Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

UL Hospitals Group

Operational Plan 2016

Ospidéil OL
UL Hospitals

Vision

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

Mission

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

Values

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

- Care
- Compassion
- Trust
- Learning

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

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

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

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

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

Table of Contents

Executive Summary

Introduction

University of Limerick (UL) Hospital Group is comprised of a group of six hospitals functioning collectively as a single hospital system in the Mid-West of Ireland. The six sites include:

University Hospital Limerick (UHL)

St. Johns Hospital Limerick (SJHL)

University Maternity Hospital (UMHL)

Nenagh Hospital (NH)

Croom Hospital (CH)

Ennis Hospital (EH)

University Hospital Limerick is the Model 4 hospital for the region providing major surgery, cancer treatment and care, emergency department services, as well as a range of other medical, diagnostic and therapy services. It is where all critical care services are located in addition to a 24/7/365 Emergency Department and it is a designated cancer centre. UHL is the second busiest Emergency Department in Ireland with over 57,000 patients annually.

Emergency and complex surgeries are only undertaken at UHL. The hospital is the hub for Ennis hospital, Nenagh hospital and St. John's hospital which manage the majority of their local population through their medical assessment units and inpatient beds.

Patients who require access to critical and complex care are seen at University Hospital Limerick and either stabilised and transferred to a local Model 2 hospital, namely Ennis or Nenagh or admitted to UHL if required. Croom Hospital is part of the UL Hospitals group. It is the dedicated orthopaedic hospital for adults and children in the Mid-West region. Croom hospital also accepts the transfer of Orthopaedic patients from UL hospital for post-acute. In addition to Orthopaedic services, Rheumatology and Pain Management services are also provided.

University Maternity Hospital, Limerick is the second largest maternity hospital outside Dublin with an average of 5,000 births per year and the sole provider of obstetrical, midwifery and neonatal intensive care to the Mid-West region. It serves Limerick, Clare and Tipperary N.R. The maternity hospital also accommodates patients from outside the Mid-west region. These include women from North Cork, Tipperary, North Kerry and areas of Offaly. They also provide tertiary referral for smaller Neonatal Units from outside the region.

Governance

The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2016 and allocated Group budgets. The UL Hospitals Group Operational Plan 2016 is aligned with this Acute Hospitals Division overarching Operational Plan.
The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the Accountability Framework of the HSE. All targets and performance criteria adopted in the service plan and the divisional Operational Plan will be reported through this framework.

UL Hospitals is governed by an interim Board and an Executive Management Team led by a CEO who reports to the Board. Our services are delivered across the six sites under the leadership of four clinical directorates namely, Medicine Directorate, Perioperative Directorate, Diagnostic Directorate, Maternal and Child Health Directorate. Each Directorate is led by a team of staff bringing Clinical. Managerial and Financial expertise together to provide quality driven safe services, focused on the experience and outcomes for the patient.

Professor Niall O'Higgins

Mr. Seamus Gubbins

Professor Don Barry

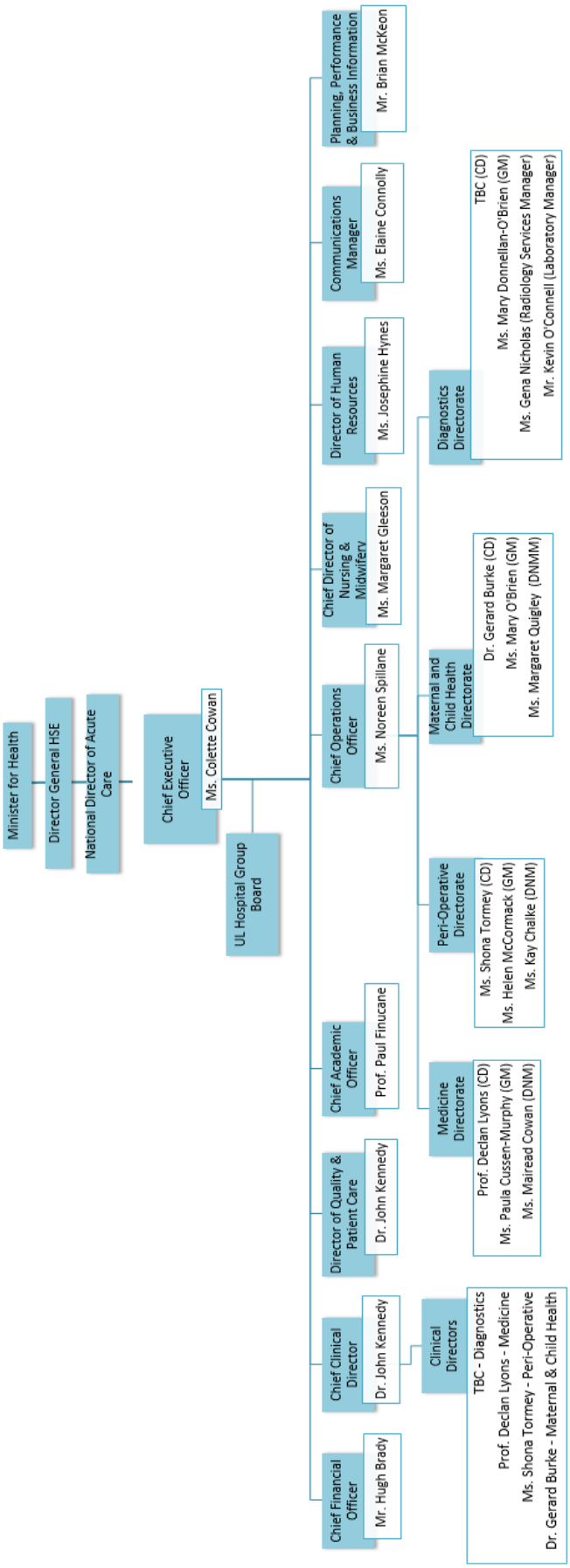
Mr. Maurice Carr

Dr. Mary Gray

Dr. Sheelah Ryan

Mr. Dara Purcell

Organisational Chart



Impact of Demographics on Hospitals

According to 2011 CSO figures, the population of the Mid West Region is 379,327. This is 5% higher than the 2006 reported figures. The biggest increase in population occurred in County Limerick (8.4%). The population in Clare grew by (5.6%), and Tipperary also saw an increase (6.5%). There was a decrease in the population in Limerick City (-4.5%).
The Hospital Group serves a socially diverse population from Limerick City which is the most deprived local authority area nationally. In contrast Limerick County is ranked as the eight most affluent County in the Country.
The national age profile particularly impacts on emergency services. Life expectancy in Ireland has increased and is above the EU average of 80.6 years (*Source: Eurostat*). People are living longer through medical advances, technology along with an increased knowledge and focus on health and general well-being. The population of over 65s is set to increase by 3.1%, or 19,400 persons between 2015 and 2016. There will be 2,900 additional persons over 85 years of age in 2016 – a 4.2% increase (CSO, 2011).

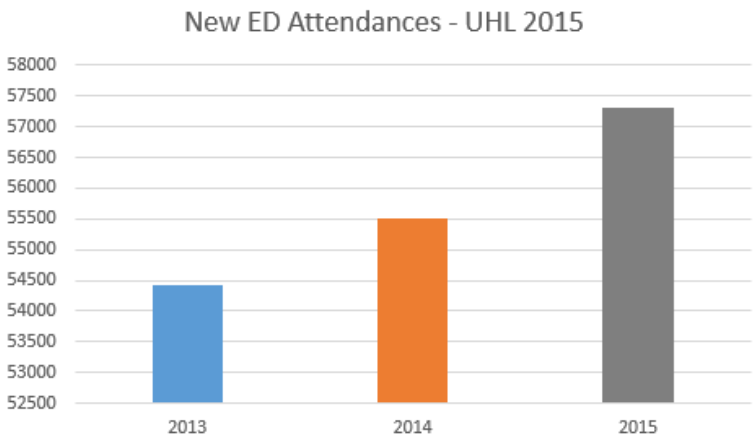
Population	Persons 2006	Persons 2011	Actual change 2006-2011	Percentage change 2006 -2011
Clare	111,950	117,196	6,246	5.6%
Limerick City	59,790	57,106	-2,684	-4.5%
Limerick County	124,265	134,703	10,438	8.4%
Tipperary North	66,023	70,322	4,299	6.5%
Mid-West	362,028	379,327	18,299	5.1%
Ireland	4,239,848	4,588,252	384,404	8.2%

Nationally, this equates to €64m of the net 2015 allocation to keep up with the demographic pressure. Clearly model of care changes relating to the frail elderly area and chronic conditions are key to addressing this challenge. However in 2016 the pressure will continue to fall directly upon hospitals with limited additional financial provision.
In addition to this, nationally it is estimated that approximately 525,590 people aged 65 and older have at least one chronic condition. Using population projections, there will be an additional 16,830 people with at least one chronic condition in 2016 and by 2021 there would be a further 94,580 people with at least one chronic condition (Tilda, 2010).
It is estimated that the major chronic diseases will increase by 20% by 2021. These include cardiovascular disease, cancer, stroke, respiratory disease and diabetes. These will all increase by between 4% and 5% per annum. However, survivorship of chronic disease in Ireland is also increasing, another success story of our society and health system.

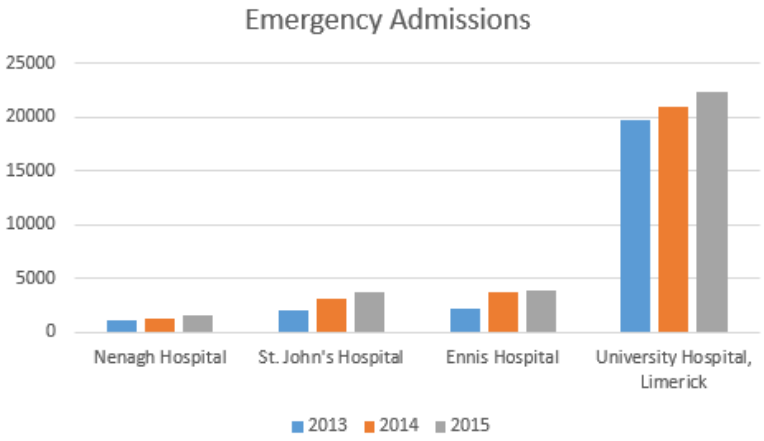
2015 Activity

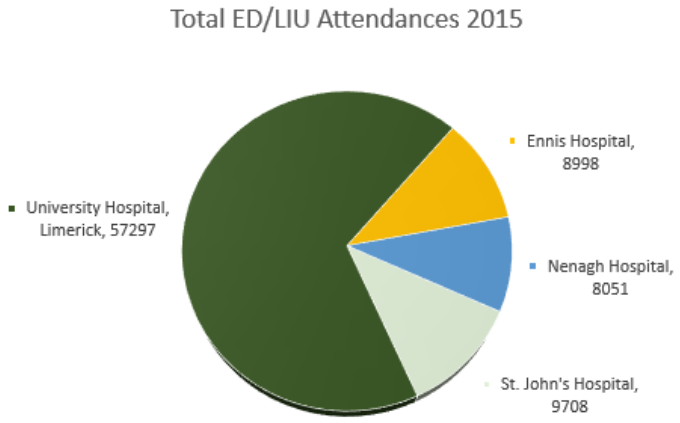
Emergency Care

In 2015 there was a 3.2% increase in the number of patients presenting to the Emergency Department in University Hospital Limerick (57,297 up from 55,502 in 2014). The Local Injury Units (LIU) also saw an increase in patients, 4.2% in both Nenagh and Ennis, 1.5% in St. John's Hospital.



The result of this pressure on emergency services was a 9.2% year on year increase in the number of emergency admissions.



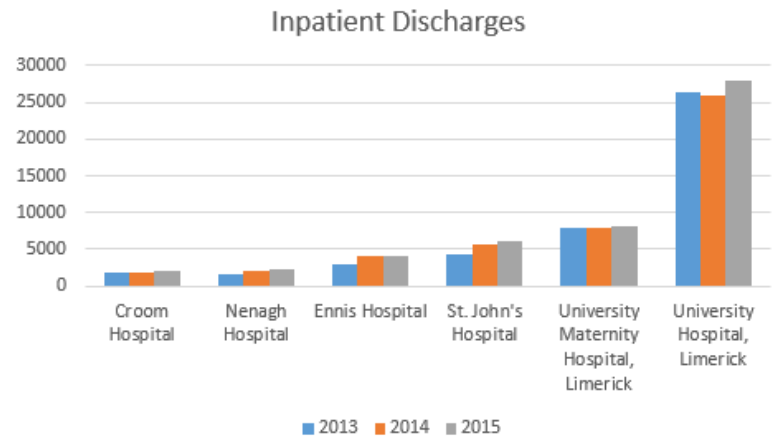


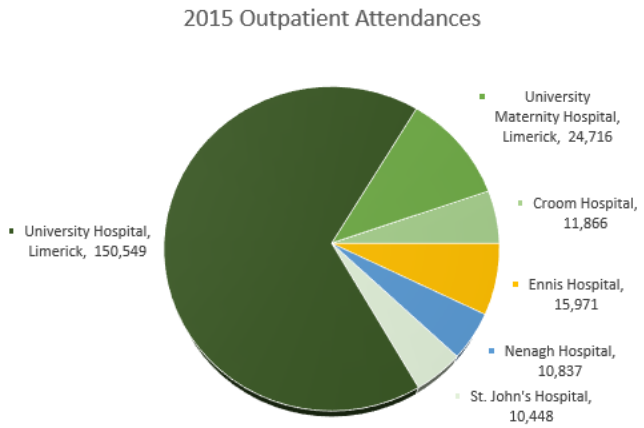
LIU's now account for just over 30% of all new emergency presentations for the group.

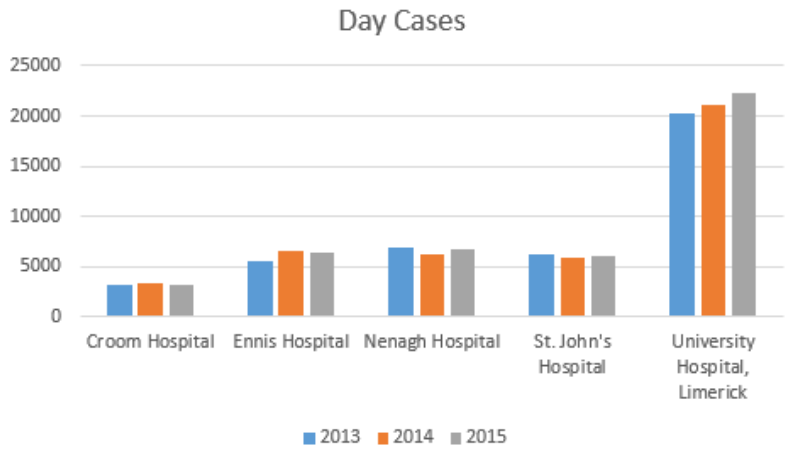
Scheduled Care

Additional capacity towards the end of 2015, reduced medical length of stay in Ennis, Nenagh and St. John's Hospital, and a 44% reduction in delayed discharges allowed the number of elective admissions to remain virtually unchanged for the group (+0.6%).

Maintaining elective admissions was a critical factor in achieving all the inpatient and outpatient waiting list targets set in 2015. With a population of 379,327, the UL Hospital Group treated over 224,000 patients in all our outpatient centres.







Developments and Challenges 2016

The services outlined in this operational plan are based on those agreed in the National Service Plan 2016 and the Acute Division Operational Plan. Substantial cost control and cost reduction by the UL Hospital Group will be required with a focus on controlling the total pay and non-pay costs as well as maximising income. The UL Hospital Group, with support from the Acute Division, will take a number of measures to control costs, reduce waste and improve efficiency while aiming to minimise any impact on services.

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 the group will also seek to optimise existing capacity through reducing length of stay and shifting care to appropriate settings including primary care.

Having regard to the available funding, it is expected that:

- Day case activity will be delivered at 100% of 2015 levels
- Inpatient activity target is to deliver 2015 levels
- Emergency inpatient activity will be delivered 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 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.

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, it will not be possible to eliminate them in full. Identified risks include:

- Capacity to cap the introduction of drugs and medical devices
- 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
- 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
- Lack of contingency funding to deal with unexpected service or cost issues

Clinical Strategy and Programmes

Clinical Strategy and Programmes will progress the establishment, enablement and delivery of integrated care through five integrated care programmes – prevention and management of chronic disease, older people, patient flow, children and maternity care.

Clinical and Integrated Care Programmes

In 2016 the clinical and integrated care programmes will 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. The UL Hospital Group will collaborate with the clinical and integrated care programmes to ensure the changes implemented are consistent with frameworks, models of care, pathways and guidelines designed by the integrated and clinical care programmes.

Integrated Care Programme for Older Persons

The purpose of the Integrated Care Programme for Older Persons is to augment primary and secondary care services for older people in the community enabling a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older person. Given the ageing demographics there is an urgent need to build capacity in the provision of healthcare services that can meet this change in the model in both community and acute services. Work is already well established in Limerick. The priority in 2016 is developing this programme across 4 pioneer sites (one being CHO 3 University Hospital Limerick (UCHL) which will commence the implementation of the integrated care programme in 2016. Social care services will lead the process which is multi-agency and multi-divisional.

Conclusion

Notwithstanding the challenges ahead, the UL Hospitals Group 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
- Implement integrated care pathways for patients with Chronic Obstructive Pulmonary Disease (COPD), asthma, heart failure and diabetes in the context of the Integrated Programme for Prevention and Management of Chronic Disease
- Improve patient access and experience by the provision of integrated care in collaboration with social care, primary care and mental health services
- Commence implementation of the Maternity Strategy
- Embed robust governance structures within the group in line with the HSE Accountability Framework
- Develop and improve capacity for quality and patient safety within the group through the implementation of the patient safety and quality framework which will be established by the Acute Division, that will address patient advocacy, complaints, incident management and response, learning systems and service improvement
- 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 the group in 2016

Improving Quality and Reforming Service Delivery

Strategic Priorities for 2016

The Acute Hospitals Division places a significant emphasis on the quality of services delivered and on the safety of those who use them and therefore will work in close collaboration with Quality Improvement Division (QID) and Quality Assurance and Verification Division (QAV) to improve the overall quality and safety of services with measurable benefits for patients and service users.

The four objectives which underpin the quality and patient safety programme led by QID and QAV are:

- Services must be relevant to the needs of the population
- Patients and service users must be appropriately encouraged and empowered to interact with the service delivery system
- Health services must work to a set of clear quality and safety standards that are based on international best practice
- Services must be safe and a strong focus must be placed on ensuring quality and safety is improved through a combination of improvement programmes and formal accountability for ensuring safe services

Progress on patient safety, clinical effectiveness and quality improvement continues to enable integrated care and promote services that are appropriate, delivered with the patient / service user at the centre, and are based on best clinical practice and integrated care pathways. In this context the objectives for 2016 include:

Leadership and Governance for Quality and Safety

- Ensure that authority and accountability for the quality and safety of services across all service areas is integrated into operational service management through appropriate leadership, governance, structures, and processes
- Develop capacity for development of quality and patient safety within Hospital Groups whereby each service has a defined patient safety and quality operating model to address service user advocacy, complaints, incident management and response, learning systems, service improvement, and change of culture
- Ensure compliance with all national standards and regulations as they relate to quality and safety of services along with a strong focus on continuous quality improvement of services
- Build capacity and capability for leadership and improvement in quality through formal education and training programmes and supporting staff to implement quality improvement initiatives in their services
- Strengthening the HSE's governance arrangements under the health service Accountability Framework by measuring, monitoring and reporting on the performance of the health service in relation to the quality and safety of care, with a specific focus on identifying and addressing areas of under-performance by recommending appropriate and proportionate action to ensure the improvement of services
- Putting in place an assurance system including measurement, healthcare audit and reviews that seek evidence that quality and safety is prioritised and committed to at all levels of the healthcare delivery system
- Establish positive and effective staff engagement as a keystone of quality improvement and person centred care by partnering with services to develop and test methodologies, build organisational leadership capacity and share learning

Safe Care

- Acting to promote the reduction of risk to the public, staff and healthcare services by adopting a risk based approach to predicting, identifying and responding to service areas where significant performance, quality and safety concerns may exist
- Improve monitoring, investigation and learning processes from serious incidents across all service areas. Progress the implementation of recommendations from major reports and serious incidents across all service areas
- Continue support and commitment to the process of development, implementation and monitoring of National Clinical Effectiveness Committee (NCEC) National Clinical Guidelines and Audit in all appropriate services including Early Warning Systems, Clinical Handover, Healthcare Associated Infections (HCAIs) and Sepsis
- Putting in place an effective system to identify, manage, investigate and implement the learning from serious safety incidents, safety investigations and regulatory investigations and inspections
- Strengthening the HSE's regulatory capacity to fulfil its responsibilities in the area of medical ionising radiation
- Continue the implementation, control and prevention of HCAIs / antimicrobial resistance (AMR) in accordance with HCAI standards across all service areas including decontamination standards
- Reduction in medication errors
- Establish a National Independent Review Panel with an independent Chair and Review Team members as part of the HSE's enhanced arrangements for investigations. The Review Panel will focus on serious incidents that occur in disability services across the HSE and HSE funded services

Effective Care

- Continue to prioritise improvements in the quality and safety of care in maternity and perinatal services
- Prioritise the safeguarding of service users, and support improvements in services in residential intellectual disability services
- Provide leadership and support to enable the services develop capacity and capability to deliver on key national patient safety programmes in primary care, social care and acute settings to address internationally recognised causes of harm to people (including HCAI, medication safety, pressure ulcers, falls prevention and nutrition and hydration)
- Develop a national policy framework for Policies, Procedures, Protocols and Guidelines (PPGs) including education training and support and commence the development of a document control system national repository for PPPGs

Service User Experience

- Listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals
- Conduct a service user and patient experience survey in each hospital (in conjunction with Health Information and Quality Authority- HIQA) and commence patient experience surveys in primary care and community services
- Develop and implement a national person-centred care Programme which engages, enables and empowers people to be at the centre of service delivery
- Continue the development of a patient-centred and improvement culture in the HSE that will deliver on sustainable quality improvement with the implementation of a framework for improving quality which provides a structured approach to improving health and social care service delivery by enabling staff to focus on the key drivers for quality improvement
- Continue to develop access to advocacy for all patients and service users within, Hospital Groups and Ambulance Services; work to ensure that advocacy is available to older people in all settings; and provide advocacy services to patients, including work with Patient Focus

- Leading a national person-centred programme (including listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals)

Health Service Reform

The Hospital Groups will continue to establish their governance structures and management teams in line with the Strategic Plans for each Group which will be finalised early in 2016. The arrangements between the Hospital Groups and relevant Academic partners will be consolidated and clinical governance structures defined. The Acute Division National Strategic Plan will be developed in conjunction with Systems Reform Group.

Operational Framework – Financial Plan

Introduction

The University of Limerick Hospital Group net 2016 allocation amounts to €255.243m.

Significantly, 2016 is the year when the funding model is migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for public hospital care covering inpatients and day-cases.

	2016 Available Budget €m	2015 Closing Budget €m
University of Limerick Hospital Group	€255.243	€263.584
Total Available Funding	**€255.243**	**€263.584**

Existing Level of Service / Cost pressures

The cost of providing the 2015 level of service will grow in 2016 due to a variety of factors. Under Activity-Based Funding cost growth is considered under two headings - 'price' and 'volume'.

1. We know that we will have 'price' effects in the following areas. This means that our underlying price will rise, but we will not obtain any additional service for that expenditure:-
   - National pay agreements
   - Public pay policy requirements
   - Quality and safety requirements
   - New drugs and improved medical technologies
   - Supplier price increases, and potentially some price savings if oil prices translate into our energy bills

2. In addition to the 2015 level of service we know that we will have 'volume' pressures in 2016 due to the nature of our demographic, over 85 population etc. Our challenge in this context is that the ABF targets have been locked with a price to fit within the funding envelope. Those targets are based on the rolling 12 months to the end of October 2015. We do not have funding to exceed that level of service.

We must not grow our activity in 2016 as this will lead to increased non-pay expenditure on bloods, laboratory, medical consumables etc. It can also lead to increased expenditure on variable pay such as overtime.

Further to these price and volume pressures, ULHG have a further €8.5m income challenge to be addressed in 2016. This relates to historic income-collection targets which have now been included in the expenditure budget.

The HSE and ULHG will ensure that appropriate management effort and attention is applied to maximising the delivery of the any savings measures in the overall budgetary performance of the hospitals. Thereafter the HSE and the Department of Health have acknowledged the shared risks inherent in the extent of the savings.

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

1. Headcount and other pay controls
2. Management of activity volume and clinical non-pay
3. System-wide approach to non-clinical non-pay
4. Maximising delivery of income targets.

1. **Headcount and other pay controls**
   Following a number of years of economic recession, the hospital system did fill a range of risk-related posts in 2015 (260) which has been vacant due to the recruitment moratorium. The strategy to deliver the EWTD and efforts to reduce agency premium also involved increases in headcount. It is clear that the financial envelope which is available in 2016 does not allow for any further recovery of vacant posts.

   The HSE has already given hospital groups a pay framework for 2016 which will require them to improve the governance of headcount, further specific agency conversion where appropriate and manage expenditure on variable pay at 2015 levels - particularly through controlling activity∞ volumes.

2. **Management of activity volume and clinical non-pay expenditure**
   The three critical components of clinical non-pay expenditure are:-
   1. Activity volume
   2. New drugs and increased volume of existing drugs due to treatment regimes
   3. Improved medical technologies

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

   The monthly performance meetings with the hospital groups will focus heavily on the volumes being produced to ensure that these are within the targeted levels for the year which have been locked in place with prices to fit the funding envelope. To the greatest extent practical and consistent with the safe delivery of services hospitals will deliver services at 2015 levels.

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

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

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

3. **System-wide Approach to Clinical Non-pay**
   Working with colleagues in ULHG, there will be reviews of all areas of non-clinical expenditure to achieve any potential savings.

4. **Maximising Delivery of Income Targets**
   The changes in legislation in relation to bed designation have allowed the hospital system to increase its income generation. The €8.5m accelerated income target is a part of the increased target together with other factors such as an expected 4.55% growth in the private patient market.

Activity Based Funding

As indicated in the introductory paragraph, 2016 is the year when ULHG funding is migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for care covering inpatients and day-cases. ABF involves a 'revenue' stream being offered to each group/hospital for specified inpatient and day-case activity, together with a block grant for other work. The combined total can be referred to as the budget, but with a very different underlying construction - *if the specified work is not delivered, the ABF revenue will not be paid.* We recognise that we will have to work with exceptions to this principle - for example a serious outbreak in a hospital might prevent them from delivering work; however the core principle is being established:

- A specified price will be paid for each weighted unit of inpatient work and each weighted unit of day-case work up to the limit of the specified activity target
- If specified work is not delivered, ABF revenue will not be paid
- If excess work is delivered further ABF revenue will not be paid

A national envelope of funding has been determined based on the exchequer funding allocation. Inpatient and day case care is being purchased using price and activity volume, with transition adjustments. The remaining activity such as emergency care, out-patients etc. will remain in the block grant allocation.

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

The UL Hospital Group currently has two hospitals under the ABF programme, University Hospital Limerick and Croom Orthopaedic Hospital. The remaining hospitals in the group will be in a position to fall under ABF in 2017.

Operational Framework – Workforce Plan

Introduction

The UL Hospital Group recognises and acknowledges its people 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 "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. Through supporting and facilitating continuous professional development and learning, embracing leadership and teamwork and accepting and managing change, service delivery and performance will improve.

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 the Acute Hospital Division, 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. UL Hospitals will have greater discretion and flexibility in how they manage their workforce and payroll costs should they meet their budget targets. This needs to be achieved whilst ensuring services are delivered in line with the National Service Plan. The UL Hospital Group is currently working collaboratively with National HR and Finance to develop workforce plans that are closely aligned to funding projections and the group strategy.

Hospitals Employment Levels

The whole time equivalent numbers employed by UL Hospitals Group fell significantly during the years of austerity and by Oct 2015 have returned to 2009 levels (Government Moratorium on public sector recruitment) but over that period there has been a reconfiguration of the skills mix. The hospitals nationally and UL Hospitals will need to reduce total staff numbers in 2016 to achieve the financial targets contained within the Acute Hospital Division Operational Plan. The range of adjustment will vary depending upon the outturn for the group in 2015.

Reducing Agency and Overtime Costs

Whilst UL Hospital Group did a lot of work on reducing agency in 2015 we 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.

UL Hospitals Group will continue to monitor and review agency and overtime costs whilst working to support the directorates with implementing initiatives to reduce costs, such as redeployment, skill mix review, and changes in work practices.

2016 Developments

The planning, approval, notification, management, monitoring and filling of service development posts will be in line with the existing process for approved and funded new service developments as specified in Acute Hospital Division Operational Plan. Other workforce additions, not specifically funded at the outset of the year, will be implemented only where offset by funding redirection within the allocated pay envelope in line with UL Hospitals Group strategic plans.

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. This will also involve 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. The UL Hospital Group will implement actions agreed by the division 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 associated National Framework and Task Transfer Verification Process (December 17th 2015):

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

Workforce Planning

The UL Hospital Group will engage in high quality workforce planning, ensuring that funded workforce plans are developed 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 the group by right-sizing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals. This is required for future planning and to ensure the delivery of safe quality services to patients. 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. Workforce planning for UL Hospitals Group will focus on the strategic objectives of the group over the next 3 years which will take consideration of demographic requirements.

European Working Time Directive (EWTD)

Through the forum of the National EWTD Verification and Implementation Group, the Acute Hospital Division continues to work collaboratively with Irish Medical Organisation, the Department of Health and other key stakeholders to work collectively towards the achievement of full compliance with the EWTD. The Acute Hospital Division is also currently working jointly with National Human Resources in consultation with the Hospital Groups to develop a comprehensive framework plan to support the achievement of full compliance. UL Hospitals Group through the local EWTD steering committee will work to move the group toward the achievement of full compliance.
UL Hospitals through the local EWTD steering committee will work to move the group towards the achievement of full compliance and the ongoing review of rosters/rotas.

Recruitment

The Acute Hospitals continue to work with national HR to recruit and retain highly skilled Medical and Nursing staff to approved positions to support services.

The division will support the work of the HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including:

- Developing a strategy for specialties within UL Hospitals 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 trauma services
- Developing a statement on shared service division within the relevant specialty
- Compiling information on the precise allocation of available facility resources including, for example, allocation staffed theatre time, protected beds, Outpatients (OPD), endoscopy sessions, Non consultant hospital doctor (NCHD) staffing, specialist nursing, allied health staffing and administrative resources. This will ensure that we attract and retain the best to work in the service.

Attendance and Absence Management

UL Hospital Group have made progress in 2015 in reducing our absenteeism. In 2016 we will continue to maintain and build upon the progress achieved during the past year in improving attendance levels through the consistent implementation of the Managing Attendance Policy and Procedures. The performance target for 2016, remains at less than or equal to 3.5% staff absence rate. In addition, the group will continue to support the implementation of an agreed performance management framework. In doing so, managers will receive support to manage absenteeism and performance appropriately.

Employee Engagement

As outlined previously, the UL Hospital Group will support the implementation of The People Strategy throughout the directorates. Particular emphasis will be placed on the employee experience and increased levels of engagement through ensuring that each staff member is aware of how their role links to the organisational objectives.

Building on what the Group has already put in place further 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. In this context, the group will continue to actively engage with staff and will continuously seek to identify opportunities to involve more staff in planning and decision making. UL Hospitals have put in place an Information and Consultation with the union representing staff. This along with listening forums and communication roadshows have increased the communications with staff working in the group.

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 a divisional 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.
UL Hospitals have prioritised Health & Safety in 2016 and have developed a training plan to ensure that all staff attend mandatory training when required.

Accountability Framework

Introduction

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

The key components of the Performance Accountability Framework for the Health Services 2016 as they relate to the acute hospital services are as follows:

- Continued strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group Chief Executive Officers and the CHO Chief Officers
- Completion of Formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers
- A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance
- Continued cooperation with the National Performance Oversight Group with respect to accountability responsibilities with the focus on the balanced scorecard
- Accountability arrangements will be put in place in 2016 between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Operational Business Plans

Accountability Framework

In the second half of 2015 a review of the operation, effectiveness and application of the Accountability Framework was commissioned and completed. The learning from this and recommendations arising will be taken on board during 2016 as appropriate and the acute hospital division will roll out the associated implementation plan once finalised.

The 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. The HSE's Escalation and Intervention Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels.

Accountability Levels relevant to Acute Hospital Services

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

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

Level 1 Accountability:	■ The HSE's accountability through the Directorate to the Minister for Health
Level 2 Accountability:	■ The Director General's accountability to the Directorate
Level 3 Accountability:	■ National Director accountability to the Director General
Level 4 Accountability:	■ Hospital Group CEOs accountability to National Director Acute Hospitals.
Level 5 Accountability:	■ Service Managers accountability to the relevant Hospital Group CEO.Section 38 and Section 39 funded agencies accountability to the relevant Hospital Group CEO.

Throughout 2015 the UL Hospital Group participated in monthly level 4 meetings between the group CEO and the National Director Acute Hospitals. The group has also fully implemented level 5 accountability, through monthly meeting between the CEO and the group Directorate management team. The accountability framework is currently being expanded within directorates to departments/sections, which will provide a comprehensive framework through to senior management level.

Service Arrangements and Compliance

The HSE Acute Hospitals Division provides funding to 16 Voluntary Hospitals, known as Section 38 Agencies for the delivery of a range of healthcare services. St. John's Hospital is the only Section 38 agency provider in the UL Hospital Group.

These agencies are required to enter into a formal Service Arrangement with the Executive. 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

Delivery of Services

UL Hospitals Group Key Priorities and Actions to Deliver on Goals in 2016

CEO Priorities

No.	Priority	Persons Responsible	Target/ Date
1.	Sustain Improvements – Access, Quality, and Finance. Review resources. Prepare Group for Trust Style Business Model	Executive Team	Q 1-4
2.	Review and Refine UL Group Strategic Plan. Align to National Legal Framework (pending June 2016). Present to DoHC.	Board & Executive Team	Q 2
3.	Empower Clinical Directorates as Operations Function. Develop Facilities Directorate and decide on HCSP Directorate.	CEO & COO	Q 2 & 3
4.	Embed Strategic Function and Direction of Group Executive. 10 year forward plan.	CEO	Q 2 & 3
5.	Develop robust, transparent and accountable QRPS Function aligned to National Policy.	CEO & CCD	Q 3
6.	Develop Accountability Framework for Board Sub Committees: QRPS – Develop framework to include Quality Metrics, Outcomes, and Morbidity & Mortality Data.	CEO, CCD & Board Sub Committee	Q 3
7.	Continue to place patient at centre and embody our brand of Caring, Courteous and Professional.	CEO & Executive Team	Q 1-4
8.	Embed Performance Management Process. Expand Plan of Actions (POAs) Commence 10+5 Objectives with Group Executive	CEO	Q 1
9.	Develop St John's Hospital's linkages further and focus on Accountability, Compliance and SLA with UL Hospitals Group	CEO & COO	Q 2
10.	Progress Ambitious Capital Development Plans for UL Hospitals Group Emergency Dept, Dialysis Unit, CERC, Croom Development, 96 Bed Single Room Block, Nenagh and Ennis Development and St John's Bed Block Feasibility Study.	CEO	Q 2-4
11.	Progress New Maternity Hospital for Group. Secure design funds and progress planning.	CEO & Executive Team	Q 1-4
12.	Continue to improve Patient Care, Improve Culture and Staff Value.	CEO & Executive Team	Q 2- 4
13.	Progress Learning, Development and Succession Planning for the Group. Recruit and Retain the Best. Become a Magnet Group.	CEO, DHR & Executive Team	Q 1- 4

14.	Focus on Research with University of Limerick and UL Hospitals Group. Agree and Develop the Research Function in one centre – CRSU. Publish and showcase work.	CEO & CAO	Q 2 & 3
15.	Progress ICT Development to include EPR, iPMS and Finance Systems. Improve ICT Support and Function.	CEO & Executive Team	Q 3 & 4
16.	Establish Patient Council. Develop Patient Feedback Metrics.	CEO & CDONM	Q 1
17.	Implement Activity Based Funding Model across Group. Define Activity by site align HIPE coding.	CEO & CFO	Q 2 – 4
18.	Implement Priorities of National Service Plan 2016.	CEO & Executive Team	Q 2 -4
19	Implement National Maternity Strategy.	CEO & Executive Team	Q 2 -4
20.	Develop a Health & Wellbeing Implementation Plan for the Group	CEO, CFO & CDONM	Q 2 – 3

Acute Hospital Division Priorities

The University of Limerick Hospital Group will deliver the following goals in 2016 in association with the Acute Hospitals Team:

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 hospital group *Healthy Ireland* plans	Q1-Q3
	Complete Healthy Ireland Plan	Q3
	Appoint Healthy Ireland Implementation Plan Lead	Q1-Q4
	Increase the number of hospital frontline staff trained in brief intervention	Q1-Q4
	Promote increased uptake of seasonal flu vaccination by hospital staff	Q1
	Implement the HSE Policy on Calorie Posting in all hospitals	Q1-Q4
	Support Health and Wellbeing Division in the development of a Hospital and Patient Food Policy and contributing to the development of the NCEC guideline for the Identification and Management of under nutrition in Acute Hospital settings	Q1-Q4
Cancer Screening	Support the expansion of BreastCheck from 65–69 years and develop the BowelScreen Programme in 2016 to support a two year screening round by 2017	Q1-Q4
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*	Ongoing
	Commence monthly reporting of key performance indicators on the number of patients colonised with multi-drug resistant organisms (MDRO) that cannot be isolated in single rooms or cohorted with dedicated toilet facilities	Ongoing
	Monthly reporting of hospital acquired S Aureus bloodstream infection and hospital acquired new cases of C Difficile infection	Ongoing
Models of Care	Develop a national model of care for haemachromatosis In collaboration with Primary Care	Ongoing

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

Priority Area	Action 2016	Target/ Date
Scheduled Care	Improve performance in relation to scheduled care by ensuring active management of waiting lists for inpatient and day case procedures and reduce waiting times by strengthening operational and clinical governance structures including: • Monitor and report chronological scheduling for routine inpatient and day case procedures including waiting lists for a range of diagnostic procedures • Commence monitoring of waiting lists for a range of diagnostic procedures • Adherence to National Treatment Purchase Fund (NTPF) guidelines in relation to scheduling of patients for surgery • Commence monitoring of Scheduled waiting list cancellation rate • Reorganise hospital group services with an increased focus on small hospitals managing routine urgent or planned care locally and more complex care managed in the larger hub hospitals • 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 the Primary Care Division 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	Ongoing
Out Patient Improvement Programme	Continue to 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. • Musculoskeletal (MSK) and Dermatology out-patient pathways to be completed, with proof of concept in hospital groups • Ophthalmology and neurology out-patients pathways of care to be commenced • Finalise roll-out of e-referrals (Phase 1) to all hospitals • Initiate formal audits of Outpatient Services, as per OP KPIs • Develop an Outpatient Patient Satisfaction Tool • Review and update protocol for the management of Outpatient Services • Refinement of New to Review metrics to exclude Obstetric and Warfarin Clinics	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 but in particular 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	Q1-Q2
	Activate full escalation response in the event of red status on trolleygar or any patient breaching the 9 hour maximum trolley wait as per Mandatory National Directive 27/11/15	Ongoing
	Implement the Irish Hospital Redesign Programme in Limerick University Hospital in 2016 and continue to implement the programme in Tallaght Hospital, which has been established to improve healthcare delivery in Irish hospitals, using a redesign approach in conjunction with the integrated programme for patient flow.	Q1-Q4
Quality	Continue to implement the *National Standards for Safer Better Healthcare in Acute Hospitals (NSSBHC)*	Q1-Q4
	Complete first and second assessments against NSSBHC in all hospitals and develop action plans to address any gaps identified	Q2
	All Acute Hospitals to report and publish monthly hospital patient safety statement	Q1-Q4
	Implement the aspects of Memo of Understanding between State Claims agency and HSE as it relates to Acute Hospitals to ensure the timely sharing of actual and potential clinical risk information.(once approved)	Q1-Q4
	Co-operate with Quality Assurance and Verification Division on the roll out Phase Two of the National Incident Management System	Q1-Q4
	Establish processes and governance structures in Hospital Groups which reduce the incidence of and support the management of Serious Reportable Events (SREs) and Serious Incidents (SI s)	Q1-Q4
	Establish 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	Q1-Q4
	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	Q1-Q4
	The Acute Hospitals Division will work with the Quality Improvement Division to: • Improve the safe management of medicines • Ensure nutritional assessment of vulnerable inpatients and good nutritional management of those at risk • Ensure our services are truly person centred • Ensure the governance arrangement in hospital groups has a clear structure and process to prioritise the focus on the quality of care provided. • Improve the measurement and analysis of quality in the acute sector • Further develop the role of clinical leadership in the hospital system • Train staff in quality improvement methodology	Q2-Q4

	Based on the findings of the HIQA Portlaoise Report: • Each Hospital Group will undertake a risk assessment of clinical and corporate governance within their Group with a view to identifying and stratifying immediate risks and mitigating actions, (in particular the transfer policy for high risk patient cohorts) • 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 Continue to develop the hospital's capacity to respond to Category 4 (e.g. Ebola) type threats Continue to support the implementation of the Major Emergency Response function in Acute Hospitals.	Ongoing Q1-Q4
Maternity Services	Implement maternity service improvements in line with HIQA recommendations and other relevant reviews including: • Commence implementation of the National Maternity Strategy • ULMH to report and publish monthly maternity patient safety statement • Implement the Maternity Charter which will be informed by the Maternity Strategy • Appoint Director of Midwifery to UL • Implement the midwifery workforce planning study (Birthrate Plus) • Plan and develop the provision of equitable access to antenatal anomaly screening in all Maternity Units in the context of emerging clinical maternity networks • Implement the Standards for Bereavement Care in UL • Progress plans for the relocation of Limerick Maternity Hospital	Q1-Q4 Q1 Q2-Q4 Q1-Q3 Q1-Q4 Q1-Q4 Q1-Q4 Ongoing
National Specialty Services and Care Pathways	Develop a detailed national implementation plan for targeted hip ultrasound screening programme for infants at increased risk of developmental dysplasia of hip (DDH) Support the phased implementation of the policy when published on Trauma Networks for Ireland within existing resources Continue to work with the National Renal Office to: • Increase the number of patients accessing Renal Home Therapy (Peritoneal Dialysis and Home Haemodialysis) treatments • Establish a National Plan for Haemodialysis Patient Transport Establish a National Endoscopy Working group to target improvements in endoscopy services nationally. This working group will be clinically led and will target actions to improve current capacity and demand management	Ongoing Q1-Q4 Q1-Q4 Q1-Q2
Clinical and Integrated Care Programmes	Support the development of implementation plans for integrated care pathways across all hospitals in collaboration with the Clinical and Integrated Care Programmes **Integrated Care for Patient Flow** Support the establishment of the Integrated Care Programme for Patient Flow and prioritised work-streams Merge the Irish Hospital redesign Programme to support the planned and phased implementation of a pilot project to design, test and deploy the application of scientific management practices in healthcare to tackle patient flow.	Q1-Q4 Q1-Q4 Q1-Q4

	The Clinical Strategy and Programmes will lead in the design and phased implementation of new service delivery models and methods supported by the Acute Hospital Division: • Emergency service communication project • Enhancing Acute surgical Assessment Services • Enhancing Musculo-skeletal physiotherapy services • Phased implementation and planned rollout NQAIS **Integrated Care for Older People** Support the phased implementation of evidence based, integrated care pathways for older persons in conjunction with the Integrated Care Programme Older Persons (ICP OP) and National Clinical Care Programme older People (NCCOP) to improve quality, access and value for older persons requiring acute care. This includes; • NCCOP and ICP OP will engage with CHO and Hospital Group Leadership to prepare pioneer areas to work towards shifting models of care, building on local initiatives and combining the ICP operation framework. • NCCOP and ICP OP will support the establishment of local Integrated Care Team. • NCCOP and ICP OP will establish project work streams to develop and evaluate model. **Integrated Care Programme for the Prevention and Management of Chronic Disease** Support the phased implementation of integrated care pathways across all hospitals in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease for patients with : • COPD, • Asthma, • Ischaemic heart disease, • Diabetes. Collaborate with ICPCD and the Office of the Chief Information Officer (OCIO) in the design of chronic disease registries for use in primary, secondary and continuing care **Integrated Care Programme for Children** • Support the establishment of the Integrated Care Programme for Children and associated work-streams. • Complete the roll-out of PEWS in UL.	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4
Ambulance Service	Develop a performance indicator which will monitor time taken for clinical handover of patients in ED that will be based on the National Ambulance Handover Protocol for the Handover of Ambulance Patients in EDs and differentiates between completion of clinical handover and the time ambulance crew are available for next call, in conjunction with NAS.	Q1-Q4
Organ Donation	Continue to develop an improved organ donation and transplantation infrastructure with a view to achieving target donation and transplant rates.	Q1-Q4
Cancer Services	Improve rapid access services for patients where there is a high index of suspicion of prostate or lung cancer. Improve access for patients attending Symptomatic Breast Disease services who are	Q1-Q4 Ongoing

	triaged as non-urgent within a 12 week timeframe. Support improvements in diagnosis, medical oncology, radiation oncology, surgery and multi-disciplinary care for cancer. Implement the National Clinical Guidelines – No. 7 Diagnosis, Staging and Treatment of Patients with Breast Cancer, No. 8 Diagnosis, Staging and Treatment of Patients with Prostate Cancer and No. 13 Diagnosis, Staging and Treatment of Patients with Gestational Trophoblastic Disease. Appoint Advanced Nurse Practitioners to support consultants in cancer services	Ongoing Q1-Q4 Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Governance	Embed the hospital group structures within Acute Hospital Services Develop the Hospital Group Strategic plans and The Acute Division National Strategic Plan in conjunction with Systems Reform Group. Consolidate arrangements between Hospital Groups and Academic Partners as per Reform Programme. Comply with recommendations from local audits and potentially systemic recommendations in accordance with HSE Internal Audit procedures. Complete Service Arrangements as appropriate in accordance with HSE Governance Framework for Funding Non-Statutory Provided Services. Align Emergency Management structures for emergency planning and crisis response to new Hospital Groups. Appoint Hospital Group Leads for Emergency Management. Working with the emergency management function of the HSE, ensure emergency management structures across hospitals continues to develop.	Q1-Q4 Q2 Q1-Q4 Q1-Q4 Q1 Q1 Q1-Q4
Patient Experience	Implement plans to build the capacity and governance structures needed to promote a culture of patient partnership across acute services. Use patient insight to inform quality improvement initiatives and investment priorities Undertake Patient Experience Surveys in conjunction with HIQA and DOH in all acute hospitals on a phased basis within available resources. Support the implementation of the HSE Open Disclosure National Guidelines.	Q1-Q4 Q1-Q4 Q3-Q4 Q1-Q4
National Clinical Guidelines	Continue implementation of the National Clinical Guidelines: • **Communication (Clinical Handover) in Maternity Services,** ○ National Clinical Guideline No. 5	Q2-Q4

	• **Communication (Clinical Handover) in Acute and Children's Hospital Services**, National Clinical Guideline No. 11
	• **Sepsis Management,** National Clinical Guideline No. 6
	  ○ Hospital Group Sepsis leads will complete a gap analysis of the implementation of the guideline in each Hospital.
	  ○ Sepsis Leads will develop an action plan informed by GAP analysis for implementation of the Guideline in each Hospital Group.
	  ○ Develop performance indicators that will provide assurance of compliance with the Guideline
	
	Develop self-audit schedules and follow-up action plans in each of the hospital groups for:
	• NEWS -National Early Warning Score
	• IMEWS -Irish Maternity Early Warning System
	• PEWS -Paediatric Early Warning Score
		Q1
		
		Q2
		
		Q1-Q4
		
		Q2

Protection of Children and Vulnerable Persons	Ensure the appropriate staff are appraised of the Children First Act and their duties and responsibilities. Provide training to relevant staff in conjunction with Children First development officers. Implement the policy on Safe-guarding Vulnerable Persons at Risk of Abuse in conjunction with Social Care Division.	Q1-Q4 Q1-Q4
Staff Engagement	Use learning from the employee survey to shape organisational values and ensure that the opinions of acute hospital staff are acknowledged.	Ongoing

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

Priority Area	Action 2016	Target/ Date
People Strategy 2015-2018	Implement the People Strategy 2015-2018 within UL. Develop Staff engagement programmes which aim to involve staff in service delivery planning. 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 within current resources Support National HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including: • Develop an agreed Hospital Group strategy for specialties. • Develop a statement on shared service division within the relevant specialty. • Compile information on the precise allocation of available facility resources for consultant services. Continue to work with National HR on Nursing Recruitment and Retention initiatives Ensure that health education campaigns will include specific information and supports to help staff improve their own health and wellbeing	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4

	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 Local Implementation Groups (LIG) which will oversee the local implementation of the Final Agreement of the *Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement December 17th 2015*	Q1
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. Monitor and report through the Office of the Nursing and Midwifery Services: • The number of nurses registered to prescribe medicinal products. • The number of nurses registered to prescribe ionising radiation. • The number of ED and AMAU nurses who receive clinical skills and competence education to improve patient flow. • The number of oversees nurses who completed a mandatory adaptation programme.	Q1-Q4 Q1-Q4
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	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	Move to the next phase of transition to an Activity Based Funding model of funding hospital activity with the initial focus on inpatient and day cases. All hospitals will complete HIPE coding within 30 days	Q1-Q4 Q1
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.	Q1-Q4
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.	Q1-Q4

	• 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
NQAIS-Mortality	Continue the roll out of the NQAIS-NAHM (National Audit of Hospital Mortality) Module to UL.	Q1-Q4
NQAIS-Radiology	Continue to support the development of Radiology Clinical Programme in NQAIS radiology system.	ongoing
Health Business Services	Acute Hospitals continue to collaborate with Health Business Services to embed and adapt the HBS customer relationship model	Q1-Q4

UL Hospital Group Directorate Priorities

The UL Hospitals Group is comprised of four clinical directorates and one service directorate. While each directorate works for the specialties/areas within their remit, as can be seen from the group priorities, there is a close working relationship between all directorates to improve the quality of service we deliver to our patients.

The directorates are as follows:

- **Medicine Directorate**
  The Medicine Directorate is the largest directorate in the UL Hospital Group in terms of the wide range of sub-specialties it provides on an inpatient and outpatients basis, such as Emergency Medicine, Gastroenterology, Cardiology, Nephrology, Respiratory, Dermatology, Rheumatology, Endocrinology, Oncology Haematology, Palliative Case and Breast Services.

- **Perioperative Directorate**
  The Perioperative Directorate in UL Hospital Group is charged with the provision of quality, safe patient care before, during and after surgery. The Directorate provides Emergency and Elective Surgical and Anaesthetic Services across all six hospital sites.

- **Maternal & Child Health Directorate**
  The Maternal and Child Health Directorate provides inpatient and outpatient services to the Obstetric, Gynaecological and Paediatric patients of the Mid-West at the University Maternity Hospital Limerick and the Paediatric Department at University Hospital Limerick.

- **Diagnostics Directorate**
  The Diagnostics Directorate was established to unify the governance structures of Radiology and Pathology. This Directorate also incorporates Health and Social Care Professionals.

- **Facilities Directorate**
  The Facilities Directorate has responsibility for Clinical Engineering, Health Care Records, Hospitality, Porter Services, Security, Maintenance and Capital Projects.

Key Priorities identified as local to the UL Hospital Group 2016

The following are the UL Hospital Group key priorities that relate to the Directorates outlined above for 2016.

Promote Better Health and Wellbeing as part of everything we do so that people will be healthier

Priority Area	Action 2016	Directorates Responsible	Target/ Date
Health & Wellbeing	**Review of facilities conducive to health and wellbeing lifestyles** • Completion of Group Employee staff survey to assess health and wellbeing needs of our staff with a response rate of 30%. • Engagement with Limerick Smarter Travel and National Travel Authority with regard to extension of bike lanes and Coca-Cola Rent a Bike scheme to the Raheen-Dooradoyle area. **Review of health and wellbeing initiatives for the community** • Continue to support Hospitals Outreach Committee in developing initiatives to promote health and wellbeing in our community. • Previous initiatives were day & evening sessions in Community Centres by members of Dietetics, Paediatric, and Elderly Care Teams • Extension of MDT Health Information Road show to community & educational settings • Invite member of community to sit on committee – member of community on Design and Development Steering Group for new maternity build • Support a culture of health and wellbeing for staff & patients	Facilities, Diagnostics Facilities Perioperative, Medicine, Diagnostics, Child & Maternal Health	Q1-Q4 Q1-Q4 Q1-Q4
Tobacco Free Campus	**Continue to work towards compliance with the Tobacco Free Campus Policy** • Hospital Group wide working group established. • Ongoing audit of documentation of smoking status of all patients and brief intervention offered.	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics. Diagnostics, Facilities	Q1-Q4 Q1-Q4

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

Priority Area	Action 2016	Directorates Responsible	Target/ Date
Capital Development	**Reduce delays with opening of new ED, UHL** • A key priority for 2016 will be planning for the new Emergency Department opening in early 2017. This will require the extensive commissioning of the unit in conjunction with a comprehensive ED-targeted recruitment.	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics.	Q4
	New Dialysis Unit • The dialysis service in the University Hospital Limerick is at capacity and consequently in 2016 this service will relocate and expand to a more suitable location in the campus. A new 25 bed dialysis unit is being commissioned to provisionally open in Q3 2016.	Medicine, Diagnostics, Facilities	Q3
	Clinical Education and Research • This project is a partnership initiative between the UL Hospitals and University of Limerick and will provide teaching space including a 150 seat lecture theatre and various tutorial rooms, library facilities, academic offices and research and development space.	Facilities	Q4
	Leben Building • The opening of the remaining units in the Leben project will progressed in the Q1 2016. The areas already open include a 24 bed stroke unit and an inpatient Cystic Fibrosis units. The remaining areas to open are the outpatient CF unit, a Specialist Breast Unit and a Dermatology Unit.	Perioperative, Medicine, Diagnostics, Facilities	Q1-Q2
	Sterile Services ULHG • Progress the upgrading of CSSD services on all sites	Perioperative	Q1-Q4
	Surgical Assessment Unit • Expansion of existing SAU model of care with access to more surgical subspecialties.	Perioperative	Q1-Q4
	Opening of Additional Critical Care Beds • Phased opening of further ICU and HDU beds to enable delivery of critical care services.	Perioperative	Q1-Q4
	New Pre-Operative Assessment (PoA) and Day of Surgery Admission (DoSA) Unit • Progress expansion of this service which is pivotal to reducing demand for Inpatient Beds The current facility is at capacity. In line with National Clinical Program for Elective Surgery further expansion of this service at UHL is dependent on relocation to larger physical space and staffing.	Perioperative	Q1-Q4

	Croom Orthopaedic Hospital upgrading of theatres and OP facilities • Progress development of new theatre, CSSD and Outpatient facilities at COH, ULHG.	Perioperative	Q1-Q4
	Acute Fracture Unit • Progress the design of the new acute fracture unit to be implemented in UHL – this unit will provide immediate access to senior decision makers for patients.	Perioperative	Q1-Q4
	Urology Unit and Vascular Suite • Progress development of new Vascular Suite and Urology Unit.	Perioperative	Q1-Q4
	Robotic Surgery • Progress implementation of Robotic Surgery Program at UHL	Perioperative	Q1-Q4
Winter Initiative	**Continue to provide additional capacity as per Winter Capacity Initiative**: • Additional 17 Medical Beds • Additional 5 Isolation Rooms To address some of the capacity issues on the UHL site, 22 patient beds will be opened, in addition the group will commence a phased opening of acute Stroke/Neurology beds, and five beds/rooms for the treatment of patients with Cystic Fibrosis.	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics.	Q1
	• Support UL Hospital Executive in developing linkages with Primary and Respite Care to support timely and appropriate patient flow across services.	Perioperative, Medicine	Q1
	• Continue development of Post-Operative Care Unit (POCU), for high risk patient care post operatively (23 hours) to optimise patient safety and outcomes and reduce post-operative morbidity, thus enhancing patient and organisational outcomes.	Perioperative	Q1
	• Reduce the MRI waiting times for non-life-threatening out-patients.	Diagnostics	Q1-Q4
	• Reduce the waiting times for GP and Out-patient Ultrasound Referrals.	Diagnostics	Q1-Q4
	• Review current capacity in Radiology and address deficits in MRI service.	Diagnostics	Q1-Q4
	• Review current CT service provision across the hospital group, explore opening additional room at UHL and agree a plan to optimise the use of CT in both Ennis and Nenagh	Diagnostics	Q1-Q4
	• Implement the winter resilience plan as required and ensure appropriate service provision when there is a surge in demand	Diagnostics	Q1-Q4
	• Develop a modified appointment system for the Obstetric Ultrasound Ante-Natal Clinics to improve the patient's pathway.	Diagnostics	Q1-Q4

	• Develop "forward ordering" KPI to improve the patient's pathway when attending the Fracture and Orthopaedic Clinics. (This results in some patients being scheduled for their images before the clinic, and reduces bottlenecks).	Diagnostics	Q1-Q4
Maternal & Child Health	• Develop our Neonatal Unit to cater for the newborn babies of the catchment area. • Develop Obstetrics and Gynaecology 'care teams', to improve gynaecology waiting time, enhancing senior medical presence in-house. • Progress the development of a Maternal Day Assessment via a dedicated maternal Day Assessment Unit. • Enhance our paediatric links with our colleagues in the community to better facilitate children to be cared for in their own homes. • Link with the National Children's Hospital Group to agree the implementation of the paediatric model of care for the ULHG as a regional centre. • Plan the expansion of paediatric day services • Explore the need for an Adolescent unit. • Enhance the paediatric high dependency unit, and agree governance. • Explore the relocation the EPAU and Bereavement Service in UMHL	Maternal & Child Health	Ongoing Q2-Q4 Q4 Ongoing Ongoing Ongoing Q4/Q2 Q2-Q3 Q2-Q3
Hospital Redesign	Implement the Irish Hospital Redesign Programme in Limerick University Hospital in 2016 which has been established to improve healthcare delivery in Irish hospitals, using a redesign approach in conjunction with the integrated programme for patient flow. A group lead has been appointed to progress our engagement with the Irish Hospital Redesign Programme in 2016.	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics.	Q1-Q4
Cancer Services	Continue to monitor access to Prostate and Lung Cancer Rapid Access Services and support initiatives to improve the same.	Medicine	Q1-Q4
Integrated Care Programme for Older Persons	Continue early implementation of the Model for Integrated Care Programme for Older Persons at University Hospital Limerick in association with local CHO, Clinical Strategy and Programmes, and Social Care Division.	Medicine	Q1-Q4
Point of Care Testing	Enhance governance and infrastructure to facilitate expansion of point of care testing	Diagnostics	Q1-Q4
Scheduled Care	• Progress development of common central access system to perioperative services with visibility of scheduling across diagnostics/surgery and postoperative care. • Implement the Pathway for Management of the Acute Surgical Patient presenting to ED to strengthen governance arrangements.	Perioperative Perioperative	Q1-Q4 Q1-Q4

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

Priority Area	Action 2016	Directorates Responsible	Target/ Date
Open Disclosure and Good Faith Reporting	**Embed a culture of transparency in the UL Hospital Group.** Further promote a culture of Patient and public partnership through • Develop the UHL Strategy for Public and Patient Involvement • Initiate regular meetings of UHL Patient Council • Implementation of a systematic real time patient feedback programme • Enhanced staffing in PALS service to support patient and public engagement and greater promotion of Your Service Your Say Feedback process • Provide PALS service to the Emergency Department.	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics.	Q1-Q4
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.	Medicine	Q1-Q4
NQAIS-Mortality	Continue the roll out of the NQAIS-NAHM (National Audit of Hospital Mortality) Module to all hospital groups.	Medicine, Perioperative, Child & Maternal Health	Q1-Q4

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	Persons Responsible	Target/ Date
Education, Research & Innovation	**Further development of Clinical Research Unit** • Further growth and development of the Clinical Research Unit (CRU), which is a joint initiative between UL and ULHG and which is a component of UL's recently established Health Research Institute. It will be housed in the new €12 million Clinical Education & Research Centre (CERC) which will open on the UHL site in September 2016. • Integrate undergraduate and post graduate education programme. • Further support staff education • Strategic engagement for innovation and funding. • Continue to participate in National Clinical Audit Programs including Trauma, Critical Care and Hip Fracture.	ULHG Perioperative	Q1-Q4 Q1-Q4
Learning and Development	**Roll out of performance management training** • Working with national colleagues to roll out performance management training in 2016. • Develop and support educational programs for healthcare staff. • Develop Perioperative Education and Research Program strategically aligned with the National Clinical Programs and international best practice. • Promote and continue to build on the success of the Sylvester O'Halloran Symposium; • Develop the surgical Grand Rounds Platform • Continue to share the learning from the Perioperative Collaborative projects. • Continue to share and implement the learning from safety incidents across disciplines • Support colleagues locally and nationally through sharing educational video on implementing the Safe Surgery Checklist.	Peri-Op, Medicine, Child & Maternal Health, Facilities, Diagnostics Perioperative Perioperative Perioperative Perioperative Perioperative Perioperative	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4
Communications	**Encourage supportive communication between all staff** • To improve employee communications focus on: • The continuation of quarterly two-way communication between staff and management through CEO led and Directorate led roadshows • Continue to run Executive led Listening Forums for cross functional staff groups • Publication of a number of publications for all staff keeping them updated with information on	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics	Q1-Q4

	Patients, People, Performance, Quality and Projects • Encourage the public and staff to highlight issues of concern in an open manner • Publication of Paediatric Surgery Strategy for ULHG	 Perioperative Perioperative	 Q1-Q4 Q1-Q4
IPC Staff training and development	Continue linkages with UL for IPC research and the provision of training & education.	Medicine, Diagnostics	Q1-Q4
Staff Recognition	**Recognise and acknowledge hospital staff who go to extraordinary lengths to provide exceptional care and support to our patients, their families and friends.** The CEO Awards will provide an opportunity to recognise the contribution of all staff through a number of awards and celebrate their achievements in such areas as: 1. Best Patient Experience 2. Caring & Compassionate Workplaces 3. Best Innovation – Clinical 4. Best Innovation – Non Clinical 5. Education & Training 6. Best Team 7. Unsung Hero	ULHG	Q4
Development of Multi-disciplinary Team Based Care	Continue engagement of healthcare professionals in quality based health care through the existing MDT based care.	Perioperative	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	Persons Responsible	Target/ Date
National ICT Systems	• Continue to roll out iPMS (National Patient Management System) • To progress the installation of a new server in the laboratory at UHL a project team to be formed to progress the implementation plan. • Engage in the consultation process for Medlis and work with the project team to ensure that the group is prepared for the implementation going forward.	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics Diagnostics Diagnostics	Q3 Q1-Q4 Q1-Q4
Sustainability	• Establish a sustainability programme to become more environmental friendly. The initiation of this programme will lead towards achieving the Green Flag in 2017 on waste management. Learning from a successful pilot programme will roll out across the UL Hospital site in 2016.	Facilities	Q1-Q4

Equipment Management	• Continue the Medical Equipment Replacement programme • Develop a "Closed Loop" system re Medical Device Alerts within the hospital group. • Establish a process for managing "Field Safety Notices" that emanate directly from suppliers • All service contract in Ennis and Nenagh UL Hospitals will be managed by the Clinical Engineering Dept. • The transfer of medical equipment asset data from the UL existing registers to the National Medical Equipment database- "ECRI-AIMS". **Laboratory UHL** • Advance the blood sciences project in 2016 – pending securing capital funding to commence the enabling works.	Facilities Facilities Facilities Facilities Facilities Diagnostics	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4
Pay-Bill Management and Control	• Ensure compliance with the Pay-bill Management and Control	Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics	Q1-Q4
Financial Management	• Implement an efficient and accurate ABF model to support service delivery and development • Reduce unit costs by maximising efficient use of resources	ULHG	Q1-Q4
Clinical Equipment Library	• Progress the development of centralised medical equipment library facilities, in line with HSE recommendations. These facilities will support the Hospital in terms of patient safety, risk management and cost liabilities.	Facilities	Q1-Q4
Health & Social Care Professionals	• Review the structure and clinical governance for Health and Social Care Professionals.	Diagnostics	Q1-Q2

National Cancer Control Programme

Introduction

Since its establishment in 2007, the National Cancer Control Programme (NCCP) has been steadily implementing cancer policy as outlined in "*A Strategy for Cancer Control in Ireland 2006"* using a programmatic approach to the management of hospital and community based cancer services across geographical locations and traditional institutional boundaries. Accountability for service delivery and expenditure has continued to rest with the designated cancer centres. The NCCP will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally. In 2014, the Department of Health commissioned the "*Evaluation Panel Report - National Cancer Strategy 2006*". Many of the initiatives in the 2016 Estimates Submission are a direct result of recommendation in the evaluation. Both the 2014 Evaluation Panel Report on the 2006 Cancer Strategy and the 2006 Strategy for Cancer Control will provide the foundation for the Department of Health's recently commissioned expert group tasked with developing a strategy for Cancer Control in Ireland 2016.

In the UL Hospitals Group Cancer Services is part of the Medicine Directorate. All the priorities below relate specifically to the group and therefore to that directorate.

UL Hospital Group NCCP Key Priorities and Actions to Deliver on Goals in 2016

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

Priority Area	Action 2016	Target/ Date
Cancer Prevention	Promote skin cancer prevention including greater awareness of risks, knowledge of suspicious moles and facilitate behaviour change towards better sun safety among key at risk groups i.e. schools, outdoor worker and recreational settings.	Q1-Q4
	Promote smoking cessation including engagement with national tobacco control initiatives and the inclusion of pharmacotherapy as a standard part of treatment.	Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Cancer Services in Acute Setting	Progress multidisciplinary human resources planning, development of evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery, technology implementation and the introduction of a nationally funded oncology drugs and molecular testing programme.	Q1-Q4
	NCCP will continue to collaborate with the UL Hospital Group in relation to the implementation of Service Plan 2016 and the implementation of new Cancer Strategy 2016 – 2025.	Q1-Q4
Cancer Services in Community Setting	Support and deliver cancer education and training programmes in the community for nursing and general practitioners.	Q1-Q4
	Develop and evaluate referral pathways that prioritise patients with greatest healthcare requirements.	Q1-Q4

	Monitor the appropriateness of urgent referrals to rapid access cancer services.	Q1-Q4
Cancer Control Programme - Support to carry out National Cancer Strategy	Support practice guideline development, health promotion, preventive and survivorship activities. Advance the Cancer Survivorship Programme in line with the new Cancer Strategy 2016-2025: • Conduct a health needs assessment to ascertain the most suitable model of survivorship care. • Promote patient empowerment for self-management for survivors. • Develop a Patient Treatment Summary and Care Plan cancer survivors • Develop a mechanism for patient input into the development of survivorship programme. • Development of best practice education and guidance on survivorship care	Q1-Q4 Ongoing
Cancer Drugs	Continue to improve access to all Cancer Drugs including new cancer drugs through the national oncology drug management system (ODMS) Expand the scope of the activity based model for projected growth in existing high cost oncology drugs Continue the implementation of the NCCP Oncology Medication Safety report and recommendations for practice. Continue to fund molecular testing to support personalised medicines and targeted therapies.	Q1-Q4 Q1-Q4 Ongoing Q1-Q4

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

Priority Area	Action 2016	Target/ Date
Partnership	Continued collaboration with the Major Academic Institutions and Major teaching hospitals across the country	Ongoing
Patient Experience	Collaborate with HSE/HIQA/DOH Patient Experience study development , ensure inclusion of cancer specific questions	Q1-Q4
Audit	Continue the programme of Clinical Audit and Quality Meetings for each of the tumour sites which will facilitate peer review of NCCP KPI suites.	Q1-Q4

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
Workforce Development	Develop professional staff knowledge, through education, research and collaboration with relevant colleges and educational bodies.	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
Managing Performance	Procure and roll-out a national Medical Oncology Clinical Information System to support the care of medical oncology and haemato-oncology patients, including the provision of systemic anti-cancer therapy, in cancer centres, satellite centres and other locations where patients are receiving systemic anti-cancer treatment, to improve quality, safety and access to patient information.	Q1-Q4

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%
Lung Cancers	
• Clinical Detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer.	> 25%

Quality	Expected Activity / Target 2016
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
• Total inpatient and daycase Weighted Units	1,633,652
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%
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%

Access	Expected Activity / Target 2016
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 ABF and weighted unit (WU) activity supplied by HPO. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU*

Appendices

Appendix 1: Hospital Group Budget

Table 1: Net 2016 Budget

Directorate	Net Expenditure (€m)
Diagnostics	43,755,138
Maternal & Child Health	24,903,937
Medicine	65,070,959
Peri Operative	59,221,131
Shared Services	47,296,559
Voluntary Hospital	
St. John's Hospital	16,248,426
ULHG Total	**256,496,151**

Appendix 2: HR Information

Hospital Group	WTE Dec 14	WTE Oct 15	Medical/ Dental	Nursing	Health and Social Care Professionals	Management/ Admin	General Support Staff	Patient and Client Care
University of Limerick	3,109	3,369	432	1,410	332	556	239	399

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%

System-Wide				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
< 48 hour working week (Acute and Mental Health)	M	100%	78%	95%
Health and Safety 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

UL Hospitals Group - Activity Based Funding Targets by site

Hospital Name	Inpatients		Daycases	
	Cases	WU	Cases	WU
Dooradoyle	26,122	23,900	33,083	36,152
Croom Orthopaedic Hospital	1,866	3,139	3,296	5,316
ABF Total	**27,988**	**27,040**	**36,379**	**41,468**
Ennis	4,107	2,021	6,399	7,393
Nenagh	2,168	1,961	6,349	9,471
St. John's Limerick	3,456	4,280	7,087	8,050
Limerick Maternity	7,783	5,138	256	186
Non-ABF Total	**17,514**	**13,400**	**20,091**	**25,101**
UL Hospitals Total	**45,502**	**40,440**	**56,470**	**66,569**

Acute Hospitals					
Service Area	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**	
Activity				**University of Limerick Hospitals**	**National Target**
Beds Available Inpatient beds **	Existing	Monthly	10,503		10,804
Day Beds / Places **	Existing	Monthly	2,024		2,024
Discharges Activity∞ Inpatient Cases	Existing	Monthly	621,205	45,502	621,205
Inpatient Weighted Units	New PI 2016	Monthly	623,627	40,440	623,627
Day Case Cases∞	New PI 2016	Monthly	1,013,718	56,470	1,013,718
Day Case Weighted Units	New PI 2016	Monthly	1,010,025	66,569	1,010,025
Total inpatient and day case Cases∞	New PI 2016	Monthly	1,634,923	101,972	1,634,923
Shift of day case procedure to Primary Care	New PI 2016	Monthly	New PI 2016		Up to 10,000
Emergency Care - New ED attendances	Existing	Monthly	1,102,680	57,007	1,102,680
- Return ED attendances	Existing	Monthly	94,948	4,113	94,948
- Other emergency presentations	Existing	Monthly	94,855	27,375	94,855
Inpatient Discharges Emergency Inpatient Discharges	New	Monthly	New PI 2016	29,799	408,879
Elective Inpatient Discharges	New	Monthly	New PI 2016	8,543	95,430
Maternity Inpatient Discharges	New	Monthly	New PI 2016	7,158	116,890
Outpatients Total no. of new and return outpatient attendances	Existing	Monthly	3,242,424	220,327	3,242,424
Outpatient attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)	New PI 2016	Monthly	New PI 2016	1 : 2	1 : 2
Births Total no. of births	Existing	Monthly	65,977	4,726	65,977

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%
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

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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 cannot 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	**4.09 * (ULHG Adjusted 2016)**
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
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

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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%	**81.3% * (ULHG Adjusted 2016)**
% 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	**BDU 32% * (ULHG Adjusted 2016)**
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 Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition **	Existing	Annual	Not Yet Reported	TBC
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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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%
% 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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
% 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 of 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%
% usage of O Rhesus negative red blood cells **	Existing	Monthly	<14%	<14%
% of red blood cell units rerouted **	Existing	Monthly	<4%	<4%
% of red blood cell units returned out of total red blood cell units ordered **	Existing	Monthly	<1%	<1%
Reportable events % 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%

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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%
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

Acute Hospitals				
Service Area – Performance Indicator	**New/ Existing KPI**	**Reporting Frequency**	**National Projected Outturn 2015**	**Expected Activity/ Targets 2016**
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*

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

Δ *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									
University of Limerick Hospital Group									
Ennis Hospital, Co. Clare	Redevelopment of Ennis General Hospital (phase 1) to include fit out of vacated areas in existing building to accommodate physiotherapy and pharmacy and development of a local (minor) injuries unit.	Q4 2016/Q1 2017 (phased)	Q1 2017 (phased)	0	50	0.45	1.19	0	0.00
University Hospital, Limerick	Construction and fit out of renal dialysis unit over ED.	Q3 2016	Q4 2016	13	11	1.50	7.20	0	0.00
	Acute MAU and OPD reconfiguration. Ward 1B reverts to a 29 bed ward and the acute MAU will be accommodated in the (old) Ward 6A.	Q4 2016	Q1 2017	5	0	0.50	1.00	0	0.00
	Clinical education and research centre (co-funded with University of Limerick).	Q4 2016	Q4 2016	0	0	2.80	11.20	0	0.00
	Equipping of Leben building - breast unit, dermatology, stroke and cystic fibrosis OPD.	Q4 2015	Q1/Q2 2016	0	0	1.00	4.50	0	0.00