Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Ireland East Hospital Group

Operational Plan 2016

Contents

Ireland East Hospital Group Operational Plan 2016

Introduction

The Ireland East Group is the largest of the seven hospital groups and comprises eleven hospitals in Leinster (including 6 voluntary hospitals) and is partnered with University College Dublin. The group provides services covering the full range of clinical tertiary and a number of quaternary services to upwards of 1 million people. IEHG tertiary services include: the National Centre for Cardiothoracic Surgery, the National Spinal Surgery Centre, National Cystic fibrosis and Pulmonary Hypertension centres as well as national centres for Heart, Lung, Heart & Lung, Liver, Pancreas, and Cornea transplantation. It has a budget allocation of €814m and employs just over 10,000 staff.

The Group aims to deliver consistent high quality safe healthcare outcomes for the 1.1 million people served across the 11 hospitals. This will be undertaken by providing a patient-focused, quality health system that is accessible and sustainable for all patients receiving or needing care within the Ireland East Hospital Group.

The Group includes the following hospitals:

Mater Misericordiae Hospital	Midlands Regional Hospital, Mullingar
National Maternity Hospital, Holles Street	Our Lady's Hospital, Navan
Cappagh National Orthopaedic Hospital	Wexford General Hospital
Royal Victoria Eye and Ear Hospital	St. Luke's General Hospital, Kilkenny
St. Michael's Hospital, Dun Laoghaire	St. Columcille's Hospital
St. Vincent's University Hospital	

IEHG has a significant number of national specialties and delivers a complex range of specialists services which include:

- National Centre for Cardiothoracic Surgery '
- National Heart and Lung Transplantation Centre
- National Liver Transplant centre
- National Spinal Surgical Unit
- National Pancreatic Transplant Programmes (commencing 2016)
- National adult Cystic Fibrosis Centre
- National Pulmonary Hypertension Unit and adult ECLS
- Two designated Cancer centres including the national referral centres for neuroendocrine tumours, hepatoma and retroperitoneal cancers.

- Tertiary referral centres for ophthalmology and corneal transplantation and complex Intensive Care Medicine

The establishment of the IEHG is supported with a detailed Work Programme which provides a comprehensive framework for delivering on the Groups key strategic priorities as it works initially towards creating an academic Hospital Group and ultimately as the Group progress towards the establishment of an integrated Hospital Trust.

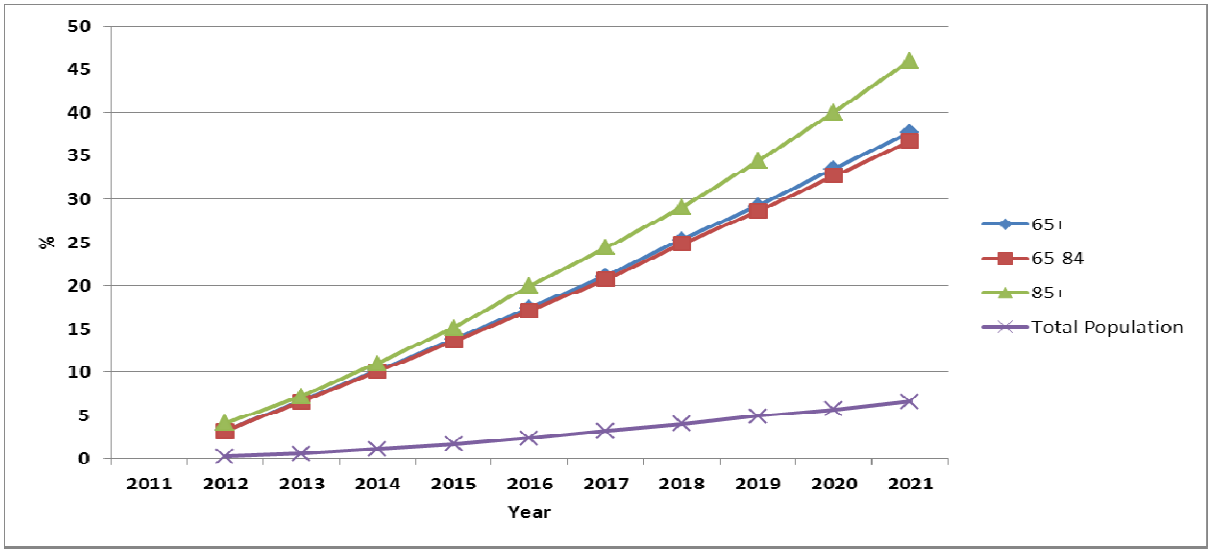
The work programmes include: Governance, Quality and Patients Safety, Clinical Services Design and Re-organisation incorporating the development of an Academic Health Sciences Centre, Corporate Services, Communication, Innovation, Integration with Primary, Continuing and Community Care and Influencing. UCD, our partner university participates on all of the framework programmes.

A steering group will oversee the development of a Group Strategic Plan for service configuration and integration consistent with national objectives for delivery of patient services. At present the Group is mapping services across each of the 11 hospitals as part of the strategic plan. The group will work closely with the System Reform Group to progress the individual projects within each hospital.

Impact of Demographics on Hospitals

Nationally the demand for acute hospital services 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 over 65 year age group is increasing at a steeper rate, and of the order of 3-4% per year. In 2016 we can expect a projected increase of 32,500 persons in our population, including an increase of 19,400 aged 65 years and over and an increase of 2,900 persons of 85 years and over. Figure 1 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.

Figure 1: Projected cumulative percentage change in 65 years and older population versus total population 2011 – 2021



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 Inpatient and Day Case activity, 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.

- In 2014, adults 85 years and over represented 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 age 65 is an increase of 3.4% from 2015 to 2016.

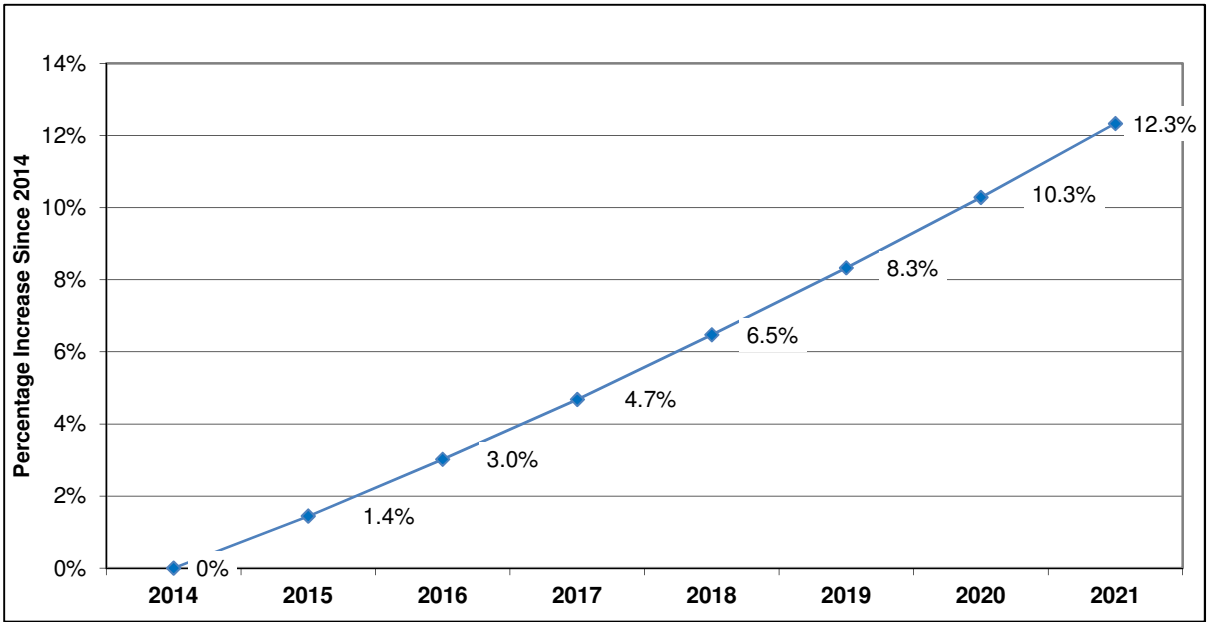
The increase in the population and the higher increase in the population over 65 is putting increasing pressure on hospital resources. Combining in-patient and day case discharges provides a view of total cost pressures facing publicly funded acute hospitals in managing their in-patient workloads over 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.

Comparing 2014 and 2015I, there was a 4% increase in ED attendances of patients aged 85 and over and an increase of 6% in admissions from the ED resulting in a 6% increase in bed days used in one IEHG level 4 hospital.

From 2015 to 2016, demographically driven cost pressures of 1.6% are predicted. Figure 2 below represents total in-patient and day case cost pressures for 2014 to 2021 and 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.

Nationally this equates to €64m of the net 2015 allocation to keep up with the demographic pressure. It is clear that changes in the model of care relating to the frail elderly area and chronic conditions are key to addressing this challenge in the medium to longer term. However in 2016 pressure will continue to fall directly upon hospitals adding to demands without a corresponding increase in resources.

Figure 2: Total in-patient and day-case cost pressures, 2014 to 2021.



- *Source: HPO and CSO.*

In the context of developing Activity Based Funding (ABF) as the funding model for the health services this 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 current budget allocated to IEHG for 2016 however does not reflect the affordable activity level and this is outlined in the finance section below.

Developments and Challenges 2016

The services outlined in this operational plan are aligned with those agreed in the HSE National Service Plan 2016. It is intended in 2016 to deliver an equivalent volume of activity as that delivered in 2015 however there is widespread acknowledgement that the financial challenges for all Hospital Groups are significant. IEHG will have to comply with significant cost control and cost reduction measures and there will be a significant focus on controlling the total pay and non-pay costs as well as maximising income. The specific challenges in meeting the financial and activity targets while ensuring delivery of safe care at the 2015 volumes are further discussed in this report. The Group is currently in discussion with the HSE Acute Hospitals Division to address the disparity in funding sought by IEHG to address service requirements and planned/approved developments (including winter initiative, the new developments in Wexford and Kilkenny as well as full costs associated with the establishment of the pancreatic transplant service to SVUH and full year costs of 2015 developments) with the actual allocation received in 2016.

When account is taken of the 2015 cost of services, expected cost growths, approved service developments and initial cost saving measures, a preliminary funding shortfall for IEHG of €45m remains to be addressed. The Group is conscious of the ongoing considerable challenges faced by staff in managing increasing demands within an environment of fiscal constraint, reducing budgets and higher expectations. Notwithstanding the cost reduction measures implemented in recent years and the Group will continue to impose a number of measures to control costs, reduce waste and improve efficiency aimed at minimising any impact on clinical services. There is however limited scope to manage within the allocated funding without risk of compromising service delivery.

Options to address the funding shortfall have been considered during the service planning process and there will be ongoing discussions with hospitals and the HSE during the year to aligning activity levels to the funding available. There are significant risks inherent in operationalising such an option and more importantly on the negative impacts for patient access to services and for staff morale. Cost containment measures will impact hospital's abiltiy to address the growing demand for services, curtail new developments and impact the management of waiting lists within the target times and increase access times to core services and potentailly impacting patient safety .

The targets that need to be achieved in relation to these measures are very challenging and carry significant delivery risk. IEHG will ensure that appropriate management effort and attention are applied to maximising the delivery of savings measures and overall budgetary performance. The HSE and the Department of Health (DOH) have already acknowledged the shared risks inherent in the extent of the savings targets and the assumptions underpinning them, which have been mutually agreed following extensive engagement in light of the alternative which is service reductions, within the service planning process. This is considered preferable in light of the alternative which is service reductions.With regard to inpatient activity it is recognised that the imperative is to continue to shift to day case activity in terms of enabling optimum access at the most efficient cost. The planned work undertaken by the system will give priority to urgent and complex cases. In terms of activity IEHG will also seek to optimise existing capacity through reducing length of stay and shifting care to appropriate settings including primary care.

Allowing for the financial constraints IEHG will seek to deliver:

- Day case activity∞ at 105% of 2015 levels (including a number of cases to be provided within primary care)

- Inpatient activity∞ target is to deliver 2015 levels
- Emergency inpatient activity∞ will be at 100% of 2015 levels
- OPD activity will be funded at 100% of 2015 levels
- The target for % of adults waiting < 15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 90% compliance against this target. The projected compliance for 2016 is 95%
- The target for % of adults waiting < 8 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 66% compliance against this target. The projected compliance for 2016 is 70%
- The target for % of children waiting <15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 95% compliance against this target. The projected compliance for 2016 is 95%
- The target for % of children waiting < 20 weeks for elective procedure (inpatient and cay case) was 100% in 2015 and it is expected that the outturn for 2015 will be 55% compliance against this target. The projected compliance for 2016 is 60%
- The target for % of people waiting <15 months for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 90%. The projected compliance for 2016 is 100%
- The target for % of people waiting < 52 weeks for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 85%. The projected compliance for 2016 is 85%

In Patient and Day Case Activity 2016

The National Service Plan 2016 has already set out the inpatient and day case activity based on projected activity outturn for 2015 using data returns from the hospitals to the Acute Business Intelligence Unit (BIU). 2016 sees the migration from BIU data to Hospital In- Patient Enquiry Scheme (HIPE) which determines the inpatient and day case activity that can be delivered within the envelope of funding available.

Traditionally hospitals submit monthly data to BIU from reports generated by the Patient Admissions Systems (PAS) which often have to be manually adjusted to provide full data set. The HIPE data are validated, available at discharge level and include administrative, demographic and clinical information. Each record on HIPE is grouped to a diagnostic related group (DRG) and a complexity-weighted unit of activity is applied, allowing for comparison in resource use in addition to simple comparisons of numbers of discharges. While BIU data are available more quickly than HIPE data it is less granular and it is not possible to drill down to individual discharges.

As part of the reconciliation of BIU and HIPE data in preparation for the transition in 2016 to ABF 2.3% additional discharges (inpatient and day cases) were noted to have been reported to BIU in 2015 from a number of hospitals. 63% (1.5% total activity) of the additional discharges can be attributed to patients being treated as an inpatient in ED prior to being transferred to a ward bed, acute psychiatry patients and outpatient procedures being inadvertently reported as day cases. Whilst the HSE address the financial challenges of achieving increased efficiency, value for money and budgetary control in 2016, it is imperative to have full alignment between activity and costs. Therefore only HIPE activity will be used for measuring and monitoring inpatient and day case activity and this is reflected in activity projections included in this operational plan and in the Hospital Group Operational Plans.

IEHG intends to increase the amount of day case activity undertaken in St. Luke's Hospital, Kilkenny in 2016. This will be facilitated with the opening of the Suzi Long Day Surgery Unit which has doubled the capacity from 12 to 24 dedicated day beds. Availing of this capacity will enable the hospital to address the significant backlog in endoscopy services locally and to manage referrals on an ongoing basis in line with national targets.

Risks to the delivery of Acute Hospitals plan within funding available

In identifying potential risks to the delivery of this operational plan, it is acknowledged that while every effort will be made to mitigate these risks however it will not be possible to eliminate them in full.
The shortfall in the 2016 allocation is the most significant risk to IEHG's ability to deliver high quality safe care in line with the Service Plan. The clinical risks arise from an inability to provide appropriate timely access to service and to support optimal staffing levels.

Other identified risks include:

- Capacity to cap the introduction of drugs and medical devices including transcatheter aortic valve implantations (TAVIs)
- Capacity to control activity∞ volumes to the targeted level under ABF
- Capacity to maintain and collect income
- Capacity to achieve pay and non-pay cost control at the level required while demographic impacts drive demand for services
- Ability to contain activity∞ to 2015 levels for emergency care and urgent and routine elective treatments
- Delayed discharges are not reduced to and maintained for IEHG at <140 during 2016
- Service risks related to limited capacity in Intensive Care (ICU)
- Continued or accelerated demographic pressures over and above those already planned for in 2016
- The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce
- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system constraints
- Pay cost growth which has not been funded
- Risks associated with the delivery of procurement savings (targeted at €9.9M nationally).
- Lack of contingency funding to deal with unexpected service or cost issues
- Curtailment of new development particularly around the opening of new units.
- Impact of pay bill management framework
- Increasing numbers of elderly patients and no additional beds coming on stream.
- Risk associated with delivering the 2% DRG price reduction

Clinical and Integrated Care Programmes

IEHG will work with the clinical and integrated care programmes as they lead a number of priority programmes to design, develop and progressively implement models of care which will incorporate cross service, multi-disciplinary care and support which will facilitate the delivery of high quality evidence based and coordinated care.
In view of the increasing numbers of elderly patients presenting to acute hospitals, particular focused will be required on the integrated care programme for Older Persons.

Conclusion

Notwithstanding the challenges ahead, IEHG will strive to achieve key service objectives for 2016 which include:

- Sustain access to urgent and planned care by increasing efficiencies, streamlining processes and maximising capacity in hospitals. IEHG pursue an ambitious programme of productivity improvement in order to reduce the disparity between need and the availability of funding. This will be supported through the roll out of Lean/Six Sigma initiatives to improve processes across the scheduled and unscheduled care setting
- Commence implementation of the Maternity Strategy
- Embed robust governance structures in line with the HSE Accountability Framework

- Build effective managerial and clinical networks across the IEHG hospital group which will provide direct support to the smaller hospitals in the groups. This will include development of model 2 hospitals to support elective activity in the level 4 hospitals
- Develop and improve capacity for quality and patient safety within the Group through the establishment of a defined patient safety and quality framework that will address patient advocacy, complaints, incident management and response, learning systems and service improvement
- Continue to progress a strategic plan and progress the Framework Programme to enable the Group to move towards independent Trust status.
- Support the phased implementation of Activity Based Funding Model with the use of the Hospital Inpatient Enquiry *system (HIPE)* data to determine the volume of cases required to be undertaken by IEHG hospitals in 2016 ∞
- Work with the National Cancer Control Programme (NCCP) in the implementation of the new National Cancer Strategy 2016-2025 and establish a joint Cancer Clinician Academic Directorate (CAD) across the Mater Hospital and St. Vincent's University Hospital with UCD as the academic partner.
- Delivery of an IEHG Strategic Plan.

Improving Quality and Reforming Service Delivery

Quality and patient safety is at the heart of healthcare delivery within IEHG. During 2015, IEHG established a Quality and Patient Safety Committee and has recently appointed a director to head up a Quality and Risk Directorate within the Group. The directorate will be further supported with the appointment of a Head of Risk and a Head of Quality Improvement.

This directorate has a wide remit which includes monitoring and oversight of all Serious Reportable Events (SREs) and clinical investigations. It will also be responsible for, system analysis training and the introduction of learning systems for serious safety incident and for the implementation of all regulatory reports including HIQA reports

In addition the directorate will have responsibility for ensuring IEHG compliance with the National Standards for Safer Better Healthcare (self-assessments, quality initiatives) and other HIQA, NOCA and HSE quality improvement processes.

A Quality & Safety baseline assessment will be completed in 2016. As part of the baseline assessment a review of PPPG's (Policies, Procedures, Protocols and Guidelines) across the group will be undertaken to see how these can be aligned to national PPPG's

Clinical Governance

Establishing a clinical governance framework will be a priority in 2016. This will include:

- Developing a Group QPS structure with internal and external stakeholders.
- Developing a Group Quality & Risk strategy.
- Implementing a monitoring framework incorporating continuous quality improvement initiatives.

Quality-driven Clinical Performance

- **Medication Safety:** Medication errors resulting in harm will be considered a core patient safety metric for the IEHG. A newly appointed Group Risk manager will undertake a group-wide gap analysis of medication incidents, and adherence to operational controls. This will inform IEHG policy for medication error investigation, reporting, analysis and improved controls and identify the tolerance threshold for medication errors. In addition, a separate project will examine medication reconciliation success at individual sites with a preliminary target of achieving 80% reconciliation at time of discharge from hospital.

- **Sepsis**: IEHG recently appointed a Group ADON for Sepsis who will provide intensive programme and change management support to the hospitals in the Group when implementing the Sepsis Management – National Clinical Guideline No. 6 and represent the Group on the National Clinical Programme for Sepsis. The Group ADON will ensure a standardised approach to implementing the National Clinical Guideline both at Group and National level, working collaboratively with the clinical programmes and relevant Divisions of the HSE.

  In particular, we will develop a plan for implementing the National Clinical Guideline in each hospital; complete a gap analysis in each Hospital on the implementation of the guideline; support the sepsis steering group in each hospital to develop an action plan, informed by GAP analysis, for implementation of the Guideline in each Hospital Group; undertake a series of compliance audits in each hospital at identified intervals; provide feedback on compliance audits to individual hospitals, the IEHG and the National Sepsis Programme; provide a report of activity to date for National Clinical Lead for Sepsis; undertake a roll out status audit for all hospitals and report findings to the IEHG and the National Sepsis Programme.

Ensure control and prevention with compliance with targets of healthcare associated infections/AMR with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms, underpinned by the implementation of HIQA *National Standards for the Prevention and Control of Healthcare Associated Infections*.

Outputs from this initiative will include 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 and monthly reporting of hospital acquired S Aureus bloodstream infection and hospital acquired new cases of C Difficile infection.

- **Pressure Injuries**: All IEHG hospitals (excluding NMH) will participate in the Pressure Ulcer to Zero Collaborative, co-ordinated with Quality Improvement Division at HSE. Pressure sore rate per 1000 bed days will be included in the quality dashboard metrics made available to the IEHG executive and Board.

- **EWS**: Recognition of the clinical deteriorating patient: IEHG will develop self-audit schedules and follow-up action plans in each of the hospital groups for NEWS, IMEWS and pEWS.

- **Falls**: Decrease in the severity of injuries related to falls. IEHG will establish uniformity in the mechanism for assessing and reporting falls and falls-associated injuries.

Quality Assurance & Verification Process

The IEHG Executive will ensure that quality and risk issues are leading items on the management agenda. The reporting framework ensures that top level measurements of safety and quality are reviewed at the peak "Safety and Quality Performance Committee" and at the IEHG Executive Committee. The Risk Management Strategy will set out the IEHG approach to risk identification, stratification, and control selection in addition to gaining assurance on the effectiveness of control.

Each sub-committee of the "Quality and Patient Safety Committee" will own the individual risks identified and be responsible for assessment, management and escalation of risk.

All clinical incidents and complaints will be captured on an incident management system, with governance oversight awarded to IEHG. Additionally, we will co-operate with Quality Assurance and Verification Division, HSE on the roll out of Phase Two of the National Incident Management System. The newly appointed group risk manager will work closely with all hospitals to identify key high risk areas and actions plans for mitigation. Systems analysis training is being organised for staff within the Group and the QPS department established by the end of 2015 will act as the support base for IEHG hospitals in conducting reviews. IEHG will support the roll out of the Maternity Neonatal Clinical Management System to the National Maternity Hospital

IEHG has developed a group **risk register** which will continue to be updated and managed. Where appropriate, risks will be escalated to national level. The risk register itself will be reviewed by the Executive and the Safety and Quality Performance Committee on a quarterly and bi-monthly basis, respectively. The register will adhere to an enterprise risk register model; the principle pillars of the register will include Governance, Operating Systems, Workforce, Workplace Health & Safety, Finance, Patient Experience, Mission & Values, Estates, Environment and Infrastructure.

Discussions are ongoing in relation to management of historic cases which, prior to the establishment of IEHG had been managed by the HSE.

Key deliverables as part of the quality assurance process for 2016 will be:

a) Implementation of an IEHG Quality Strategy

b) Streamlining clinical performance reporting, with a shift from operational KPI's to treatment outcomes-based metrics; a reduction in the number but consistency in metrics captured; and creation of tailored performance dashboards from bedside to boardroom.
c) Integrated system of risk management and governance to ensure timely and responsive reaction to risks and incidents as they arise.
d) Roll out of systems analysis training for staff across the Group,

Patient Engagement

The Quality and Safety directorate will also be central to the development of an IEHG–patient engagement strategy. It will put in place effective systems in each hospital to hear concern raised by patients, service users, staff and other concerned individuals.

Response to recommendations from the Portlaoise Report

Following publication of the report, IEHG undertook a gap analysis against the recommendations to identify areas requiring attention and assistance. The implementation of the recommendations will be progressed during 2016.

Operational Framework – Financial Plan

Financial Framework

The IEHG has an allocation of €814.064m to deliver services in 2016. The allocation is €24m or 2.9% less than the final allocation for last year. The current notified allocation excludes funding for the following items of expenditure:

- Winter Initiative.
- Full Year Cost of 2015 Developments.
- 2016 Approved Developments.

The final allocation for 2015 was €838.072m. The budget reduction compared to 2015 is therefore €24m or 2.9%.

The current estimated Cost of ELS for 2016 is €882.367m. The IEHG consider it can deliver €6m in Cost Containment Plans in 2016, thus giving a projected net expenditure of €876.344m. Given the current notified allocation of €814.064m leaves an overall financial challenge of €62.280m or 7.7%. Some of this challenge would be reduced by:

- Funding of high cost drugs through the PCRS and the NCCP
- Funding of approved new developments,
- Receipt of Winter Initiative funding

These issues are currently being addressed in discussions between IEHG and the HSE Acute Hospitals Division. The plan aspires to achieve the same level of activity as delivered in 2015 but it should be recognised that there is a significant financial challenge contained in the funding allocated to the IEHG. The same level of services cannot be maintained if staffing levels reduce.

Allocation Framework

The allocation for 2016 reflects Government policy in moving from the traditional rollover allocation to an Activity Based Funding (ABF) model. The ABF model funds episodes of care in our acute services at the national average price reduced by an average of 2% for 2016, with a transitional adjustment applied in order to smooth the transition from actual costs to the national average price.

The transitional adjustment may be either positive or negative. For the IEHG, that is the most cost efficient provider of acute services in the country, this adjustment is a negative figure. Latest calculations show that the gross cost of our services is €19.5m less than the national average cost and therefore a negative adjustment of this amount was applied to the ABF funding amount. In conclusion the IEHG is significantly more cost effective than the highest cost hospital group.

ABF applies to the Gross Cost of ABF services (Inpatient and Day case Services) and a block grant remains in respect of the other services provided by our hospitals E.g. Outpatients etc.

Finally, an Income Budget is allocated to the IEHG which includes financial estimates included in the HSE 2016 NSP.

The following Table summarises the constituent elements of our 2016 Allocation:

Table 1 – 2016 IEHG Allocation

Description	€M
ABF Gross Revenue	686.530
Transition Adjustment	(15.091)
ABF Net Revenue	**671.439**
Block Grant	347.409
Gross Expenditure Budget	**1,018.848**
Income Budget	(211.938)
Net IEHG Allocation	**806.910**
LRA	**2.284**
Increments	**4.871**
Notified Allocation	**814.064**

2016 Budget Adjustments

The 2016 allocation contains significant budget adjustments that will be challenging to achieve. The following are the main elements of those adjustments and associated funding reductions:

1. DRG Prices – The national average prices are reduced by 2% versus prior year cost. This impacts the IEHG by approximately €15m. This will be difficult to achieve given that the IEHG is the most cost efficient hospital group.
2. Pay Cost – It is noted that while the cost of growth in WTE in 2015 was funded on a once-off basis, this funding did not rollover into 2016.
3. The Income Budget Target – this includes 3 specific stretched targets for the generation of private patient income in 2016. Those additional targets represent an increase income target of approximately €30m or 15.6% for the IEHG.
    a. Achieve 75% of any shortfall in the 2015 targeted Maintenance Income
    b. Achieve growth of 4.55% in private patient market
    c. Accelerated Income – IEHG shared in the €50m national target which is effectively a cash collection target that has been transformed into an income generation target.
4. Non Pay Inflation – This element of cost growth is not adequately funded for 2016.
5. Activity Targets – The IEHG have increased activity of 1.8% for inpatients and 0.8% for day cases compared to 2014

Conclusion & Financial Risks

This plan aspires to deliver an equivalent volume of activity as that delivered in 2015. It must be acknowledged that the financial challenge in this plan is significant. The focus will be on controlling the total pay and non-pay costs as well as maximising income. The plan prioritises delivering safe care at the 2015 volumes. This emphasis is partly driving the financial challenge.

In summary, when account is taken of the 2015 cost of services, expected cost growths and initial cost saving measures this leaves a preliminary funding shortfall of €50m or 6% to be addressed.

The IEHG will prioritise its efforts around strengthening payroll controls, reducing waste and increasing productivity in order to mitigate the continuing annual growth in health costs pressures being experienced in Ireland and internationally. Thereafter to the greatest extent practical and consistent with the safe delivery of services we will deliver services at 2015 levels or at an increased level where this is supported by the funding available. The demand led nature of unscheduled care and the impact of the growing number of frail elderly population are potential cost drivers that could affect performance.

The IEHG fully acknowledges the requirement to operate within the limits of the funding notified to it and will ensure this receives the very significant management focus required in 2016.

Given the scale of the demographic, regulatory and other service pressures it is estimated that across the healthcare service areas there is a substantial financial risk being managed within this operational plan. With the introduction of revised funding mechanism for hospitals, IEHG will ensure that all hospitals have appropriate

financial management systems in place to allow for appropriate coding and funding of activity. This will be supported with the appointment of an Activity Based Funding (ABF) Accountant.

In the context of the above, the following are the risks associated with this plan:

1. Reduction in the DRG cost in the IEHG may not be achievable given that the IEHG is the most cost effective hospital group. Therefore there is very limited scope for overall cost reduction initiatives across the group.
2. Activity levels will not generate the necessary level of AFB Revenue due to quantity of services delivered and/or the acuity of patients who present at our A&E's.
3. Pay Costs – The capacity to exercise effective control over pay and staff numbers in the context of safety and quality, regulatory, volume and practice driven pressures.
4. The impact of increased demand for services beyond the planned and funded levels arising from changes in demographics and consumer expectations.
5. The capacity to recruit and retain a highly-skilled and qualified medical and clinical workforce, particularly in high-demand areas and specialties.
6. Clinical Non Pay Costs – Control of clinical non pay costs such as high cost drugs, laboratory costs etc. are difficult to control given that they can be influenced by international markets and new technology costs. Pathology costs are growing due to referrals from GP practices during 2015. Capacity to cap the introduction of drugs and medical devices including transcatheter aortic valve implantations (TAVIs).
7. The introduction of ABF may give rise to confusion in the funding process.
8. The stretched Income targets set for the IEHG may not be achievable or achieved.
9. The demographic of our patient population is aging which is leading to increased presentations and longer length of stay, thus leading to increasing costs.
10. The limitations of our clinical, business information, financial and HR systems.
11. Capacity and resources to continue to develop and involve staff in driving change and improving quality and safety and the culture of the organisation.
12. Unavoidable public pay policy and approved pay cost growth in areas which have not been funded including staff increments.
13. Risks associated with our capacity to invest in and maintain our infrastructure and equipment.

Operational Framework – Workforce Plan

Introduction

IEHG employs just over 10,500 whole time equivalents. A priority for the Group is to develop a connected, committed, productive and engaged workforce to deliver world class healthcare through the provision of a patient-focused, quality health service that is accessible and sustainable for patients receiving or needing care within the Group. The Strategic Framework developed for IEHG sets out a very challenging agenda for all Hospitals and Services in the Group over the period 2015 - 2017. Key to delivering on these strategic ambitions is the willingness of staff to engage in a significant change management programme which will result in a Clinical Service Reconfiguration and Redesign to meet the current and future needs of patients.

Recognising the vital role all employees will play in the achievement of the priorities the Group is committed to develop value and support all employees and create a workplace that fosters a culture of high trust, openness and continuous professional development.

IEHG recognises and acknowledges staff as its most valuable resource and key to service delivery. Recruiting and retaining motivated and skilled staff is a high priority for the Group as specialist skills deficits within health care pose a serious threat to the delivery of services and many workforce planning initiatives are in progress to address these concerns. 2016 will see a focus on the HSE "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, value and support people, thereby creating a culture of high trust between management and employees, supporting the achievement of performance. The Group will support and facilitate continuous professional development and learning, leadership and teamwork and manage change with a view to improving service delivery and performance.

The Workforce Position

Government policy requires that the number of people employed in Acute Hospital Services is within the limit of the available funding. 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 Hospital Groups to operate within the funded pay envelope is a key priority for 2016, alongside the management of risk and service implications.
This approach sees a transition from moratorium to an accountability framework designed to support creation of annual and multi-annual workforce plans based on models of care that will deliver services within allocated pay resources. To support this framework IEHG has established an Employment Control Committee (ECC) which meets monthly to assess and where appropriate approve new posts in the statutory hospitals within the confines of the HSE control framework.

A priority for IEHG is the development of a comprehensive workforce plans for 2016 which aligns with funding projections.

Hospitals Employment Levels

The number of staff employed within the IEHG increased by 6.8% (675 WTEs) in the twelve months to December 2015. The majority of these staff were Patient and Client care (increase of 22%). Increases were also seen in health and social care professionals and medical/dental staff. The growth in staffing numbers during 2015 was a result of the lifting of the moratorium and appointment of a number of key posts to address staffing shortfalls. Hospitals were encouraged to convert agency posts as a means of improving continuity of care and reducing costs.
IEHG will work with the individual hospitals to manage the staffing demands against the national requirement to reduce total staff numbers in 2016 to achieve the financial targets contained within this plan. As a result of this converstion agency costs within IEHG reduced in between 2014 and 2015 by €3.2m and this trend is expected to continue. Additiaonl measures to improve pay-bill management and agency control have been introduced and these will continue in 2016.

IEHG expects to increase staffing in Wexford and Kilkenny for the approved new units and for additional staff in SVUH associated with the pancreatic transplant programme. Other workforce additions, not specifically funded at the outset of the year, will be implemented where offset by funding redirection within the allocated pay envelope. This includes a number of priority posts for IEHG identified under the IEHG Strategic Plan/Framework.

Reducing Agency and Overtime Costs

IEHG will continue to focus on further reductions in the cost and reliance on agency staff and overtime during 2016. This will involve services developing appropriate plans for agency conversion and reduction in overtime expenditure across all services and staff categories, to deliver appropriate and cost effective services.

The Group will continue to monitor and review agency and overtime costs whilst working to support hospitals with implementing initiatives to reduce costs, such as redeployment, skill mix review, and changes in work practices. IEHG has already established a nursing staff bank which is designed to develop a transferrable quality nursing service to meet the increasing demands for nursing care and to reduce to existing cost of agency nursing.

2016 Developments

The 2016 National Service Plan has set out approved service developments for the acute hospitals and funding has been allocated to IEHG to support the appointment of additional staff in key priority developments in maternity, organ transplantation and to support the opening of new units in Kilkenny and Wexford.

Public Service Stability Agreements 2013-18

The Lansdowne Road Agreement 2015 builds upon the agreement set out in the Haddington Road Agreement (HRA) until 2018. This includes an extension of the enablers, such as additional working hours, to support reform, reconfiguration and integration of services. It also includes issues such as skill mix initiatives, systematic review of rosters, de-layering of management structures, restructuring and redeployment of existing workforce, new organisation structures and service delivery models. The new agreement includes a strengthened oversight and governance arrangement for dealing with matters of implementation and interpretation in the event of disputes that may arise. IEHG in conjunction with the HSE Acute Hospital Division 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.

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

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

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

In 2016, as per the Final Agreement for Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement the following tasks will transfer from Medical to Nursing staff in line with the 2015 associated National Framework and Task Transfer Verification Process:

- Peripheral cannulation
- Phlebotomy
- Intra Venous drug administration — first dose; including in the appropriate setting
- Nurse led delegated discharge of patients.

Workforce Planning & Recruitment

IEHG has appointed a HR Director who is the Group lead in the development of a high quality workforce plan. The plan will ensure that funded workforce plans are developed at Hospital level, which are practical, reasonable and aligned to best practice. This will require ongoing review of skill mix requirements and effective staff deployment to manage workforce changes. The funding for these plans will be managed through the Pay Bill Management and Control framework. This will also 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. Specific emphasis will be placed on recruitment of key staff in medical, nursing and allied health for the Group. A nursing bank is to be established to support filling of nursing vacancies within the region.

IEHG is developing a strategy for specialties across the Group to meet demand and demography whilst acknowledging neighbouring group services, recognising established national specialties and matching developing national strategies such as the provision of elective services. The Group is compiling a capacity review across all hospitals to identify the precise allocation of available facility resources including, theatre time, protected beds, Outpatients (OPD), endoscopy sessions, Non Consultant Hospital Doctor (NCHD) staffing, specialist nursing, allied health staffing and administrative resources.

The IEHG Medial Executive currently reviews all new and replacement consultant appointments to optimise configuration of posts. This will result in the establishment of new and restructured joint appointments between level 2, 3 and level 4 hospitals within the Group.

European Working Time Directive (EWTD)

IEHG will continue to work with each of the 11 hospitals to gain compliance with EWTD working requirements. Most IEHG hospitals have achieved compliance with 24 hour working but many struggle to achieve the 48hr compliance and there is widespread variance between specialities and hospitals. Some hospitals have significant challenges and a range of measures are being considered to improve compliance and avoid financial penalties. Consideration will be given to reconfiguration of services within each hospital or across the Group. However in order to achieve 100% compliance with the EWTD, additional NCHD's may be required in some locations. This will become evident under our workforce plan and may require have resource implications.

Attendance and Absence Management

Within IEHG the absentee rates have traditionally been very low. Systems are in place in all hospitals to manage sick leave and monthly reviews by the HR/Employee Relations Division are ongoing. This will continue to be a focus in 2016.

Employee Engagement

Recognising that staff have a direct impact on clinical outcomes and the experience of patients, the Group is aware that when staff are well and engaged at work, the experience and outcomes for patients improves. Acknowledging this, the Group is committed to promoting a culture where wellbeing is embraced by all.

It is widely recognised that high calibre, motivated staff will provide the best services. The Group will engage, support, motivate and develop each member of staff to provide a healthy and vibrant environment in which people can work and develop. This will be achieved during 2016 by providing supportive and inclusive leadership with a clear vision and direction for the future and acknowledgment of the value of all staff within the Group. Efforts will be made to ensure that the "employee voice" is heard and their views considered with appropriate feedback being given, alongside the further development of people management practices. This will be

undertaken by building collective and distributed leadership at all levels, while striving to develop a positive organisational culture based on integrity and trust that empowers staff throughout the organisation to take on leadership roles. Emphasis will be placed on listening to employees' feedback and responding appropriately to ensure that services develop and improve.

Internal communication channels will be further developed during 2016 building on the success of Ezine launched in October 2015. All available avenues of communication, including Town Hall Meetings will be supported to ensure that 'employees' voices' are heard and that staff views considered with appropriate feedback given. The Group's commitment to excellent staff engagement will place it as a key priority along side patient experience, patient safety and clinical outcomes and will be measured through annual staff engagement surveys. This commitment will ensure staff engagement is firmly placed on all agendas and will be a key metric for IEHG and all hospitals in the Group.

Workforce Development

Performance management will be a critical component to ensure that staff are supported to deliver high quality safe care for patients. In order to support staff development IEHG will, in conjunction with UCD establish a leadership development programme to support current leaders within the group and the development of future leaders. Staff will be supported with education and training in line with available funding
Where performance is regarded as suboptimal performance improvement measures will be put in place to support staff.

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. Improving staff health and wellbeing is also a key strategic priority and education campaigns will include specific information and supports to help staff improve their own health and wellbeing.

Accountability Framework

The HSE's **Accountability Framework** was introduced in 2015 and (inter alia) sets out the process by which the Hospital Groups are 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 Directors and the Hospital Group Chief Executive Officers.
- Completion of Formal Performance Agreements between the National Directors 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

The HSE Letter of Determination for 2016 requested that the National Service Plan should detail how the HSE intends to develop and build on the Framework in 2016 including the changes that are required to improve the process and, in particular, the intervention and support processes in place to address areas of underperformance.

Areas for development and improvement during 2016 include:

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

As part of the Performance Accountability Framework 2015 an enhanced Escalation and Intervention Framework and process was developed for implementation during 2016.

Accountability Levels relevant to Acute Hospital Services

The CEO of IEHG reports to the National Director for Acute Services and is accountable for the safe delivery of services withing the available funding under the accountability framework of the HSE. All targets and performance criteria adopted in the operational plan will be reported through this framework. For IEHG the focus of accountability is on Level 4 and Level 5 of the HSE Accountability Framework.

Level 4 Accountability:	■ Hospital Group CEOs accountability to National Director Acute Hospitals.
Level 5 Accountability:	■ Service Managers accountability to the relevant Hospital Group CEO. Section 38 and Section 39 funded agencies accountability to the relevant Hospital Group CEO.

Accountability for delivery of the 2016 Operational Plan is assessed on a monthly basis under four dimensions; access, quality and safety, financial and human resources.

Within the overall HSE accountability framework the 11 IEHG hospitals are in turn accountable to the Group CEO for the services they provide within the funding allocated. IEHG will sign service arrangements with the 5 voluntary hospitals (joint SA will be signed for St. Vincent's and St. Michael's Hospitals) by the end of quarter one.

In an environment of constrained resources and increasing demands for care:

- IEHG will develop appropriate financial and resources management framework to ensure that the Group can account for the investment in both human and financial terms to align this to the delivery of high quality safe care.
- IEHG will develop a data analytics capacity to assess the effectiveness of our investment in the context of long term patient outcomes. In the short term the analytics will focus on activity analysis.
- Individual hospital plans will be the basis against which the performance of each individual service is measured and reported upon. Monthly performance meetings with be held with all 11 hospitals which monitor the full range of activity, quality and risk issues, performance against targets and adherence to national standards and KPIs. Particular focus will be directed to management of quality and risk issues and management of finances.

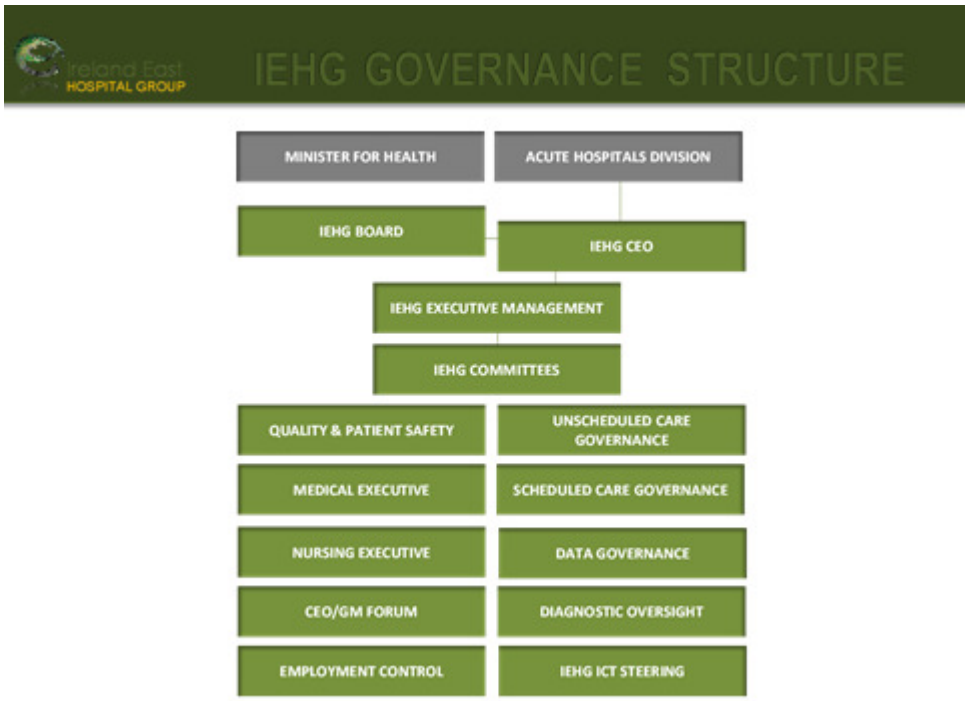
Service Arrangements and Compliance

IEHG provides funding to 6 Voluntary Hospitals, for the delivery of a range of healthcare services. These agencies are required to enter into a formal Service Arrangement with the Executive/Group. The Service Arrangement is the contract between the Executive and each individual Provider and comprises the general terms and conditions set out in the Service Arrangement and a number of schedules prepared on an annual basis that specify the services to be delivered, budget, staffing, quality and safety, monitoring requirements, etc. Under the Service Arrangement, Providers are obliged to give certain undertakings in relation to compliance with a range of standards and statutory requirements.

Given the level of investment by the State in services provided by the non-statutory sector, the Provider Board must, in respect of the Service Arrangement for 2016 and subsequent years;

- Submit a formal Annual Compliance Statement
- Adopt and implement core governance standards

Monthly performance meetings are held between IEHG executive with the 11 IEHG hospitals which monitor the full range of activity, quality and risk issues, performance against target and adherence to national KPIs. Particular focus is directed towards management of quality and risk issues and adherence to the financial framework.



IEHG Key Priorities and Actions in 2016

IEHG has identified a number of key priorities for 2016 which are discussed below these include:

Unscheduled Care:

An Unscheduled Care Governance Group has in operation since early 2015 and included within its remit is the oversight of the implementation of the report of the Emergency Department Task Force and the development of hospital specific plans to manage the demand for admission from Emergency Departments across the Group. A new unscheduled care lead has been appointed for the group to review and improve processes at all sites in order to ensure that PET times and trolley waits are minimised. However in view of the increasing numbers of elderly patients requiring admission from ED it is anticipated that despite the introduction of a range of internal process improvements, that waiting times for admission over the winter periods will continue to be challenge.

The reasons attributing to prolonged times for admission from the ED vary between hospitals and there is no single solution which will provide a panacea in all departments. IEHG has been working with the individual hospitals to develop appropriate solutions; these include appointment of more senior decision makers, development of a liaison service for older people between acute & community settings, provision of diagnostics and greater integration between acute and community sectors.

In meeting the Group's objective for 2016 to deliver a systematic, collaborative and information-based approach to Unscheduled Care, IEHG has secured the services the former CEO of Bolton Hospital Trust (Ms Leslie Doherty). She successfully improved ED performance in Bolton and consistently achieved the ambitious PET targets in the UK, while operating in a constrained financial advice. The plan is to undertake visits to all hospitals within the group during February and then host a workshop to understand the individual issues and identify how bespoke measures can be introduced to address the challenges. The Transformation Programme, currently underway in the Mater Hospital will be rolled out to other hospitals with a view to continuing to process improvement which is built on the same lean principles used in Bolton.

Scheduled Care:

While IEHG successfully met the 18 and 15 month targets in 2015, supporting by some outsourcing, the challenge for 2016 will be significant. The financial environment restricts activity to 2015 levels, which will be insufficient to meet the PTL targets. Specific challenges will present in ophthalmology,

orthopaedics, dermatology and weight management/bariatric surgery. Work programme 4 – clinical service redesign – will provide some opportunities to ensure that each hospital is using scheduled care capacity optimally, but will not address core capacity constraints in key specialities. During quarter 1 2016 IEHG will appoint a scheduled care lead, and establish a Scheduled Care Governance Committee.

IEHG Framework Programme

The establishment of the IEHG and its journey toward foundation trust status is being progressed through a detailed strategic framework programme. Throughout 2016 the Group will progress a number of work streams that will form the basis of the Group's strategic plan.

Within the framework, programme 4 relates to clinical services design and re-organisation. In this context the Group is examining the models of care and efficiency of model 3 and 2 hospitals. Initial focus is on expanding services in Our Lady's Hospital Navan (OLHN) and St Columcille's Hospital Loughlinstown (SCHL) to support the demands on the Mater & St. Vincent's University Hospitals. The principle underpinning the focus on the model 2 hospitals is that they will be complementary, but independent to the model 4 hospitals. This will ensure that the model 2 hospitals can assist in decompressing the model 4s, and to enable the Group to better meet waiting list targets. This will be supported with a number of joint appointments between model 2 and model 4 hospitals.

During 2015 SVUH commenced outreach rheumatology and cardiology clinics in Carlow/Kilkenny. Similarly the Mater hospital has introduced an initiative for general elective surgery in Navan. These initiatives have accommodated patients from hospital waiting lists and provide local access for patients who would otherwise have to travel to Dublin for assessment, treatment and follow up. IEHG intend to further expand outreach programmes in 2016 within available resources.

As part of ongoing developments of IEHG we are standardising the models of care in the large regional hospitals. As well as the workforce plan, detailed in the HR section, IEHG will establish consistent organisational structures in each hospital that are appropriate to the service need. Once that model is complete we will continue with a similar process in the model 2 hospitals, Our Lady's Hospital Navan and St Columcille's Hospital Loughlinstown.

Another priority for IEHG is to organise services to continuously improve the quality of care we give our patients and the outcomes of their treatment while supporting professional development, learning and best practice. Central to the redesign process is the development of an academic Health Science Centre model and the establishment of Clinical Academic Directorates (CADs) and Clinical Directorates (CDs) across hospitals and with UCD the Group academic partner. Both directorate forms will embody and integrate service and academia and would operate across the Group rather than within individual hospitals. Cancer and transplantation will be established as the first two CADs.

Develop, in conjunction with UCD, a strategy for education, training research and innovation.

IEHG Data Analytics

The need for access to real-time data has been identified as a key priority for the Group. IEHG will focus on development of data analytics capacity to enable the group to develop an in-depth profile of hospital activity, patient referrals and profiles and future trends.

Delivery of Services 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	Promote 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 the Group *Healthy Ireland* plan: The IEHG HI Steering Committee will provide governance and direction for the Healthy Ireland (HI) Implementation Plan 2015 – 2017 including • Development of a Health Ireland implementation plan for the IEHG. • Establishment of local implementation teams within each hospital to support implementation • Increase the number of hospital frontline staff trained in brief intervention • Promoting increased uptake of seasonal flu vaccination by hospital staff. • Implementation of the HSE Policy on Calorie Posting in all hospitals .	Q1-Q4
Healthcare Associated Infections	Ensure control and prevention with compliance with targets of healthcare associated infections/AMR with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms, underpinned by the implementation of HIQA *National Standards for the Prevention and Control of Healthcare Associated Infections*. 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 Monthly reporting of hospital acquired S Aureus bloodstream infection and hospital acquired new cases of C Difficile infection	Ongoing Ongoing Ongoing
National Screening Services	Ensure compliance with the National Screening Services e.g. Colonoscopy and Colposcopy	Ongoing
Clinical Pathways	Develop Clinical Pathways for elderly patients across hospitals and CHOs to support positive ageing	Q3

Goal 2	**Provide fair, equitable and timely access to quality, safe health services that people need**	
Priority Area	**Action 2016**	**Target/ Date**
Scheduled Care	IEHG will develop an implementation plan to address OPD, inpatient and day case waiting lists to ensure that patients are managed within the target times. It is acknowledged that particular challenge will arise in specific OPD clinics including: ENT, plastics, dermatology and ophthalmology where there are ongoing capacity constraints. Challenges also exist in managing surgical waiting lists in specialities such as bariatric surgery, urology, pain relief & ophthalmology. Particular focus will be placed on those specialities with particularly long lists and times and chronological scheduling will be closely monitored. A range of solutions including outsourcing and referrals within the	Ongoing

	Group will be evaluated. To improve the ratio of new to return patients, IEHG will support the development of enhanced primary care links and use innovative initiatives such as virtual clinics. There will be funding implications associated with the transfer of this work from secondary to primary care. During 2016 IEHG will 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. IEHG will address these targets under the auspice of a Scheduled Care Governance Committee. The Committee will develop a work programme to: • Redesign existing services to increase elective capacity within the Group • Undertake a demand and capacity profile of diagnostic resources cross the group • Assess the role of model 2 hospitals to support elective activity in the level 4 hospitals • Work with the NTPF to develop an information suite for the Group. • Commence monitoring of Scheduled waiting list cancellation rate • Reorganise hospital group services between the model 2 and model 4 hospitals to manage routine surgery and decompressing the model 4 hospitals. This initiative which is planned between the Mater and Navan (OLHN) and St Columcille's Hospital and SVUH will also enable the Group to better meet waiting list targets. • Optimise capacity by reducing length of stay in line with the surgical programme targets and increasing day of surgery rates • Shift care to the most appropriate setting including increased day surgery rates and redirection of minor operations from hospitals to primary care • Improve day of surgery admission rates for all hospitals • Improve day case rate for laparoscopic cholecystectomy • Reduction in bed day utilisation by acute surgical admissions who do not have an operation in all hospitals • Collaborate with GP practices in relation to the transfer of appropriate minor surgery procedures to be undertaken in the primary care setting • Identify minor surgical procedures currently undertaken in theatre that could be undertaken in other hospital settings such as procedure room or OPD • Ensure that all procedures are carried out in the most appropriate clinical setting and are coded accurately	Q1-Q4 Q1-Q4 Q1-Q4 Q1 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4
Out Patient Improvement Programme	Continue to support the roll-out 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. • Support the roll-out of e-referrals (Phase 1) to all IEHG hospitals • Initiate formal audits of Outpatient Services, as per OP KPIs • Implement the new Outpatient Patient Satisfaction Tool once developed • IEHG will work with the Out Patient Improvement Programme to address the long waiters particularly in key services such as dermatology and ophthalmology.	Q1-Q4
Unscheduled Care	Improve performance in relation to unscheduled care by continuing to implement the Emergency Department (ED)Task Force report recommendations in conjunction with the Acute Hospitals Division and community healthcare services to ensure that all patients are admitted or discharged from ED within 9 hours particularly those > 74 years of age	Q1-Q4

	Alleviate pressures on the hospital system over the winter period enabling achievement of the targeted reduction in trolley waits by opening a number of additional beds. Full escalation response will be activated 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 The IEHG Unscheduled Care Governance Committee (USGC) was established in 2015 with representation from all hospitals with an Emergency Department. The priority for the UCGC is to: • Minimise the numbers of patients waiting for admission for a hospital bed and to engage with primary and community care to minimise the numbers of frail elderly requiring admission to hospital. • Roll out of ED transformation programme to other EDs in the Group with a view to continuing improvement in efficiencies. • Successfully achieve Group and hospital KPIs as set out in IEHG Winter Escalation Plan. • Oversee the implementation of the report of the Emergency Department Task Force and the development of hospital specific plans to manage the demand for admission from Emergency Departments across the Group. • Have systems in place to advise the public of activity levels in Emergency Department. • Work with CHOs to reduce the number of delayed discharges • IEGH will work with the INMO to monitor activity in Emergency Departments and to implement the escalation policy designed to assist with ED overcrowding.	
Acute/Primary and Community Integration	Improving the integration between the IEHG, primary and community care will be key deliverables in 2016. With the support of the Irish College of General Practice the IEHG GP network advisory group will identify innovative ways for Primary and Secondary Care integration including: • Establishment of Local Integrated Care Committees within each IEHG acute hospital (where these do not already exist). • Establishment of an integrated forum with GPs and CHOs to address frail elderly, chronic disease management and ED avoidance • Review initiatives for improving integration across primary/secondary care within the HG. The initial priority for these committees is to support the care of elderly patients at home. Other priorities for the Committees include provision of GP access to diagnostics, faster and increased access to consultant advice and the development of pathways for direct admission or provision of alternatives.	
Clinical Programmes	Undertake a review of the implementation of the National Clinical Care Programmes across the Group with a particular focus on Surgery, ED and Acute Medicine Clinical Programmes.	
GEMS Projects	In order to address the increasing numbers of frail elderly who increasing present to Emergency Departments, IEHG will pilot two GEMS projects (Geriatric Medical Units) in SVUH/St. Columcille's Hospital and in St. Luke's Hospital Kilkenny. These units which are designed to avoid admission where possible and reduce the length of stay for those elderly patients who are admitted, will specifically focus on the frail elderly. This initiative will result in the development of new pathways and enhance existing pathways for frail elderly between primary, continuing and community care and IEHG.	
New Developments	The priority for IEHG in 2016 is the commissioning of the new units in Wexford and in St. Luke's Hospital Kilkenny. • Open new expanded ED and AMAU in Kilkenny in early 2016 • Transfer all day surgery to the new stand-alone Suzi Long Day Surgery Unit • Open two new endoscopy suits	Q2-Q4

	• Appoint new ED consultants in Kilkenny and Mullingar • Open additional delivery suite and observation unit in Wexford. • Open dedicated obstetrics theatre in Wexford	
Winter Initiative	To support the additional demands on hospitals over the winter period, IEHG received an additional €6.48m towards alleviation of overcrowding in EDs over the winter months During 2016 IEHG will open all additional beds as per Winter Initiative 2015/2016 • 22 additional medical beds - SVUH • 13 beds (10 bedded ward and 3 isolation rooms) - Loughlinstown • 12 additional beds – Kilkenny • 10 bedded ward – Wexford • 15 additional rehab beds in Navan/Mater • 10 additional beds - Cappagh	
National Pancreatic Transplant Programme	Transition of the pancreatic transplant programme from Beaumont to St. Vincent's University Hospital will continue in 2016. • Appointment of new consultant transplant surgeon and national pancreatic transplant lead • Appointment of pancreatic co-ordinators/clinical nurse specialists • Development of clinical audit and MDT links with Edinburgh Royal Infirmary to support pancreatic transplant services in Ireland. • Development of agreed pathway of care between Beaumont and SVUH for management of patients requiring simultaneous kidney and pancreatic transplants.	
Cancer Services	During 2016 IEHG will establish a single Clinical Academic Directorate for Cancer services across the Mater & SVUH hospitals in partnership with UCD. This model will provide unitary governance between both departments and the university and will embody molecular diagnostics and research capabilities at the university. The development of shared care pathways, joint MDT's and shared data analysis will provide increased expertise and an advanced model of care which will provide better outcomes for patients. A group with representation from both cancer centres and UCD has recently been established to progress the integration of the existing cancer departments. One of the key challenges for IEHG is that despite it being the largest group there is no public radiotherapy within the group. Priorities for 2016 include: • Integration of cancer services between the Mater and St. Vincent's University Hospitals. • Establishment of new pathways for patients in IEHG • Establishment of the Mater Hospital as the national retroperitoneal cancer centre incorporating HIPEC (hyperthermic intraoperative peritoneal chemotherapy treatment). • Development of a national hepatoma service at SVUH in conjunction with the NCCP • Application for European accreditation of SVUH as a centre of excellence for the treatment of Neuroendocrine tumours. • Continue to monitor and address access within target times to rapid access clinics in MMUH and SVUH. • Establish an electronic pigmented lesions clinic in Mullingar. • Work with the NCCP to support hospitals address the increasing costs of oncology drugs • Support the implementation of the new Cancer Strategy 2016-2025. • With the support to the NCCP, improve access for patients attending Symptomatic Breast Disease services who are triaged as non-urgent within a 12 week timeframe.	Q3 Q1-Q4 Q1-Q4 Q2 Q2 Q3 Q1-Q4 Q2 Q1-Q4 Q1-Q4 Q1-Q4

	• Improve rapid access services for patients where there is a high index of suspicion of prostate or lung cancer. • Seek appointment of Advanced Nurse Practitioners in the Mater & SVUH	Q1-Q4 Q1
Emergency Planning	• IEHG will continue to support the implementation of the Major Emergency Response function in Acute Hospitals. • A number of IEHG staff will be trained in Hospital Major Incident Medical Management and Support (HMIMMs). • Continue to develop the hospital's capacity to respond to Category 4 (e.g. Ebola) type threats in the Mater Hospital.	Q1-Q4
Quality	Continue to implement the National Standards for Safer Better Healthcare in all IEHG Hospitals. Complete first and second assessments against NSSBHC in all hospitals and develop action plans to address any gaps identified. Publish hospital patient safety statement Co-operate with Quality Assurance and Verification Division on the roll out Phase Two of the National Incident Management System. Establish processes and governance structures in Hospital Groups which reduce the incidence of and support the management of SREs and SI s. • Establishment of defined patient safety and quality framework in all hospitals that will address: • Patient experience /satisfaction • Clinical Governance and Accountability • Performance Monitoring: Incident Reporting, Mortality/Morbidity Review Complaints • Service improvement Commence Reporting of additional indicators of Safe Care with the measurement of adverse events monthly in relation to: • Postoperative wound dehiscence • In-hospital fractures • Foreign body left during procedure • Pressure Ulcer Incidence/Falls Prevention Based on the findings of the HIQA Portlaoise Report: • Each Hospital within the Group will undertake a risk assessment of clinical and corporate governance with a view to identifying and stratifying immediate risks and mitigating actions, (in particular the transfer policy for high risk patient cohorts) • 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	Q1-Q4 Q2 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q2-Q4 Q1 Q2 Q1-Q4
Maternity Services	Implement maternity service improvements across the Group in line with HIQA recommendations and other relevant reviews including: • Establish an IEHG maternity network across the four maternity units • Progress the relocation of the National Maternity Hospital, Holles Street to the St. Vincent's University Hospital. Enabling works to commence in 2016.	Q2 Q1-Q4

	• Appoint a Director of Midwifery to all maternity units. • Continue to report and publish maternity patient safety statement • Implement the midwifery workforce planning study (Birthrate Plus) within the Group • Implement the new National Maternity Strategy 2016	Q3 Q1-Q4 Q1-Q4 Q1-Q4
Metabolic Service	• Continue to develop the adult metabolic service in the Mater Misericordiae University Hospital for the transition of adolescents from paediatric services within the limits of funding provided. • Expand staffing in Mater to accommodate the transfer all remaining adult PKU and LSD patients to the Mater Hospital subject to the availability of adequate funding:	Q3 Q1-Q4
2015 Service Development	Continue the roll out of approved 2015 service developments • Appointment of additional consultants in MMUH & SVUH Acute Medical Assessment Units • Appointment of a TRASNA stroke post to support stroke telemedicine in the Mater Hospital. • Appointment of podiatry post in Mullingar • Appointment of additional staff for national and rare diseases office in the Mater Hospital	 Q1-Q3 Q3 Q1 Q2
Congenital Cardiology	• Appointment of an additional cardiology post between the Mater Hospital and Our Lady's Children's Hospital, Crumlin to further develop the adult congenital cardiology programme.	Q4
Capital	• The capital plan has identified a small number of new developments within IEHG. Ongoing discussions will be required in order to address some key additional requirements particularly relating to the perilous sate of the laboratories in the Mater and Navan Hospitals, the Cardiac Catheter laboratory in SVUH and priority developments such as MRI scanners for SVUH, Kilkenny, Mullingar and Wexford.	Q1-Q4

Goal 3	**Foster a culture that is honest, compassionate, transparent and accountable**	
Priority Area	**Action 2016**	**Target/ Date**
Governance	Develop the IEHG Strategic Plan Complete Service Arrangements with the voluntary hospitals within the Group in accordance with HSE Governance Framework for Funding Non-Statutory Provided Services. Working with the emergency management function of the HSE, ensure emergency management structures across the Groups continue to develop. Comply with recommendations from local audits and potentially systemic recommendations in accordance with HSE Internal Audit procedures.	Q1-Q4 Q1 Q1-Q4 Q1-Q4
Patient Experience	• Development of an IEHG patient engagement strategy and complaints management plan. • Monitor and review patients satisfaction	Q1-Q4
Quality & Patients Safety	Establish a quality and patients safety directorate which will, inter alia, oversee the implementation of the National Standards for Safer Better Healthcare and the recommendations of the Portlaoise Report (and other reports and investigations).	Q1-Q4

	Establishing a clinical governance framework will be a priority in 2016. This will include: • Developing a Group QPS structure with internal and external stakeholders. • Developing a Group strategy. • Implementing a monitoring framework incorporating continuous quality improvement initiatives.	
National Clinical Guidelines	Continue to support the implementation of the National Clinical Guidelines: Continue implementation of the National Clinical Guidelines: **Sepsis Management,** National Clinical Guideline No. 6**.** Under the direction of the sepsis ADON, during 2016, IEHG will: • Develop a plan for implementing the National Clinical Guideline in each hospital. • Complete a gap analysis in each Hospital on the implementation of the guideline. • Support the sepsis steering group in each hospital to develop an action plan, informed by GAP analysis, for implementation of the Guideline in each Hospital Group. • Undertake a series of compliance audits in each hospital at identified intervals. • Provide feedback on compliance audits to individual hospitals, the IEHG and the National Sepsis Programme. • Provide a report of activity to date for National Clinical Lead for Sepsis • Undertake a roll out status audit for all hospitals and report findings to the IEHG and the National Sepsis Programme. Develop self-audit schedules and follow-up action plans in each of the hospital groups for: • NEWS • IMEWS • PEWS	Q1-Q4 Q1-Q4 Q1-Q4 Q3 Q3 Q1-Q4 Q1-Q4 Q1-Q4 Q3 Q3

Goal 4 **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 IEHG. Implement the Healthy Workplace Policy and support initiatives to encourage staff to look after their own health and wellbeing.	Q1-Q4
Public Service Agreement	Establish a 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*	Q3
Nursing Services	Support phase 1 pilot of the framework on staffing and skill mix for nursing related to general and specialist medical and surgical care in acute hospitals in conjunction with the Office of the Nursing and Midwifery Services. This will be piloted in the Mater Hospital	Q1-Q4
Workforce Planning	Develop a workforce plan for the Group through a structured approach based on models of care and service delivery requirements that informs near term and medium term workforce planning. It is proposed to commence this process on a pilot basis in Wexford General Hospital	Q4

Staff Engagement Strategy	• Develop a staff engagement strategy as part of the IEHG internal communications plan. • Develop an IEHG integrated multimedia communication strategy including a range of social media platforms to improve staff and public communication including provision of live data on ED waiting times.	Q2
Staff Performance and Development	• Develop a performance management framework for staff across the Group. • Develop an Executive Leadership Programme for CEO/GM/Clinical Directors and Senior Managers across the Group. • Develop, in conjunction with UCD, a strategy for education, training research and innovation.	Q1-Q4
Nursing & Midwifery Bank	• Establish a Nursing and Midwifery Bank for the IEHG to ensure the provision of quality safe patient care by the appropriately qualified competent healthcare professionals within a cost effective structure. • Ensure that appropriate systems are in place for measuring quality of outcomes and the effective use of resources.	Q1-2
EWTD	Ensure compliance with the European Working Time Directive within all Hospital Groups and provide reports on; • Maximum 24 hour shift • Maximum 48 hour week In order to achieve 100% compliance with the EWTD, additional NCHD's may be required in some locations. This will become evident under our workforce plan and may require some additional funding.	Q1-Q4
National Guidelines on Accessible Health and Social Care Services	Participate on Working Group to oversee the implementation of the strategy for People with Disabilities as it applies to the HSE. Work with services to ensure that they are examining their services for accessibility, in line with the national guidelines.	Q1-Q4 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	• Develop ABF benchmarking capability across the hospitals to investigate the reasons for differences in costs; • Manage the financial aspects of the transition to ABF; • Develop the costing process including Patient-Level costing and Specialty costing; • Actively involve partners across IEHG to deliver better understanding of ABF financial analysis and HIPE coding through collaboration • Complete HIPE coding within 30 days	Q1-Q4
Pay-bill Management and Control	Ensure 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
Surgery Improvements NQAIS	Continue to use to monitor and measure surgical activity across all hospitals using the National Quality Assurance Information System (NQAIS) Surgery. • Improve day of surgery admission rates for all hospitals • Reduction in bed day utilisation by acute surgical admissions who do not have an operation in all hospitals	Q1-Q4

	• Ensure that all procedures are carried out in the most appropriate clinical setting and are coded accurately.	
Acute Medicine NQAIS	Continue the development and implementation of NQAIS medicine: • Adopt a quality improvement approach to the further development and roll-out of the system to all acute hospitals in conjunction with HSE Health Intelligence Unit. • Provide training and education on NQAIS Medicine to key staff in Acute Hospitals. • Provide support and advice to Clinical Directors and Senior Managers in the application of the system.	Q1-Q4 Q1-Q4 Q1-Q4
Group Structure	• Implement a robust organisation structure which will encompass service delivery, academic partnership and research priorities for the IEHG.	Q1-Q4
Data Analytics Capacity	• Development of ~~a~~ data analytics capacity to assess the effectiveness of investment in terms of long term patient outcomes and effective day to day operational management. • Develop health analytics capacity within the IEHG to support deliver of evidence based care and direct planning for service provision.	Q3
Service Reorganisation	• Lean Academy: The Mater/UCD lean Academy will be extended across the Group in 2016 and will be a key strategic objective for the Group to support process improvement.. • Increase training of staff in white and green belt level across IEHG • Development of appropriate evidence based clinical care pathways (including diagnostic pathways) across the group.	Q1 – Q4

Appendix 1: Ireland East Hospital Group Budget

	IEHG ALLOCATION							
	ABF	Block	Gross Budget	Income Budget	Net Budget	LRA	Increments	FINAL Allocation
Hospital	**€M**	**€M**	**€M**	**€M**	**€M**	**€M**	**€M**	**€M**
Mater	194.451	**101.477**	**295.928**	-67.077	**228.851**	0.655	1.171	**230.677**
St Vincents	184.355	**84.275**	**268.630**	-59.562	**209.068**	0.569	1.326	**210.963**
St Michaels	0.000	**32.168**	**32.168**	-8.810	**23.358**	0.076	0.262	**23.696**
NMH	44.473	**19.978**	**64.451**	-19.912	**44.539**	0.166	0.632	**45.337**
RVEEH	17.709	**9.848**	**27.557**	-5.311	**22.246**	0.066	0.112	**22.424**
Cappagh	30.047	**6.563**	**36.610**	-8.877	**27.733**	0.068	0.089	**27.890**
Total Voluntaries	**471.035**	**254.309**	**725.344**	**-169.549**	**553.795**	**1.600**	**3.592**	**560.987**
Wexford	48.880	**19.154**	**68.034**	-12.541	**55.493**	0.134	0.409	**56.036**
St Lukes	50.557	**20.106**	**70.663**	-12.941	**57.722**	0.171	0.418	**58.311**
Columcilles	20.715	**11.422**	**32.137**	-1.627	**30.510**	0.085	0.007	**30.602**
Mulingar	47.327	**28.608**	**75.935**	-11.700	**64.235**	0.191	0.334	**64.760**
Navan	31.425	**13.310**	**44.735**	-3.581	**41.154**	0.096	0.111	**41.361**
Total Statutories	**198.904**	**92.600**	**291.504**	**-42.390**	**248.364**	**0.677**	**1.279**	**251.070**
IEHG HQ	0.000	**2.000**	**2.000**		**2.000**	0.007	0.000	**2.007**
Grand Total	**669.939**	**348.909**	**1,018.848**	**-211.939**	**806.909**	**2.284**	**4.871**	**814.064**

Appendix 2: HR Information

Ireland East HG

Hospital	WTE Dec 14	WTE Oct 15	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support Staff	Patient & Client Care
Cappagh National Orthopaedic Hospital	330	345	43	124	50	51	43	33
Mater Misericordiae University Hospital	2,651	2,750	404	1,104	381	393	277	191
Midland Regional Hospital, Mullingar	745	857	133	307	114	126	41	135
National Maternity Hospital	724	779	90	376	57	122	105	29
Our Lady's Hospital, Navan	436	475	57	181	44	67	23	103
Royal Victoria Eye & Ear Hospital	258	258	52	98	14	54	32	8
St. Columcille's Hospital	388	393	40	143	54	62	53	41
St. Luke's General Hospital	817	923	127	376	73	128	181	40
St. Michael's Hospital	367	388	35	177	43	63	49	22
St. Vincent's University Hospital	2,445	2,573	402	886	376	393	285	231
Wexford General Hospital	827	872	110	343	47	130	187	54
Ireland East HG	**9,987**	**10,612**	**1,491**	**4,114**	**1,255**	**1,588**	**1,276**	**886**

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

System-Wide				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	New PI 2016	New PI 2016	15% increase
Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	M	75%	75%	75%
Serious Reportable Events % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	M	New PI 2016	New PI 2016	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	62%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	New PI 2016	New PI 2016	90%
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	New PI 2016	To be set in 2016

Hospital Care –

	Acute Hospitals														
Service Area	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**		**Expected Activity/ Targets 2016**										
Activity				Ireland East Hospitals Group	**Cappagh**	**SCH**	**SLHK**	**Mater**	**MRHM**	**OLHN**	**NMH**	**RVE&E**	**SVUH**	**WGH****	**SMH***
	*in relation to St. Michael's Hospital, HPO targets are indicative as SMH is funded 100% through block grant.														
Beds Available Inpatient beds **	Existing	Monthly	10,503												
Day Beds / Places **	Existing	Monthly	2,024												
Discharges Activity∞ Inpatient Cases	Existing	Monthly	621,205	128,488	2,355	5,162	17,716	19,483	19,274	6,512	16,375	2198	19,304	16,969	3,140*
Inpatient Weighted Units	New PI 2016	Monthly	623,627	133,632	5,951	3,181	11,089	35,969	10,129,	5,654	10,538	2,348	33,957	11,563	13,382*
Day Case Cases∞	New PI 2016	Monthly	1,013,718	183,895**	6,526	2,428	7,051**	53,961	8,666	4,842	3,468	9,751	70,169	10,749**	6,284*
Day Case Weighted Units	New PI 2016	Monthly	1,010,025	197,773	6,499	3,728	6,953	59,126	9,487	7,001	3,720	20,742	64,084	9,628	6,805*
Total inpatient and day case Cases∞	New PI 2016	Monthly	1,634,923	309,903	8,881	7,590	24,767	73,444	27,940	11,354	19,843	11,949	89,473	25,238	9,424*
Shift of day case procedures to Primary Care	New PI 2016	Monthly	New PI 2016												
Emergency Care - New ED attendances	Existing	Monthly	1,102,680	235,703	-	-	39,139	56,206	29,319	18,096	-	-	48,496	31,450	12,997
- Return ED attendances	Existing	Monthly	94,948	23,781	-	-	6,352	3,290	2,250	2,098	-	-	2,314	3,947	3,530
- Other emergency presentations	Existing	Monthly	94,855	14,155	-	6,078	0	0	4,324	0	-	-	0	3,753	0
Inpatient Discharges *(Note this section previously detailed Inpatient Admissions but has been modified to align with HIPE data which is discharge*	New	Monthly	New PI 2016	82,077											

Service Area	New/ Existing KPI	Reporting Frequency	National Projected Outturn 2015		Acute Hospitals Expected Activity/ Targets 2016										
Activity				Ireland East Hospitals Group	**Cappagh**	**SCH**	**SLHK**	**Mater**	**MRHM**	**OLHN**	**NMH**	**RVE&E**	**SVUH**	**WGH****	**SMH***
based) Emergency Inpatient Discharges															
Elective Inpatient Discharges	New	Monthly	New PI 2016	18,172											
Maternity Inpatient Discharges	New	Monthly	New PI 2016	28,239											
Outpatients Total no. of new and return outpatient attendances	Existing	Monthly	3,242,424	725,756	7,215	12,554	29,991	231,298	50,362	32,070	124,047	40,077	142,431	36,183	19,528
Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	New PI 2016	Monthly	New PI 2016	1 : 2											
Births Total no. of births	Existing	Monthly	65,977	15,198	-	-	1,734	-	2,221	-	9,351	-	-	1,892	-

∞*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.*

The projected activity for the Group is as per SP16 (based on extrapolation of October 2015 data). The projected activity by hospital is based on actual year end data Dec 2015).
***The number of day cases in St. Luke's Hospital in Kilkenny is expected to rise by 50% in the current year with the opening of the new Suzi Long Day Surgery Unit and the volume of day case activity in Wexford will also increase with the opening of the obstetric theatre. The figures included in this table reflect a 50% increase in 2015 day case activity in Kilkenny and 30% in Wexford. Delays in recruitment of additional nursing staff may limit achievement of this target by year end.*

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 % 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 % 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 % 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 % 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 % of medical patients who are discharge ed or admitted from AMAU within 6 hours AMAU registration	Existing	Monthly	65.5%	75%
Access to Services % of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	Existing	Monthly	79.8%	90%
Ambulance Turnaround Times % 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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
Health Care Associated Infections (HCAI) Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used	Existing	Quarterly	0.054	< 0.055
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 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 HIPE Completeness – Prior month: % of cases entered into HIPE	Existing	Monthly	93%	> 95%
Average Length of Stay 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	5.73
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) New attendance DNA rates **	Existing	Monthly	12.9%	12%
Dermatology OPD No. of new Dermatology patients seen **	Existing	Monthly	41,732	41,700

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	1:2	1:2
Rheumatology OPD No. of new Rheumatology patients seen **	Existing	Monthly	13,818	13,800
New: Return Attendance ratio **	Existing	Monthly	1:4	1:4
Neurology OPD No. of new Neurology patients seen **	Existing	Monthly	16,994	16,900
New: Return Attendance ratio **	Existing	Monthly	1:3	1:3
Stroke % 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 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 % 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 % of elective surgical inpatients who had principal procedure conducted on day of admission	Existing	Monthly	69.4%	85.4%
% 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 (ie to 26%)
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	Existing	Monthly	84.5%	95%
Surgery Scheduled waiting list cancellation rate **	New PI 2016	Monthly	New PI 2016	New PI 2016
Hospital Mortality	Existing	Annual	Not Yet Reported	TBC

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition **				
Re-admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	Existing	Monthly	10.8%	10.8%
% 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 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 % of hospital groups conducting annual patient experience surveys amongst representative samples of their patient population	Existing	Annual	Not yet reported	100%
Dialysis Modality 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 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 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) % 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) % 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 % of maternity units / hospitals with implementation of the guideline for clinical handover in maternity services	New PI 2016	Quarterly	New PI 2016	100%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
% of acute hospitals with implementation of the guideline for clinical handover	New PI 2016	Quarterly	New PI 2016	100%
National Standards % 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%
% 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 Mean and median LOS (and bed days) for patients admitted with COPD **	Existing	Quarterly	7.6 5	7.6 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 % 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 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 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 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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
% usage of O Rhesus negative red blood cells **	Existing	Monthly	<14%	<14%
% of red blood cell units rerouted to hub hospital **	Existing	Monthly	<4%	<4%
% of red blood cell units returned out of total red blood cell units ordered **	Existing	Monthly	<1%	<1%
Reportable events % of hospitals that have processes in place for participative engagement with patients about design, delivery & evaluation of health services **	New PI 2016	Annual	Data not due to be reported until Q2 2016	100%
Outpatients (OPD) % 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 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 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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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 No. of centres providing surgical services for prostate cancers **	Existing	Monthly	8	7
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 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 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*

Appendix 4: Capital Infrastructure

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

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
ACUTE SERVICES									
Ireland East Hospital Group									
Cappagh National Orthopaedic Hospital, Dublin	Provision of a recovery unit to serve the theatre department (co-funded with Cappagh).	Q1 2016	Q1 2016	0	0	0.10	1.00	0	0.00
Midland Regional Hospital, Mullingar, Co. Westmeath	Emergency Department (ED), phase 2b (stage 2).	Q1 2016	Q2 2016	0	0	0.30	3.56	0	0.00
St. Luke's General Hospital, Kilkenny	Redevelopment (phase 1) to include a new ED, medical assessment unit (MAU), day service (including endoscopy) including medical education unit, (co-funded by the Royal College of Surgeons of Ireland and the University of Limerick).	Q3 2015	Q2 2016 (phased opening)	10	12	2.50	26.00	0	0.00
	Conversion of day ward into a 12 bed inpatient ward [Winter capacity initiative]	Q1 2016	Q1 2016	12	0	0.10	0.10	0	0.86
Wexford General Hospital	Provision of an early pregnancy assessment unit, a foetal assessment unit and a urodynamics laboratory (co-funded by the Friends of Wexford Hospital)	Q4 2016	Q4 2016	0	0	0.10	0.10	0	0.00
	Upgrade and replacement of fire detection and alarm systems, emergency lighting and passive fire protection works. This project includes the fit-out of the vacated old ED as a decant ward to allow these works proceed.	Q4 2015	Q1 2016	0	0	0.15	5.24	0	0.00

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%
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%

Quality	Expected Activity / Target 2016
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%
• % 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%

Access	Expected Activity / Target 2016
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*