hospital Services National Director.

The Service Arrangements or Grant Aid Agreements will continue to be the principal accountability agreement between the Hospital Group CEO and each Section 38 and Section 39 Agency.

# Delivery of Services

# Dublin Midlands Hospital Group

## Introduction

| Acute Services | |
|---|---|
| **2016 Budget €m** | |
| Dublin Midlands Hospital Group | 766.448 |
| Full details of the 2016 budget are available on page 14 | |

The reform actions necessary to enable the Government to deliver 'whole system' health reform, as undertaken within the Programme for Government, are laid out in ***Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015***. The establishment of Hospital Groups is an integral part of this reform, which sees public hospitals reorganised into more efficient and accountable hospital groups that will harness the benefits of increased independence and greater control at local level. The Government's decision regarding the establishment and operation of the new hospital groups is informed by two reports ***The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts*** and ***The Framework for Development – Securing the Future of Smaller Hospitals***. These reports fulfil important commitments in Future Health for the reform of the health service.

The overarching aim of the wider health system reform programme is to deliver a single-tier health system based on Universal Health Insurance (UHI), underpinned by the principle of social solidarity, with equitable access based on need and not on ability to pay.

The Dublin Midlands Hospital Group (DMHG) began development in early 2015. The CEO, Dr. Susan O'Reilly was appointed in November 2014 with the Senior Management Team being established in Q2, 2015. Additional appointments for leadership in Quality and Safety and Information Technology are to be finalised.

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The Dublin Midlands Hospital Group includes the following hospitals:

Adelaide and Meath incorporating the National Children's Hospital (Tallaght Hospital)
Coombe Women and Infants University Hospital
St. James's Hospital
Naas General Hospital
Midlands Regional Hospital Portlaoise
Midlands Regional Hospital Tullamore
St. Luke's Radiation Oncology Network

Trinity College Dublin is the Academic Partner for the Group.

The Group has already implemented a new formal Clinical and Operational Governance Model across the Statutory Hospitals. The Group collaborates closely with the Voluntary Hospitals in accordance with their Service Level Agreements in the planning and performance management of their services. The Group has authority for the delegated budget allocation of €766.448m. DMHG serves a population of approximately 800,000 people, with over 9,500 staff.

The Group will finalise its Strategic Plan for 2016 – 2018 in Q2 2016 with the focus on improving clinical performance in scheduled and unscheduled care and in the development of clinical networks and delivery systems to improve access to excellent care in accordance with the HIQA National Standards for Safer Better Healthcare and in alignment with the National Committee on Clinical Excellence, the National Clinical Programmes and the National Cancer Control Programme Guidelines.

# Dublin Midlands Additional Key Priorities and Actions to Deliver on Goals in 2016

| Goal 1 | **Promote Better Health and Wellbeing as part of everything we do so that people will be healthier** | |
|---|---|---|
| **Priority Area** | **Action 2016** | **Target/ Date** |
| **Healthy Ireland** | Promoting healthy lifestyle for patients and staff, reduce incidence of disease and support best management of chronic diseases such as diabetes, COPD and coronary heart disease through the development and phased implementation of hospital group *Healthy Ireland* plan. | Q1-Q3 |
| | Completion of Group Healthy Ireland Plan. | Q3 |
| | Appointment of Healthy Ireland Group Implementation Plan Lead. | Q1-Q4 |
| | Increase the number of hospital frontline staff trained in brief intervention smoking cessation. | Q1-Q4 |
| | Encourage frontline staff to engage with patients on smoking cessation strategies and support - also to participate in smoking cessation strategies for themselves. | Q1-Q4 |
| | Ensure compliance with the HSE Tobacco Free Campus Strategy and ensure ongoing 100% compliance. | Q1-Q4 |
| | Promoting increased uptake of seasonal flu vaccination by hospital staff. | Q1 |
| | Implementation of the HSE Policy on Calorie Posting in all hospitals. | Q1-Q4 |
| | Support Health and Wellbeing Division in the development of a *Hospital and Patient Food Policy* and contributing to the development of the NCEC guideline for the *Identification and Management of under nutrition in Acute Hospital settings.* | Q1-Q4 |
| **Healthcare Associated Infections** | Ensure compliance with Nationally agreed infection prevention & control performance indicators with a particular focus on antimicrobial stewardship, and monitoring & control measures for:<br>• Surgical Site Infection<br>• Multi-Resistant Organisms<br>• Clostridium Difficile<br>underpinned by the implementation of HIQA *National Standards for the Prevention and Control of Healthcare Associated Infections*. | Ongoing |
| | Commence monthly reporting of key performance indicators on the number of patients colonised with multi-drug resistant organisms (MDRO) that cannot be isolated in single rooms or cohorted with dedicated toilet facilities. | Ongoing |
| | Monthly reporting of hospital acquired S Aureus bloodstream infection and hospital acquired new cases of C difficile infection. | Ongoing |
| | Comply with standards for Hand hygiene training and education every two years. Monitor compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool. | Ongoing |
| **National Screening Services** | Monitoring compliance with the National Screening Services KPIs e.g. Colonoscopy and Colposcopy. | Q1-Q4 |

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| **Cancer Screening** | Support the expansion of BreastCheck from 65-69 years and develop the BowelScreen Programme in 2016 to support a two year screening round by 2017. | Q1-Q4 |
| **Positive Aging Projects** | Work with community partners on positive aging projects including admission avoidance and education in accordance with the National Dementia Framework. | Q1-Q4 |
| | Develop clinical pathways for elderly patients across hospitals and CHOs to support positive ageing. | Q1-Q4 |
| | Support the transition of services for the elderly to the new MISA building at St James's Hospital. | Q2 |
| **Health and Wellbeing Programmes** | Evaluate and extend health and wellbeing programmes for chronic diseases including diabetes, obesity and alcohol related conditions. | Q2-Q4 |

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

| Priority Area | Action 2016 | Target/ Date |
|---|---|---|
| **Scheduled Care** | Improve performance in relation to scheduled care by ensuring active management of waiting lists for inpatient and day case procedures and reduce waits of over 8 months by strengthening operational and clinical governance structures including:<br>• Maximisation of current capacity.<br>• Monitoring of chronological scheduling processes.<br>• Adherence to NTPF guidelines in relation to scheduling of patients for surgery.<br>• Commence monitoring of scheduled waiting list cancellation rate.<br>• Reorganise hospital group services with an increased focus on small hospitals managing routine urgent or planned care locally and more complex care managed in the larger hub hospitals.<br>• Target admission/avoidance with the introduction of Admission Assessment Units.<br>• Improve day case rates in all hospitals through implementation of the recommendations of the Surgical Clinical Care Programme.<br>• Target increased proportion of minor operation procedures to be performed in a non-theatre setting that are currently completed as daycases.<br>• Improve day of surgery admission rates for all hospitals including progressing plans to increase pre-operative assessment clinics in St James's Hospital.<br>• Improve day case rate for laparoscopic cholecystectomy.<br>• Reduction in bed day utilisation by acute surgical admissions who do not have a surgical procedure performed.<br>• Ensure that all procedures are carried out in the most appropriate clinical setting and are coded accurately. | Ongoing |
| | Implement the HIQA Recommendations from the review of MRH Portlaoise across the Group. | Ongoing |
| **Out Patient Improvement Programme** | Continue to participate in the roll-out of the outpatient reform programme with an emphasis on the new minimum dataset, improved pathways of care and efficiency measures through the outpatient services performance improvement programme. The Group will engage as required with the Acute Services Division and OPD programme in the following developments: | Q1-Q4 |

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| | • Support the National development of MSK and Dermatology out-patient pathways.<br>• Participate in the commencement of Ophthalmology and neurology out-patients pathways of care.<br>• Finalise roll-out of e-referrals (Phase 1) to all hospitals commencing with MRH Tullamore.<br>• Initiation of formal audits of Outpatient Services.<br>• Support the National development of the Outpatient Patient Satisfaction Tool.<br>• Evaluate New to Review OPD metrics. | |
| | Adopt the concept of virtual outpatient clinics for orthopaedic services across the Group as piloted in MRH Tullamore and subsequently adopt learning to other specialty areas. | Q1-Q4 |
| **Unscheduled Care** | Improve performance in relation to unscheduled care by continuing to implement the Emergency Department Task Force report recommendations and the Workplace Relations Commission proposals on hospital emergency departments in conjunction with the Acute Hospitals Division and community healthcare services. | Q1-Q4 |
| | Ensure that all patients are admitted or discharged from ED within 9 hours but in particular those > 75 years of age. | Q1-Q4 |
| | Activate full escalation response in the event of red status on trolleyGAR or any patient breaching the 9 hour maximum trolley wait as per Mandatory National Directive 27/11/15. | Ongoing |
| | Support the continued development of AMAU service in Tallaght and MRH Tullamore Hospital. | Q1-Q4 |
| | Focus on development of the patient pathways and opening the new Medical Assessment Unit at the MRH Portlaoise. | Q1-Q4 |
| | Prioritise admission/avoidance and development of the respiratory pathway across hospital and community in MRH Portlaoise. | Q1-Q4 |
| | Plan for the development of a short-stay ward at MRH Tullamore. | Q2-Q4 |
| | Improve Patient Experience Time (PET) in Emergency Departments by 10% on 2015 figures:-<br>- Reduce number of patients on Trolleys subject to successful recruitment of staff for funded projects under the Winter Bed Initiative.<br>- Conduct capacity review of access to diagnostics and formulate capacity plan. | Q1-Q4 |
| | Collaborate and plan with National Ambulance Service appropriate transport to deliver optimum services across the Group. | Q1-Q4 |
| **Winter Initiative** | Alleviate pressures on the hospital system over the winter period enabling achievement of the targeted reduction in trolley waits by opening additional 16 beds in Tallaght Hospital and 11 beds at Naas contingent on recruitment. | Q1-Q2 |
| | Prioritise recruitment and succession planning for nursing inclusive of specialist posts for delivering on the un-scheduled care agenda – includes active | Q1 |

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| | monitoring of local recruitment and development of robust international recruitment strategy. | |
| | Develop a Model of Care Proposal for expansion of rehabilitation services in Laois/Offaly in conjunction with Community Health Organisation 8. | Q2 |
| | Develop Winter Plan for 2016 with an implementation strategy for same. | Q3-Q4 |
| **Quality** | Appoint a Director of Quality and Safety to lead the integration and development of quality and safety across the Group aligned with corporate identities including the establishment of the quality executive for the Group. | Q2-Q4 |
| | Based on the findings of the HIQA MRH Portlaoise Report:<br>• Each Hospital Group will undertake a risk assessment of clinical and corporate governance within their Group with a view to identifying and stratifying immediate risks and mitigating actions, (in particular the transfer policy for high risk patient cohorts).<br>• Each Hospital should implement on-going mandatory clinical training programmes for all clinical staff in respect of day-to-day care of pregnant women where such programmes do not already exist. | Ongoing |
| | Continue to develop the hospital's capacity to respond to Category 4 (e.g. Ebola) type threats. | Ongoing |
| | Implementing all HIQA recommendations across all hospitals. | Q1-Q4 |
| | Continue to implement the *National Standards for Safer Better Healthcare* in Acute Hospitals (NSSBHC). | Q1-Q4 |
| | Complete first and second assessments against NSSBHC in all hospitals and develop action plans to address any gaps identified. | Q2 |
| | Participate with AHD in roll-out, reporting and publishing monthly hospital patient safety statements. | Q1-Q4 |
| | Implement the aspects of the Memo of Understanding between the State Claims Agency and HSE as it relates to Hospital Groups to ensure the timely sharing of actual and potential clinical risk information (once approved ). | Q1-Q4 |
| | Continue to have active management of the Group Risk Register. | Q1-Q4 |
| | Co-operate with Quality Assurance and Verification Division on the roll out Phase Two of the National Incident Management System and complete Incident Management Training. | Q1-Q4 |
| | Following transfer of appropriate resources establish processes and governance structures in the Group which support the management of Serious Reportable Events and Serious Incidents. | Q1-Q4 |
| | Following transfer of appropriate resources establish defined patient safety and quality frameworks that will address:<br>• Patient Advocacy<br>• Complaints<br>• Incident Management, Response and Review | Q1-Q4 |

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| | • Service Improvement | |
| | Commence Reporting of additional indicators of Safe Care with the measurement of adverse events monthly in relation to:<br>• Postoperative Wound Dehiscence,<br>• In-Hospital Fractures<br>• Foreign Body left during Procedure<br>• Pressure Ulcer Incidence/Falls Prevention | Q1-Q4 |
| | Continue to build on 2015 progress in education and training of staff in approved quality improvement methods.<br><br>Support staff trained in quality improvement to network and build on their improvement skills. | Q1-Q4<br><br>Q1-Q4 |
| | Develop a network of staff with quality improvement training across the Group and measure impact of same. | Q1-Q4 |
| | Support the implementation of Nursing & Midwifery Quality Care Metrics to include:<br>• Patient Assessment ( Falls/ Pressure Ulcers)<br>• Patient Observation ( NEWS/ iMEWS/ PEWS)<br>• Mediation Management<br>• Nursing Documentation<br>• Midwifery Documentation<br>• Patient Experience | Q1-Q4 |
| | Support System Analysis Training for core staff across all Hospitals and build capacity through mentorship in conducting System Analysis Reviews. | Q1-Q4 |
| **Maternity Services** | Implement maternity service improvements in line with HIQA recommendations and other relevant reviews including:<br>• Commence implementation of the National Maternity Strategy. | Q1-Q4 |
| | • All maternity units in the Group to report and publish monthly maternity patient safety statement. | Q1-Q4 |
| | • Implement the Maternity Charter which will be informed by the Maternity Strategy. | Q2-Q4 |
| | • Implement the recommendations of the midwifery workforce planning study (Birthrate Plus 2015). | Q1-Q4 |
| | • Focus on demand and capacity workforce planning for undergraduate and postgraduate midwives inclusive of retention strategy for new graduates. | Q1-Q4 |
| | • Target sustainable recruitment strategies for experienced midwives for medium and long-term planning consistent with Birthrate Plus 2015. | Q1-Q4 |
| | • Embed development of maternity clinical network. | Ongoing |
| | • Participate in the planning and development for the provision of equitable access to antenatal anomaly screening in maternity services in the context of emerging clinical maternity network. | Q1-Q4 |
| | • Embed development of bereavement specialist service. | Ongoing |
| | • Implement the local recommendations from the Dr Peter Boylan Review of Maternity Complaints in Group Maternity and Infant Services. | Q1-Q4 |
| | Progress plans for the relocation of the Coombe Women and Infants University Hospital to St. James's site. | Q1-Q4 |

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| | Continue to establish the Coombe/MRH Portlaoise maternity network and recruit appropriate specialty staff as funded. | Q1-Q4 |
| | Provide focussed nurse specialist support to work with the prenatal specialists within the network. | Q1-Q4 |
| **Care Pathways** | Improve integrated care pathways for those patients who require access to long-term care and to primary care services in order to reduce the number of delayed discharges through developing a system wide approach in conjunction with National Clinical Strategy and Programmes and the CHOs. | Q1-Q4 |
| | Work with National integrated care pathways across all hospitals in Group in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease for patients with :<br>• COPD,<br>• Asthma,<br>• Heart Failure<br>• Diabetes | Q1-Q4 |
| | Support the phased implementation of the policy when published on Trauma Networks for Ireland within existing resources. | Q1-Q4 |
| | Develop and implement prioritised clinical networks in accordance with DMHG Strategic Plan 2016 – 2018. | Q3-Q4 |
| | Improve peri-operative clinical pathway by more efficient use of pre-assessment, pre-admission ward and operating theatre utilisation. | Q1-Q4 |
| | Participate as required in the new National Endoscopy Working Group to target improvements in endoscopy services nationally. This working group will be clinically led and will target actions to improve current capacity and demand management. | Q1-Q2 |
| **Integrated Care Programme for Older Persons** | Initiate implementation of the Model for Integrated Care Programme for Older Persons at Tallaght Hospital in association with local CHO, Clinical Strategy and Programmes and Social Care Division. | Q1-Q4 |
| **Ambulance Service** | Participate with Acute Services Division and the National Ambulance Service in the development of a performance indicator which will monitor time taken for clinical handover of patients in ED that will be based on the National Ambulance Handover Protocol for the Handover of Ambulance Patients in EDs and differentiates between completion of clinical handover and the time ambulance crew are available for next call. | Q1-Q4 |
| **Hospital and Patient Food Policy** | Support Health and Wellbeing Division in the development of a Hospital and Patient Food Policy and contributing to the development of the NCEC guideline for the Identification and Management of under-nutrition in Acute Hospital settings. | Q1-Q4 |
| **Cancer Services** | Improve rapid access services for patients where there is a high index of suspicion of prostate or lung cancer. | Q1-Q4 |
| | Improve access for patients attending Symptomatic Breast Disease services who are triaged as non-urgent within a 12 week timeframe. | Ongoing |

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|---|---|---|
| | Support improvements in diagnosis, medical oncology, radiation oncology, surgery and multi-disciplinary care for cancer. | Ongoing |
| | Implement the National Clinical Guideline – No. 7 Diagnosis, Staging and Treatment of Patients with Breast Cancer and the National Clinical Guideline – No. 8 Diagnosis, Staging and Treatment of Patients with Prostate Cancer. | Q1-Q4 |
| | Provision of an extended oncology/haematology day unit and relocate service from Burkitt Ward (16 beds back in use) at Tallaght Hospital. | Q1 |
| | Support the recruitment of additional staff for the phased increase in Radiation Oncology Services at St Lukes' Hospital, Rathgar associated with commissioning of new linear accelerators. | Q3 |
| **Irish Hospital Redesign Programme** | Tallaght Hospital was identified as a pilot site for the Irish Hospital Redesign Programme (IHRP). The focus of the programme is improving patient flow and the patient experience and involves both scheduled and unscheduled care. DMHG will continue to support the IHRP team at Tallaght Hospital to introduce sustainable change which is replicable across the acute hospital system. | Q1-Q4 |
| **Hospital Capacity** | Conduct capacity review of access to diagnostics and formulate capacity plan. | Q1-Q4 |
| | Open the new Stroke Unit at St. James on a phased basis. | Q1-Q4 |
| | Reduce endoscopy waiting times for non-urgent cases. | Q1-Q4 |
| | Increase capacity for spinal services at Tallaght Hospital. | Q4 |
| | Progress development of replacement MRI Unit at MRH Tullamore Hospital. | Q4 |
| | Enhance access to stroke telemedicine services at Tallaght Hospital. | Q2 |
| | Support the plan to increase capacity for critical care beds and renal services at Tallaght Hospital. | Q1-Q4 |
| **MRH Portlaoise** | Continue and validate the successful implementation of the recommendations of HIQA report at MRHP.<br><br>Enhance acute medical unit and day case activity upon completion of capital development at MRHP. | Q2-Q4<br><br>Q4 |

**Foster a culture that is honest, compassionate, transparent and accountable**

| Priority Area | Action 2016 | Target/ Date |
|---|---|---|
| **CEO** | Establish CEO Reporting Relationship with Dublin Midlands Hospital Group Board. | Q4 |
| **Governance** | Complete development of DMHG 3 year Strategic Plan by Quarter 2. | Q2 |
| | Continue to strengthen governance across the Group within the context of Service Level Agreements with the voluntary hospitals and in line with new group clinical and management structures in the statutory hospitals. | Q1-Q4 |
| | Continue to develop the hospital Group management structures including quality and patient safety. | Q2 |

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| | Establish prioritised clinical networks across the Group, consistent with 3 year strategic plan. | Q3 |
| | Communicate the core values of the HSE Corporate Plan in line with the roll out of the DMHG Strategic Plan. | Q3-Q4 |
| | Consolidate arrangements between Group and Academic Partner as per Reform Programme. | Q1-Q4 |
| | Complete Service Arrangements as appropriate in accordance with HSE Governance Framework for funding Non-Statutory provided services. | Q1 |
| | Comply with recommendations from local audits and potentially systemic recommendations in accordance with HSE Internal Audit procedures. | Q1-Q4 |
| | Appoint Group Lead for Emergency Management following alignment of Emergency Management structures for emergency planning and crisis response. | Q1 |
| | Establish Clinical Directors Network and Directors of Nursing and Midwifery Network across Group. | Q1 |
| | Enhance integrated Scheduled Care and Unscheduled Care structures across the Group. | Q1Q4 |
| | Continue to communicate proposed changes in Governance and Management across Maternity and Infant Services to patients and staff. | Q1-Q4 |
| **Patient Experience** | Participate in the implementation of plans to build the capacity and governance structures needed to promote a culture of patient partnership across acute services. | Q1-Q4 |
| | Use patient feedback to inform quality improvement initiatives and investment priorities. | Q1-Q4 |
| | Undertake Patient Experience Survey on a phased basis across all hospitals in the Group. | Q3-Q4 |
| **Patient Advocacy** | Pilot the development and implementation of patient and advocacy group engagement in MRH Portlaoise with intent to roll out across hospitals. | Q1-Q4 |
| | Implement the principles of the Open Disclosure policy including support for patients and staff in a no shame no blame culture and good will reporting. | Q1-Q4 |
| | Continue to foster open Communications with patients, family and staff regarding adverse outcomes. | Q1-Q4 |
| | Share the learning from critical events and complaints across hospitals. | Q1-Q4 |
| | Progress implementation of patient satisfaction surveys across all hospitals. | Q1-Q4 |
| **National Clinical Guidelines** | Continue implementation of the National Clinical Guidelines in partnership with clinicians in hospitals::<br>• Communication (Clinical Handover) in Maternity Services, National Clinical Guideline No. 5 | Q2-Q4 |
| | • Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No. 11 | Q2-Q4 |
| | • Sepsis Management, National Clinical Guideline No. 6 | |

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| | • Hospital Group Sepsis ADON will complete a gap analysis of the implementation of the guideline in each Hospital. | Q! |
| | • Sepsis Leads will develop an action plan informed by GAP analysis for implementation of the Guideline in each Hospital Group. | Q2 |
| | • Develop performance indicators that will provide assurance of compliance with the Guideline. | Q1-Q4 |
| | Develop self-audit schedules and follow-up action plans for:<br>• NEWS – National Early Warning Score<br>• IMEWS – Irish Maternity Earl Warning Score<br>• PEWS – Paediatric Early Warning Score | Q2 |
| **Accountability** | In accordance with the HSE Accountability Framework 2016 continue to improve performance management systems and processes across the Group to deliver improved patient care in the four domains of Quality and Safety, Access to Services, Financial Resources and Workforce. | Q1-Q4 |
| | Develop, implement and publish Group Balanced Scorecard aligned with National Performance Indicators plus Group metrics. | Q1-Q4 |
| | Develop an annual reporting process for Group activity in 2016. | Q1-Q4 |
| | Implement web-based information regarding Group services. | Q2 |
| **Protection of Children and Vulnerable Persons** | Ensure the appropriate staffs are apprised of the Children First Act and their duties and responsibilities. | Q1-Q4 |
| | Provide training to relevant staff in conjunction with Children First development officers. | Q1-Q4 |
| | Implement the policy on Safe-guarding Vulnerable Persons at Risk of Abuse in conjunction with Social Care Division. | Q1-Q4 |
| **Staff Engagement** | Use learning from the employee survey to shape organisational values and ensure that the opinions of acute hospital staff are acknowledged. | Ongoing |

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

| Priority Area | Action 2016 | Target/ Date |
|---|---|---|
| **People Strategy 2015-2018** | Implement the People Strategy 2015-2018 within the Group. | Q1-Q4 |
| | Prepare staff engagement strategy for the Group including an action plan. | Q1-Q4 |
| | Ensuring delivery of induction programmes locally. | Q1-Q4 |
| | Ensure compliance with Mandatory Hand Hygiene Training KPI. | Q1-Q4 |
| | Participate in the facilitation of the expansion of the role of care professionals within current resources. | Q1-Q4 |
| | Implement the Healthy Workplace Policy and support initiatives to encourage staff to look after their own health and wellbeing. | Q1-Q4 |
| | Support continuous development and training for staff through in-house, E Learning and shared learning initiatives. | Q1-Q4 |

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| | Target reduction in Group absenteeism rates. | Q1-Q4 |
| **Recruitment** | Streamline recruitment process under the DMHG Paybill Monitoring and Control Framework in line with service need. | Q1-Q4 |
| | Facilitate the lead person for Information Technology assignment to develop and improve data management, analytics, business intelligence and informatics in partnership with the office of the Chief Information Officer. | Q1-Q4 |
| | Champion the completion of a demand and capacity analysis to ensure under-graduate and post-graduate midwifery training meet service needs. | Q2-Q3 |
| | Prioritise recruitment including international recruitment of midwifery staffing to ensure compliance with Birthrate Plus 2015 and support delivery of the maternity strategy. | Q1-Q4 |
| | Prioritise recruitment including international recruitment for nursing and midwifery staff with a focus on speciality areas of critical care, theatre, emergency department and maternity services. | Q1-Q4 |
| | Focus on recruitment of 2016 Nursing & Midwifery graduates. | Q1-Q4 |
| | Recruit staff in Q1/2 2016 for additional treatment capacity St. Luke's Radiation Oncology Network. | Q1 |
| | Recruit additional frontline nursing staff to increase capacity for access to emergency department and inpatient care. | Q1-Q4 |
| | Develop the capacity for comprehensive spinal services across the Group. | Q1-Q4 |
| | Enhance medical oncology service in Tallaght/Naas/St James's. | Q1-Q4 |
| **Public Service Agreement** | Participate with AHD in the establishment of Local Implementation Groups (LIG) which will oversee the local implementation of the Final Agreement of the *Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement December 17th 2015* | Q1-Q2 |
| **Leadership Development** | Sustain the benefits of the Florence Nightingale Initiative for Nurse and Midwife Managers through commissioning and development of leadership networks | Q1-Q4 |
| | Support the development of leadership potential through approved Leadership development programmes | Q1-Q4 |
| | Enhance patient care through best use of resources, by the development of specialist & advanced practice in Nursing & Midwifery by:<br>• Strategic planning for development of Advanced Nurse Practitioners in all specialities (to include Emergency Departments & Medical Assessment Units)<br>• Enhancing the number of nurses/ midwives registered to prescribe medicinal products<br>• The number of nurses/ midwives registered to prescribe ionising radiation. | Q1-Q4 |
| **EWTD** | Monitor compliance with the European Working Time Directive within all Hospital and provide information on;<br>• Maximum 24 hour shift<br>• Maximum 48 hour week | Q1-Q4 |

| | | |
|---|---|---|
| **Health and Safety** | DMHG will work in partnership with the National Occupational Health and Safety Office in the rollout of new Health & Safety initiatives. | Q1-Q4 |

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

| Priority Area | Action 2016 | Target/ Date |
|---|---|---|
| **Activity Based Funding** | Move to the next phase of transition to an Activity Based Funding (ABF) model of funding hospital activity with the initial focus on inpatient and day cases. | Q1-Q4 |
| | Establish Group ABF Committee to champion improvements and efficiencies in ABF outcomes. | Q1 |
| | Improve existing finance performance metrics through ABF Group Committee. | Q1-Q4 |
| | Develop and implement processes to target and support best funding outcomes in hospitals under ABF. | Q1-Q4 |
| | Implement ABF and budget linkages in all hospitals. | Q1-Q4 |
| | All hospitals will complete HIPE coding within 30 days. | Q1-Q4 |
| | Establish Group Finance and Audit Committees. | Q1 |
| | Develop Group Estates Committee. | Q1 |
| | Develop Group CFO Network. | Q1 |
| | Establish integrated Group Finance function to include Management Accounting, Financial Accounting, ABF and Internal Audit capability. | Q1 |
| | Establish a suite of financial reports and metrics to assist Group and Hospital performance management. | Q1-Q4 |
| | Develop Group Finance Strategy that is aligned to overall DMHG Strategy. | Q3-Q4 |
| **Pay-bill Management and Control** | Monitor compliance with the Pay-bill Management and Control Framework by providing a Hospital Group compliance statement to verify that the conditions of the Pay-Bill Management and Control HSE National Framework has been adhered as set out by the HSE National Leadership Team memorandum dated 13th March 2015. | Q1-Q4 |
| **Capital Projects** | Complete appropriate capital projects that they are fit for purpose and aligned to Group strategy. | Q1-Q4 |
| | Completed redevelopment (phase 1) and commence service delivery, acute medical unit, day services at MRH Portlaoise. | Q2-Q3 |
| | Provide a replacement MRI and additional ultrasound at MRH Tullamore. | Q4 |
| | Provision of an extended oncology/haematology day unit and relocate service from Burkitt Ward (16 beds back in use) at Tallaght Hospital. Also link partially vacated Beech Ward to Lynn Ward creating 11 additional adult beds (co-funded from Winter capacity initiative). | Q1 |
| | Provision of interim facilities (phase 2 – radiation/oncology project) at St Luke's Hospital. | Q2-Q3 |

| | | |
|---|---|---|
| | Target progressing urgent capital requirements to support demand for critical care, renal services, endoscopy and ambulatory services in the Group. | Q1-Q4 |
| | Progress the planning for the extended day ward and oncology unit at Naas Hospital. | Q1-Q4 |
| | Plans are being progressed with estates for development of:-<br>- Decontamination Unit and Endoscopy Unit at St James's Hospital;<br>- Integrated Critical Care Unit at Tallaght Hospital;<br>- Outpatient Department at MRH Portlaoise,<br>- St Patrick's Ward refurbishment at the Coombe Hospital;<br>- MRI at Tallaght Hospital;<br>- Breast Imaging Equipment at St James's Hospital. | Q1-Q4 |
| **Laboratory** | Under the auspices of the Laboratory Development Group complete option appraisal and finalise plans for integrated Laboratory Development on St. James's Hospital Campus for three hospitals. | Q1-Q2 |
| **Health Identifier Programme** | Roll out of the Health Identifier Programme in collaboration with the Chief Information Officer. | Q1-Q4 |
| **MOCIS** | Collaborate with NCCP in the roll-out of the Medical Oncology Clinical Information System (MOCIS) in St James's and St Luke's Rathgar. | Q1-Q4 |
| **Information Systems** | Develop clinical information technology to support the Coombe / MRH Portlaoise Maternity Services. | Q1-Q4 |
| | Collaborate in the roll-out of the Laboratory Information System in and St James's. | Q1-Q4 |
| **Surgery Improvements NQAIS** | Continue to use, monitor and measure surgical activity across all hospitals using the National Quality Assurance Information System (NQAIS) Surgery.<br>• Provide training and education on NQAIS Medicine to key staff in Acute Hospitals.<br>• Identify minor surgical procedures currently undertaken in theatre that could be undertaken in other hospital settings such as procedure room or OPD.<br>• Ensure that all procedures are carried out in the most appropriate clinical setting and are coded accurately. | Q1-Q4 |
| **Acute Medicine NQAIS** | Participate in the development and implementation of NQAIS medicine:<br>• Adopt a quality improvement approach to the further development and roll-out of the system to all acute hospitals in the Group in conjunction with HSE Health Intelligence Unit.<br>• Provide training and education on NQAIS Medicine to key staff in acute hospitals.<br>• Provide support and advice to Clinical Directors and Senior Managers in the application of the system. | Q1-Q4<br>Q1-Q4<br>Q1-Q4 |
| **NQAIS-Mortality** | Continue the roll out of the NQAIS-NAHM (National Audit of Hospital Mortality) Module to all hospital groups. | Q1-Q4 |
| **NQAIS - Radiology** | Continue to support the development of Radiology Clinical Programme in NQAIS radiology system. | Ongoing |
| **Health Business Services** | Establish linkages and alignment with Health Business Services to deliver on Corporate and Finance Strategies. | Q1-Q4 |

# Appendices

# Appendix 1: Financial Tables

**Dublin Midlands Hospital Group Summary Financial and Activity Data 2016**

**Budget Allocation by Category 2016**

| Hospital | DRG Based Revenue 2016 € | Block Grant € | ABF and Transition Adjustment 2016 € | Gross Allocation Under ABF 2016 € | LRA and Increments Funding 2016 € | Final Revised Gross Allocation 2016 € | Final Income Budget 2016 € | Final Net Allocation 2016 € |
|---|---|---|---|---|---|---|---|---|
| Tallaght Adult Only | 132,478,556 | 76,138,445 | 13,547,627 | 222,164,628 | 2,220,000 | 224,384,628 | (56,459,000) | 167,925,628 |
| Coombe | 48,251,478 | 22,110,583 | (4,192,459) | 66,169,602 | 609,000 | 66,778,602 | (16,345,000) | 50,433,602 |
| Portlaoise | 31,753,274 | 24,076,164 | 3,806,595 | 59,636,033 | 380,000 | 60,016,033 | (8,340,000) | 51,676,033 |
| Tullamore | 61,689,678 | 26,946,963 | 9,706,349 | 98,342,990 | 658,000 | 99,000,990 | (14,517,000) | 84,483,990 |
| Naas | 42,821,928 | 20,983,563 | 362,949 | 64,168,440 | 394,000 | 64,562,440 | (8,015,000) | 56,547,440 |
| St. James's | 214,360,886 | 162,735,263 | 25,086,089 | 402,182,238 | 3,349,000 | 405,531,238 | (90,018,000) | 315,513,238 |
| SLRON | 0 | 47,560,000 | (2,100,000) | 45,460,000 | 213,000 | 45,673,000 | (5,804,000) | 39,869,000 |
| **Group Sub-Total** | **531,355,800** | **380,550,981** | **46,217,150** | **958,123,931** | **7,823,000** | **965,946,931** | **(199,498,000)** | **766,448,931** |

-

**ABF Budgeted Activity Levels Summary for 2016**

| Hospital | | Inpatient Volumes | Weighted Units | Daycase Volumes | Weighted Units |
|---|---|---|---|---|---|
| Tallaght Adult Only | | 17,443 | 25,271 | 46,259 | 48,924 |
| Coombe | | 19,088 | 10,573 | 8,374 | 7,207 |
| Portlaoise | | 13,004 | 6,840 | 6,060 | 5,849 |
| Tullamore | | 11,306 | 11,051 | 33,322 | 28,531 |
| Naas | | 9,636 | 9,307 | 7,460 | 8,039 |
| St. James's | | 22,782 | 44,943 | 47,374 | 46,600 |
| St Luke's Rathgar | | 1,410 | 2,908 | 17,041 | 7,822 |
| SLRON | | | | 48,067 | 39,845 |
| **Group Total** | | **94,669** | **110,893** | **213,957** | **192,817** |

# Appendix 2: HR Information

| Hospital | WTE Dec 14 | WTE Oct 15 | Medical/ Dental | Nursing | Health & Social Care Professionals | Management/ Admin | General Support Staff | Patient & Client Care |
|---|---|---|---|---|---|---|---|---|
| Coombe Women & Infants University Hospital | 750 | 769 | 82 | 328 | 62 | 122 | 124 | 51 |
| Midland Regional Hospital, Portlaoise | 600 | 630 | 72 | 248 | 56 | 70 | 22 | 162 |
| Midland Regional Hospital, Tullamore | 937 | 960 | 110 | 366 | 119 | 112 | 59 | 195 |
| Naas General Hospital | 656 | 682 | 77 | 242 | 111 | 84 | 32 | 137 |
| St. James's Hospital | 3,633 | 3,666 | 488 | 1,408 | 576 | 517 | 335 | 343 |
| St. Luke's Hospital, Rathgar | 449 | 503 | 41 | 80 | 191 | 89 | 61 | 41 |
| Tallaght Hospital | 2,327 | 2,362 | 323 | 832 | 377 | 425 | 228 | 178 |
| Other | 17 | 10 | | | | 10 | | |
| **Dublin Midlands HG** | **9,368** | **9,583** | **1,193** | **3,503** | **1,492** | **1,428** | **860** | **1,107** |

# Appendix 3: Performance Indicator Suite

## System-Wide

| System-Wide | | | | |
|---|---|---|---|---|
| **Indicator** | **Reporting Frequency** | **NSP 2015 Expected Activity / Target** | **Projected Outturn 2015** | **Expected Activity / Target 2016** |
| **Budget Management including savings**<br>**Net Expenditure variance from plan (within budget)**<br>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**<br>Capital expenditure versus expenditure profile | Q | New PI 2016 | New PI 2016 | 100% |
| **Audit**<br>% 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**<br>% 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**<br>% 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**<br>< 24 hour shift (Acute and Mental Health) | M | 100% | 96% | 100% |

| System-Wide | | | | |
|---|---|---|---|---|
| **Indicator** | **Reporting Frequency** | **NSP 2015 Expected Activity / Target** | **Projected Outturn 2015** | **Expected Activity / Target 2016** |
| < 48 hour working week (Acute and Mental Health) | M | 100% | 78% | 95% |
| **Health and Safety**<br>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**<br>% of complaints investigated within 30 working days of being acknowledged by the complaints officer | M | 75% | 75% | 75% |
| **Serious Reportable Events**<br>% 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**<br>% of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO | Q | New PI 2016 | New PI 2016 | 90% |
| % of claims received by State Claims Agency that were not reported previously as an incident | A | New PI 2016 | New PI 2016 | To be set in 2016 |

# Hospital Care

| Service Area | New/ Existing KPI | Reporting Frequency | National Projected Outturn 2015 | |
|---|---|---|---|---|
| **Activity** | | | | **Expected Activity/Target 2016 Dublin Midlands Hospitals Group** |
| **Beds Available**<br>Inpatient beds ** | Existing | Monthly | 10,503 | |
| Day Beds / Places ** | Existing | Monthly | 2,024 | |
| **Discharges Activity∞**<br>Inpatient Cases | Existing | Monthly | 621,205 | 94,669 |
| Inpatient Weighted Units | New PI 2016 | Monthly | 623,627 | 110,892 |
| Day Case Cases∞ ( includes Dialysis) | New PI 2016 | Monthly | 1,013,718 | 213,957 |
| Day Case Weighted Units ( includes Dialysis) | New PI 2016 | Monthly | 1,010,025 | 192,818 |
| Total inpatient and day case Cases∞ | New PI 2016 | Monthly | 1,634,923 | 308,626 |
| Shift of day case procedures to Primary Care | New PI 2016 | Monthly | New PI 2016 | |
| **Emergency Care**<br>- New ED attendances | Existing | Monthly | 1,102,680 | 173,765 |
| - Return ED attendances | Existing | Monthly | 94,948 | 14,785 |
| - Other emergency presentations | Existing | Monthly | 94,855 | 2,768 |
| **Inpatient Discharges**<br>*(Note this section previously detailed Inpatient Admissions but has been modified to align with HIPE data which is discharge based)*<br>Emergency Inpatient Discharges | New | Monthly | New PI 2016 | 58,877 |
| Elective Inpatient Discharges | New | Monthly | New PI 2016 | 13,625 |
| Maternity Inpatient Discharges | New | Monthly | New PI 2016 | 22,167 |
| **Outpatients**<br>Total no. of new and return outpatient attendances | Existing | Monthly | 3,242,424 | 610,041 |
| Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics) | New PI 2016 | Monthly | New PI 2016 | 1 : 2 |
| **Births**<br>Total no. of births | Existing | Monthly | 65,977 | 10,019 |

*∞Discharge Activity in Divisional Operational Plan target 2016 are based on Activity Based Funding (ABF) and weighted unit (WU) activity supplied by HPO. Dialysis activity is included in ABF day cases and WU. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU.*

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| | | | | |
| **Inpatient, Day Case and Outpatient Waiting Times**<br>% of adults waiting < 15 months for an elective procedure (inpatient and day case) | Existing | Monthly | 90% | 95% |
| % of adults waiting < 8 months for an elective procedure (inpatient and day case) | Existing | Monthly | 66% | 70% |
| % of children waiting < 15 months for an elective procedure (inpatient and day case) | New PI 2016 | Monthly | 95% | 95% |
| % of children waiting < 20 weeks for an elective procedure (inpatient and day case) | Existing | Monthly | 55% | 60% |
| % of people waiting < 15 months for first access to OPD services | New PI 2016 | Monthly | 90% | 100% |
| % of people waiting < 52 weeks for first access to OPD services | Existing | Monthly | 85% | 85% |
| **Colonoscopy / Gastrointestinal Service**<br>% of people waiting < 4 weeks for an urgent colonoscopy | Existing | Monthly | 100% | 100% |
| % of people waiting < 13 weeks following a referral for routine colonoscopy or OGD | Existing | Monthly | 52% | 70% |
| **Emergency Care and Patient Experience Time**<br>% of all attendees at ED who are discharged or admitted within 6 hours of registration | Existing | Monthly | 67.8% | 75% |
| % of all attendees at ED who are discharged or admitted within 9 hours of registration | Existing | Monthly | 81.3% | 100% |
| % of ED patients who leave before completion of treatment | Existing | Quarterly | <5% | <5% |
| % of all attendees at ED who are in ED < 24 hours | New PI 2016 | Monthly | 96% | 100% |
| % of patients 75 years or over who were admitted or discharged from ED within 9 hours | New PI 2016 | Monthly | New PI 2016 | 100% |
| **Patient Profile aged 75 years and over**<br>% of patients attending ED > 75 years of age ** | Existing | Monthly | 12.6% | 13% |
| % of all attendees aged 75 years and over at ED who are discharged or admitted within 6 hours of registration ** | Existing | Monthly | 32.0% | 95% |
| **Acute Medical Patient Processing**<br>% of medical patients who are discharge<br>ed or admitted from AMAU within 6 hours AMAU registration | Existing | Monthly | 65.5% | 75% |
| **Access to Services**<br>% of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled ** | Existing | Monthly | 79.8% | 90% |
| **Ambulance Turnaround Times**<br>% of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available) | New 2015 | Monthly | New 2015 | 95% |
| **Health Care Associated Infections (HCAI)** | Existing | Quarterly | 0.054 | < 0.055 |

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used | | | | |
| Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used | Existing | Quarterly | 2.1 | < 2.5 |
| Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital | Existing | Bi- Annual | 86.4 | 80 |
| Alcohol Hand Rub consumption (litres per 1,000 bed days used) | Existing | Bi- Annual | 28 | 25 |
| % compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool | Existing | Bi- Annual | 87.2% | 90% |
| Hospital acquired S. Aureus bloodstream infection/10,000 BDU ** | New PI 2016 | Monthly | New PI 2016 | <1 |
| Hospital acquired new cases of C. difficile infection/ 10,000 BDU ** | New PI 2016 | Monthly | New PI 2016 | <2.5 |
| Percentage of current staff who interact with patients that have received mandatory hand hygiene training in the rolling 24 month ** | New PI 2016 | Monthly | New PI 2016 | 100% |
| Percentage of patients colonized with multi-drug resistant organisms (MDRO) that can not be isolated in single rooms or cohorted with dedicated toilet facilities as per national MDRO policy ** | New PI 2016 | Monthly | New PI 2016 | 0% |
| **Adverse Events**<br>Postoperative Wound Dehiscence – Rate per 1,000 inpatient cases aged 16 years+ ** | Existing | Monthly | Data not available Q4 2015 | TBC |
| In Hospital Fractures – Rate per 1,000 inpatient cases aged 16 years+ ** | Existing | Monthly | Data not available Q4 2015 | TBC |
| Foreign Body Left During Procedure – Rate per 1,000 inpatient cases aged 16 years+ ** | Existing | Monthly | Data not available Q4 2015 | TBC |
| **Activity Based Funding (MFTP) model**<br>HIPE Completeness – Prior month: % of cases entered into HIPE | Existing | Monthly | 93% | > 95% |
| **Average Length of Stay**<br>Medical patient average length of stay (contingent on < 500 delayed discharges) | Existing | Monthly | 7.2 | 7.0 |
| Surgical patient average length of stay | Existing | Monthly | 5.5 | 5.2 |
| ALOS for all inpatient discharges excluding LOS over 30 days | Existing | Monthly | 4.6 | 4.3 |
| ALOS for all inpatients ** | Existing | Monthly | 5.5 | 5.0 |
| **Outpatients (OPD)**<br>New attendance DNA rates ** | Existing | Monthly | 12.9% | 12% |
| **Dermatology OPD**<br>No. of new Dermatology patients seen ** | Existing | Monthly | 41,732 | 41,700 |
| New: Return Attendance ratio ** | Existing | Monthly | 1:2 | 1:2 |
| **Rheumatology OPD**<br>No. of new Rheumatology patients seen ** | Existing | Monthly | 13,818 | 13,800 |

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| New: Return Attendance ratio ** | Existing | Monthly | 1:4 | 1:4 |
| **Neurology OPD**<br>No. of new Neurology patients seen ** | Existing | Monthly | 16,994 | 16,900 |
| New: Return Attendance ratio ** | Existing | Monthly | 1:3 | 1:3 |
| **Stroke**<br>% acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit ** | Existing | Quarterly | 67.8% | 50% |
| % of patients with confirmed acute ischaemic stroke who receive thrombolysis | Existing | Quarterly | 12.1% | 9% |
| % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit | Existing | Quarterly | 53.7% | 50% |
| **Heart Failure**<br>Rate (%) re-admission for heart failure within 3 months following discharge from hospital ** | Existing | Quarterly | 6.7% | 20% |
| Median LOS for patients admitted with principal diagnosis of acute decompensated heart failure ** | Existing | Quarterly | 7 | 6 |
| % patients with acute decompensated heart failure who are seen by HF programme during their hospital stay ** | Existing | Quarterly | 85.8% | 80% |
| **Acute Coronary Syndrome**<br>% STEMI patients (without contraindication to reperfusion therapy) who get PPCI | Existing | Quarterly | 83% | 85% |
| % of reperfused STEMI patients (or LBBB) who get timely PPCI | Existing | Quarterly | 68.4% | 80% |
| **Surgery**<br>% of elective surgical inpatients who had principal procedure conducted on day of admission | Existing | Monthly | 69.4% | 75% |
| % day case rate for Elective Laparoscopic Cholecystectomy | Existing | Monthly | 38.3% | > 60% |
| Reduction in bed day utilisation by acute surgical admissions who do not have an operation ** | Existing | Monthly | 10% Reduction | 5% Reduction |
| **Time to Surgery**<br>% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2) | Existing | Monthly | 84.5% | 95% |
| **Surgery**<br>Scheduled waiting list cancellation rate ** | New PI 2016 | Monthly | New PI 2016 | New PI 2016 |
| **Hospital Mortality**<br>Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition ** | Existing | Annual | Not Yet Reported | TBC |
| **Re-admission**<br>% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge | Existing | Monthly | 10.8% | 10.8% |

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| % of surgical re-admissions to the same hospital within 30 days of discharge | Existing | Monthly | 2.0% | < 3% |
| % of all medical admissions via AMAU ** | New PI 2016 | Monthly | New PI 2016 | 35% |
| **Medication Safety**<br>No. of medication incidents (as provided to the State Claims Agency) in acute hospitals reported as a % of bed days | Existing | Quarterly | 0.12% | ≤0.12% |
| **Patient Experience**<br>% of hospital groups conducting annual patient experience surveys amongst representative samples of their patient population | Existing | Annual | Not yet reported | 100% |
| **Dialysis Modality**<br>Haemodialysis patients Treatments Δ ** | Existing | Bi-Annual | 271,638-275,226 | 288,096 - 295,428 |
| Home Therapies Patients Treatments ** | Existing | Bi-Annual | 86,300 -87,161 | 90,647-93,259 |
| **Delayed Discharges**<br>No. of bed days lost through delayed discharges | Existing | Monthly | 225,250 | < 183,000 |
| No. of beds subject to delayed discharges | Existing | Monthly | 577 | < 500 |
| **HR – Compliance with EWTD**<br>European Working Time Directive compliance for NCHDs - < 24 hour shift | Existing | Monthly | 98% | 100% |
| European Working Time Directive compliance for NCHDs - < 48 hour working week | Existing | Monthly | 75% | 95% |
| **National Early Warning Score (NEWS)**<br>% of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals | Existing | Quarterly | 100% | 100% |
| % of all clinical staff who have been trained in the COMPASS programme | Existing | Quarterly | 63.6% | > 95% |
| **Irish Maternity Early Warning Score (IMEWS)**<br>% of maternity units / hospitals with full implementation of IMEWS | Existing | Quarterly | 100% | 100% |
| % of hospitals with implementation of IMEWS for pregnant patients | Existing | Quarterly | 78% | 100% |
| % of hospitals with implementation of PEWS (Paediatric Early Warning Score) ** | New PI 2016 | Quarterly | New PI 2016 | 100% |
| **Clinical Guidelines**<br>% of maternity units / hospitals with implementation of the guideline for clinical handover in maternity services | New PI 2016 | Quarterly | New PI 2016 | 100% |
| % of acute hospitals with implementation of the guideline for clinical handover | New PI 2016 | Quarterly | New PI 2016 | 100% |
| **National Standards**<br>% of hospitals who have commenced second assessment against the NSSBH | New PI 2016 | Quarterly | New PI 2016 | 95% |
| % of hospitals who have completed first assessment against the NSSBH | Existing | Quarterly | 80% | 100% |

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| % maternity units which have completed and published Maternity Patient Safety Statements and discussed at Hospital Management Team each month | New PI 2016 | Monthly | New PI 2016 | 100% |
| % of Acute Hospitals which have completed and published Patient Safety Statements and discussed at Hospital Management Team each month ** | New PI 2016 | Monthly | New PI 2016 | 100% |
| No. of nurses prescribing medication | New PI 2016 | Annual | New PI 2016 | 100 |
| No. of nurses prescribing ionising radiation (x-ray) | New PI 2016 | Annual | New PI 2016 | 55 |
| **COPD**<br>Mean and median LOS (and bed days) for patients admitted with COPD ** | Existing | Quarterly | 7.6<br>5 | 7.6<br>5 |
| % re-admission to same acute hospitals of patients with COPD within 90 days ** | Existing | Quarterly | 27% | 24% |
| No. of acute hospitals with COPD outreach programme ** | Existing | Quarterly | 15 | 18 |
| Access to structured Pulmonary Rehabilitation Programme in acute hospital services ** | Existing | Bi- Annual | 27 Sites | 33 Sites |
| **Asthma**<br>% nurses in secondary care who are trained by national asthma programme ** | New PI 2016 | Quarterly | New PI 2016 | 70% |
| No. of asthma emergency inpatient bed days used ** | New PI 2016 | Quarterly | New PI 2016 | 3% Reduction |
| No. of asthma emergency inpatient bed days used by <6 year olds ** | New PI 2016 | Quarterly | New PI 2016 | 5% Reduction |
| **Diabetes**<br>Number of lower limb amputations performed on Diabetic patients ** | Existing | Annual | Not Yet Reported | ≤488 |
| Average length of stay for Diabetic patients with foot ulcers ** | Existing | Annual | Not Yet Reported | ≤17.5 days |
| % increase in hospital discharges following emergency admission for uncontrolled diabetes. ** | New PI 2016 | Annual | New PI 2016 | ≤10% |
| **Epilepsy**<br>Reduction in median LOS for epilepsy inpatient discharges ** | New PI 2016 | Quarterly | New PI 2016 | 2.5 |
| % reduction in the number of epilepsy discharges ** | Existing | Quarterly | 11.4% | 10% Reduction |
| **Blood Policy**<br>No. of units of platelets ordered in the reporting period ** | Existing | Monthly | 21,000 | 21,000 |
| % of units of platelets outdated in the reporting period ** | Existing | Monthly | <5% | <5% |
| % usage of O Rhesus negative red blood cells ** | Existing | Monthly | <14% | <14% |
| % of red blood cell units rerouted ** | Existing | Monthly | <4% | <4% |
| % of red blood cell units returned out of total red blood cell units ordered ** | Existing | Monthly | <1% | <1% |
| **Reportable events**<br>% of hospitals that have processes in place for participative engagement with patients about design, | New PI 2016 | Annual | Data not due to be reported until Q2 | 100% |

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| delivery & evaluation of health services ** | | | 2016 | |
| Outpatients (OPD)<br>% of Clinicians with individual DNA rate of 10% or less ** | New PI 2016 | Monthly | New PI 2016 | 70% |
| Ratio of compliments to complaints ** | New PI 2016 | Monthly | New PI 2016 | TBC |
| National Cancer Control Programme | | | | |
| **Symptomatic Breast Cancer Services**<br>No. of patients triaged as urgent presenting to symptomatic breast clinics | Existing | Monthly | 16,800 | 16,800 |
| No. of non urgent attendances presenting to Symptomatic Breast clinics ** | Existing | Monthly | 23,500 | 24,000 |
| Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals ** | Existing | Monthly | 16,100 | 16,000 |
| % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals | Existing | Monthly | 96% | 95% |
| Number of attendances whose referrals were triaged as non- urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals (No. offered an appointment that falls within 12 weeks) ** | Existing | Monthly | 19,300 | 22,800 |
| % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks) | Existing | Monthly | 82% | 95% |
| Clinic Cancer detection rate: no. of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer ** | Existing | Monthly | >1,100 | >1,100 |
| Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer | Existing | Monthly | 11% | >6% |
| **Lung Cancers**<br>No. of patients attending the rapid access lung clinic in designated cancer centres | Existing | Monthly | 3,300 | 3,300 |
| Number of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres ** | Existing | Monthly | 2,800 | 3,135 |
| % of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres | Existing | Monthly | 86% | 95% |
| Clinic Cancer detection rate: Number of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer ** | Existing | Monthly | >825 | >825 |
| Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer | Existing | Monthly | 29% | >25% |
| **Prostate Cancer**<br>No. of centres providing surgical services for prostate cancers ** | Existing | Monthly | 8 | 7 |

| Acute Hospitals | | | | |
|---|---|---|---|---|
| **Service Area – Performance Indicator** | **New/ Existing KPI** | **Reporting Frequency** | **National Projected Outturn 2015** | **Expected Activity/ Targets 2016** |
| No. of patients attending the rapid access clinic in cancer centres | Existing | Monthly | 2,600 | 2,600 |
| Number of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres ** | Existing | Monthly | 1,630 | 2,340 |
| % of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres | Existing | Monthly | 62% | 90% |
| Clinic Cancer detection rate: Number of new attendances to clinic that have a subsequent diagnosis of prostate cancer ** | Existing | Monthly | >780 | >780 |
| Clinical detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of prostate cancer | Existing | Monthly | 38% | >30% |
| **Radiotheraphy**<br>No. of patients who completed radical radiotherapy treatment (palliative care patients not included) ** | Existing | Monthly | 4,900 | 4,900 |
| No.of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care ** | Existing | Monthly | 4,153 | 4,410 |
| % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included) | Existing | Monthly | 84% | 90% |
| **Rectal**<br>No. of centres providing services for rectal cancers ** | Existing | Monthly | 13 | 8 |

*** KPIs included in Divisional Operational Plan only*

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

# Quality and Access Indicators of Performance

| Quality | Expected Activity / Target 2016 |
|---|---|
| **Service User Experience** | |
| • Complaints | *System-wide PIs. See PI appendix* |
| **Safe Care** | |
| • Serious Reportable Events | |
| • Safety Incident Reporting | |
| • % of hospitals with implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals | 100% |
| • % of maternity units / hospitals with implementation of IMEWS | 100% |
| • % of hospitals with implementation of IMEWS for pregnant patients | 100% |
| • % maternity units which have completed and published Maternity Patient Safety Statements at Hospital Management Team each month | 100% |
| **Healthcare Associated Infections (HCAI)** | |
| • Rate of MRSA blood stream infections in acute hospital per 1,000 bed day used | < 0.055 |
| • Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used | < 2.5 |
| **Colonoscopy / Gastrointestinal Service** | |
| • % of people waiting < 4 weeks for an urgent colonoscopy | 100% |
| **Effective Care** | |
| **Stroke** | |
| • % of patients with confirmed acute ischaemic stroke who receive thrombolysis | 9% |
| • % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit | 50% |
| **Acute Coronary Syndrome** | |
| • % STEMI patients (without contraindication to reperfusion therapy) who get PPCI | 85% |
| **Re-admission** | |
| • % emergency re- admissions for acute medical conditions to the same hospital within 28 days of discharge | 10.8% |
| • % of surgical re-admissions to the same hospital within 30 days of discharge | < 3% |
| **Surgery** | |
| • % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2) | 95% |
| • % day case rate for Elective Laparoscopic Cholecystectomy | > 60% |
| • % of elective surgical inpatients who had principal procedure conducted on day of admission | 75% |

| Quality | Expected Activity / Target 2016 |
|---|---|
| **Emergency Care and Patient Experience Time** | |
| • % of all attendees at ED < 24 hours | 100% |
| • % of patients 75 years or over who were admitted or discharged from ED within 9 hours | 100% |
| **Average Length of Stay** | |
| • Medical patient average length of stay | 7.0 |
| • Surgical patient average length of stay | 5.2 |
| • ALOS for all inpatient discharges excluding LOS over 30 days | 4.3 |
| **Symptomatic Breast Cancer Services** | |
| • Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer. | > 6% |
| **Lung Cancers** | |
| • Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer. | > 25% |
| **Prostate Cancers** | |
| • Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of prostate cancer. | > 30% |

| Access | Expected Activity / Target 2016 |
|---|---|
| **Discharge Activity ∞** | |
| • Inpatient Cases | 621,205 |
| • Inpatient Weighted Units | 623,627 |
| • Daycase Cases | 1,013,718 |
| • Daycase Weighted Units | 1,010,025 |
| • Total inpatient and daycase Cases | 1,634,923 |
| **Outpatients** | |
| • No. of new and return outpatient attendances | 3,242,424 |
| • Outpatient attendances – New : Return Ratio (excluding obstetrics and warfarin haematology clinics) | 1:2 |
| **Inpatient, Day Case and Outpatient Waiting Times** | |
| • % of adults waiting < 15 months for an elective procedure (inpatient and day case) | 95% |
| • % of adults waiting < 8 months for an elective procedure (inpatient and day case) | 70% |
| • % of children waiting < 15 months for an elective procedure (inpatient and day case) | 95% |
| • % of children waiting < 20 weeks for an elective procedure (inpatient and day case) | 60% |
| • % of people waiting < 15 months for first access to OPD services | 100% |

| Access | Expected Activity / Target 2016 |
|---|---|
| • % of people waiting < 52 weeks for first access to OPD services | 85% |
| **Colonoscopy / Gastrointestinal Service** | |
| • % of people waiting < 13 weeks following a referral for routine colonoscopy or OGD | 70% |
| **Emergency Care and Patient Experience Time** | |
| • % of all attendees at ED who are discharged or admitted within 6 hours of registration | 75% |
| • % of all attendees at ED who are discharged or admitted within 9 hours of registration | 100% |
| • % of ED patients who leave before completion of treatment | < 5% |
| **Delayed Discharges** | |
| • No. of bed days lost through delayed discharges | < 183,000 |
| • No. of beds subject to delayed discharges | < 500 |
| **Acute Medical Patient Processing** | |
| • % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration | 75% |
| **Symptomatic Breast Cancer Services** | |
| • No. of patients triaged as urgent presenting to symptomatic breast clinics | 16,800 |
| • % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals. | 95% |
| • % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals *(% offered an appointment that falls within 12 weeks)* | 95% |
| **Lung Cancers** | |
| • No. of patients attending the rapid access lung clinic in designated cancer centres | 3,300 |
| • **%** of patients attending the lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres. | 95% |
| **Prostate Cancers** | |
| • No. of patients attending the rapid access prostate clinics in cancer centres | 2,600 |
| • % of patients attending the prostate rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre. | 90% |
| **Radiotherapy** | |
| • % of patients undergoing radical treatment who commenced treatment within 15 working days of being deemed ready to be treated by radiation oncologist (palliative care patients not included). | 90% |

*∞Discharge Activity in Divisional Operational Plan target 2016 are based on Activity Based Funding (ABF) and weighted unit (WU) activity supplied by HPO. Dialysis activity is included in ABF day cases and WU. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU*

# Appendix 4: Capital Infrastructure *– Capital Projects that will be completed in 2016*

| Facility | Project details | Project Completion | Fully Operational | Additional Beds | Replace-ment Beds | Capital Cost €m | | 2016 Implications | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 2016 | Total | WTE | Rev Costs €m |
| **Dublin Midlands Hospital Group** | | | | | | | | | |
| Midland Regional Hospital, Portlaoise Co. Laois | Redevelopment (phase1), acute medical unit, day services. | Q2 2016 | Q3 2016 | 0 | 20 | 2.10 | 5.50 | 0 | 0.00 |
| Midland Regional Hospital, Tullamore, Co. Offaly | Provision of a replacement MRI and additional ultrasound. | Q4 2016 | Q1 2017 | 0 | 0 | 2.05 | 2.57 | 0 | 0.00 |
| Tallaght Hospital – AMNCH | Provision of an extended oncology/haematology day unit and relocate service from Burkitt Ward (16 beds back in use). Also link partially vacated Beech Ward to Lynn Ward creating 11 additional adult beds [co-funded from Winter capacity initiative]. | Q4 2015 | Q1 2016 | 16 | 11 | 0.4 | 1.20 | 0 | 1.90 |
| **NATIONAL CANCER CONTROL PROGRAMME** | | | | | | | | | |
| St. Luke's Hospital, Dublin | Provision of interim facilitates, (phase 2 – radiation/oncology project). | Q2 2016 | Q3 2016 | 0 | 0 | 3.58 | 7.00 | 0 | 0.00 |