Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NATIONAL SERVICE PLAN 2008

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19th November 2007

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FOREWORD

I am pleased to introduce the HSE's National Service Plan for 2008. This Plan outlines how we will deliver the country's public health and personal social services during 2008 using taxpayers' money allocated to us by Government.

In considering this Plan it is important to firstly consider our Mission, what are we trying to achieve in the medium to long term: *To enable people live healthier and more fulfilled lives,* and view 2008 as a further step on the route to this ultimate goal.

The actions and priorities set out in this document are designed to take us closer to delivering on our long term Vision for the public health service, which is one where *everyone will have easy access to high quality health and social services that they have confidence in and staff are proud to provide*.

The opportunities, challenges and pressures facing Ireland's health system mirror those facing health systems around the world. People are living longer, populations are growing and getting older, expectations and demands for services are increasing, and medical costs are rising at an alarming rate. As people get older they are more likely to suffer from chronic illness and disease such as diabetes, heart failure, some cancers, chronic obstructive pulmonary disease, dementia and arthritis.

The community needs a health and personal social service system that is affordable and capable of delivering nationally consistent high quality services, within the resources available. Citizens need easy access to quality services in the most appropriate and convenient setting, whether this be at home, in a community facility, hospital or centre of excellence.

Against this backdrop, in 2007 we commissioned a review of acute bed capacity requirements for Ireland until 2020. The outcome of this review reaffirms the case for continuing to strengthen the orientation of our system towards a primary and community care model.

In the preferred health system patients can get in, through and out of the health service more quickly. They spend less time in hospital and more time being cared for in their communities or in their own homes. They will receive the type and quality of care they need, when they need it, in the most appropriate setting and from the most appropriate health care professional. This model of care also enables staff to maximise their skills and the care they can provide. It also promotes greater accountability, transparency and value for money.

The concept of the preferred health system which emerged from the review reaffirms the vision set out in the National Health Strategy 2002 that "Primary care needs to become the central focus of the health system". It is also consistent with the six priorities in the HSE's Transformation Programme, viz: simplified patient journeys; easier access to primary and community care; easier access to excellent hospitals; more chronic illness programmes to enable people to be cared for outside hospitals; more transparent and measurable standards; and greater staff involvement in transformation.

Many of the things that we need to do to achieve our ambition are already underway, such as: the development of Primary Care Teams; more outreach services; closer working relationships between hospital-based and community-based service providers, as displayed during the Winter Initiative 2006/2007; the Needs Assessment for Residential Care for Older People; the strong emphasis on primary / community care services in major strategies; and increasing rates of day case work, discharge planning and a focus on reducing average length of stays.

This Service Plan details the various services we will provide during 2008, all of which will focus on improving the experience of those who need them, managing all resources efficiently and effectively, and driving increased value for money.

I am particularly pleased that during 2008 we will be strengthening how we monitor and measure our performance. Being able to measure our progress is an important part of what we do and is essential in terms of accountability and transparency.

It is my intention to support ongoing improvements in the experience patients and clients have of the services we provide, by setting reduced waiting times for access to services as a key target for 2008. Driving performance in this area is a key priority for me.

Finally, I would like to take this opportunity to acknowledge the commitment and contribution of all staff, agencies and individuals to the ongoing development of our public health service.

Prof. Brendan Drumm
Chief Executive Officer

EXECUTIVE SUMMARY

This executive summary sets out the key priorities and objectives of the National Service Plan (NSP) of the Health Service Executive (HSE) for 2008. Our priorities are (1) to direct the provision of care away from acute settings where appropriate and towards services in the community; (2) for those who require care in acute settings, to provide service in line with best international standards, treating the maximum number of patients on a day case rather than inpatient basis; (3) to deliver services within our Vote and within our employment ceiling.

Delivering services within Vote for 2008
We have a total resource of €14.1 billion in 2008 (excluding capital). The service levels in this NSP are those we can deliver based upon the funds available to us for 2008 through Vote 40 of the Oireachtas.

Value for money (VFM) will continue to be a key focus. We plan to deliver €280m of savings through more efficient and effective management of our resources. This NSP and supporting financial framework includes these target VFM savings.

We will have in place robust monitoring and control processes for 2008 to ensure that this NSP is delivered within the Vote from the Oireachtas. There will be a full performance review at the end of each month to address any emerging variances from Vote and other trends. We will not commence or continue developing any new services until we have completed a comprehensive Quarter 1 review to ensure that we stay within Vote in 2008. The exceptions to this include older people services and primary care services, as additional monies have been provided for these areas.

Human Resource Management
Control of employee numbers is critical to successful delivery of the Service Plan 2008 within Vote. Employment levels in 2008 will not be allowed to grow beyond authorised levels. Any recruitment in 2008 will be within the national employment ceiling.

Health Status of the Population
Ireland has the largest population growth rate in the EU at an annual average rate of 1.6% between 1996 and 2006. According to the 2006 census there were 4,234,925 people living in the Republic of Ireland, compared with 3,917,203 in 2002. This represents an increase of 317,722 (8.1%) in four years.

Births have increased by 1,146 per year on average. In addition, the proportion of births to single mothers has risen from 26% in 1997 to 33% in 2006. This rate of growth, and the nature of it, has placed significant pressure on existing maternity and personal and social services.

The increase in population in the 65+ year age group impacts particularly on demand for our services. Our service response to this group will be crucial.

SERVICE DELIVERY

Primary, Community and Continuing Care (PCCC) Services
Our priorities for PCCC are to provide a local point of access to a range of health and personal social services, to enhance services in the community, to provide timely care in appropriate settings and to direct the provision of care away from acute and institutional / residential care and towards services in the community. We will continue to realign the current model of fragmented service delivery towards multidisciplinary Primary Care Teams (PCT) serving populations of approximately 8,000 people.

PCCC's service deliverables for 2008 are framed to ensure delivery within resources, the achievement of financial break-even and the strengthening of efficiency measures to achieve VFM whilst prioritising service delivery areas. A concerted focus will be placed on service reconfiguration to provide cost reductions on the one hand and the expansion of service on the other.

PCCC will continue to provide core services such as 8,500 clients in receipt of Home Care Packages, with a throughput in excess of 10,500, 11.7 million home help hours, over 800,000 contacts to GP out-of-hours services, 25,000 disability day care services, 3,327 foster care places, 30.7 mental health inpatient places per 100,000 population and 7,000 monthly methadone treatment places. In addition, PCCC will prioritise the following:

- Recruitment of staff for 87 Primary Care Teams providing clinical services to their local populations
- A further 606 Public Fast Track Beds for Older Persons.
- Provision of allied health professionals, strengthening the make-up of Home Care Packages to meet the needs of complex cases to avoid admission to, and support early discharge from, acute hospitals.
- Provide additional defined residential places for persons with intellectual disabilities.
- Progress development of Child and Adolescent psychiatric services including more inpatient beds.
- Further development of palliative care in areas such as specialist inpatient services, specialist care in acute general hospitals and specialist services in the community / home care.

Other commitments to be advanced in 2008 will include:

- Progression of a further 100 Primary Care Teams
- New contractual arrangements with dental contractors for emergency and routine dental treatment.
- New contractual arrangements with community pharmacists as a key element of the reform of the community drug schemes.
- Review of Demand Led Schemes carried out addressing areas such as procurement of non-drug items, oral nutritional supplements etc.
- Improved quality in foster care by roll-out of agreed national foster care standards.
- New standardised monitoring arrangements for pre-schools.
- Improved immunisation rates.
- Development of Geriatrician-led Teams in the Community.

Population Health
The key priority for the Population Health Directorate in 2008 is to progress the population health approach which influences the strategic development of the health services as well as influencing the way services are delivered. The Directorate has developed strong inter-directorate working relationships, particularly with National Hospitals Office (NHO) and PCCC. Key areas of collaboration for 2008 include cancer services, chronic illness, hospital configuration, emergency management and healthcare associated infections.

Acute Hospital Services and Pre-Hospital Emergency Care
A key priority for the NHO is to improve our hospital performance in line with best national and international practice. Effective bed utilisation, discharge planning, reduced length of stay and increased use of day surgery are key enablers in this regard, supported by hospital-specific action plans and robust health intelligence / information.

The NHO is also committed to the reconfiguration of hospital services in line with international best practice, to deliver optimal and cost-effective results. More robust governance and service delivery arrangements with hospital service providers will be established at the start of 2008. In addition, specific service transformation projects in areas such as cancer, paediatrics, maternity services and emergency departments will receive particular attention. The NHO is committed to service reviews as an essential component of the development of evidenced based services. These reviews will benchmark hospital services against international best practice, focussing on workforce planning, clinical practice, emerging clinical trends and emerging technology.

The thrust of NHO plans for 2008 will be to favour day case over inpatient treatment, thereby providing more services to patients without requiring access to an inpatient bed. This will further improve efficiency in bed use.

Better management of Emergency Department (ED) presentations is planned in 2008 by developing alternative settings for such treatment.

There are a number of key service areas which are demand-led, arising from demographic adjustments such as:

- Increased demand for maternity services arising from birth rate growth.
- Pressure on dialysis services arising from population growth, chronic illness prevalence and ageing.
- More demand for specialist acute services such as critical care and liver transplantation, arising from increasing patient acuity.
- Increased drug / diagnostic costs, resulting from technological advances.

During 2008, planned or expected activity levels are as follows:

- A total throughput of 1,183,875 inpatients and day cases are planned. Movement from inpatient to day case activity, where appropriate, will increase the ratio of day case to inpatient by 10% (for those specific procedures where patients should be treated on a day case basis).
- A total of 1,168,412 Emergency presentations are expected. Based on experience in 2007, 369,368 hospital admissions from Emergency Departments are expected for 2008.
- The target for 2008 is 2,770,851 Outpatient Department Attendances. More senior decision making and prompt discharge of patients back to the community (where appropriate) will result in more effective management of Outpatient Department Attendances allowing for an increase in new patient appointments and reducing the number of return Outpatient visits.
- Birth numbers for 2008 are projected at 72,653, an increase of over 7% on the expected outturn for 2007.

Other advances targeted for 2008 include:

- Living Donor Programme established at Beaumont Hospital.
- Appointment of Neurology / Neurophysiology consultant posts progressed.
- Recruitment of essential posts agreed to address birth rate growth.
- Contracts in place for dialysis provision.
- Implementation of funded Cystic Fibrosis service developments continued.
- Opening of new Emergency Department at Mercy University Hospital.
- Transfer of services to new facility in Mullingar.
- Joint department of paediatric surgery will be established in Dublin.
- Implementation of findings from tertiary paediatric neurosurgery review progressed.
- New consultant contract agreed.
- PET / CT diagnostic services available in Cork University and St. James's Hospitals. These will be the first publicly funded PET / CT services to be provided in the country.
- Co-location Private Hospitals to be significantly progressed.
- Day Procedure Unit in Cork will be opened on a phased basis throughout 2008.
- A new national ambulance fleet management system will be introduced which will improve national co-ordination and standardisation of the management of the ambulance fleet.
- 7 additional fast response units will be commissioned.
- The application of different incentive systems to reward positive hospital performance.
- No patient will wait more than 12 hours in an ED following decision to admit.
- Measurement of total patient time from attendance to discharge at an ED will commence, dependent on stakeholder agreement.

Cancer Control Programme
Work on progressing the recommendations of the Cancer Control Strategy 2006 will be continued in 2008. A new Cancer Control Programme will be established. Cancer budgetary funding, employees and other resources will be transferred to the new Cancer Programme Director, who took up post in November, 2007.

Cardiovascular Health
Specific areas will be targeted in 2008, including improvement in Acute Myocardial Infarction, Heart Health services, Sudden Cardiac Death and Stroke.

Emergency Management
Emergency Management (EM) is about the planning for, and management of, major events of a scale beyond the normal response capacity of the Health Services. The new national office for EM will standardise and coordinate emergency plans across all parts of the Health Service and with the fire service and the Garda Siochana.

System-Wide Service Integration
Service integration is always a challenge. Key initiatives have been identified to progress this very important agenda. These will ensure service delivery that is well organised and connected across the organisation enabling patients to move more easily through the entire care system.

Quality Improvement
Quality is implicit and embedded in the delivery of all our services. The HSE's organisational-wide Quality and Risk agenda continues to be developed and rolled-out. Particular areas of focus include implementation of the

Quality and Risk Management Framework throughout all Directorates; development of a Corporate Risk Register; code of practice for decontamination of reusable invasive medical devices; healthcare records management; development of criteria and guidance for clinical audit and hospital hygiene.

Issues identified in the 3rd report on hospital hygiene completed by the Health Information and Quality Authority (HIQA) in 2007 will be addressed during 2008. In addition, a particular focus for 2008 will be on the prevention and control of Hospital and Healthcare Associated Infection (HCAI). Targets will be identified for a number of key performance infection control measures, including a reduction in the percent of HCAIs, MRSA infections and reductions in antibiotic consumption.

Value for Money
We will deliver cost reductions of 2% in 2008, i.e. €280m. This includes drug cost savings in 2008 which are estimated at €120m. An ambitious programme of VFM is planned for implementation to support achievement of these targets during 2008.

Consistency and Social Inclusion
Cross directorate initiatives which enable improved harmonisation and equity of all services nationally have been identified. Examples of initiatives which ensure consistency include standardised service level agreements with the non-statutory sector; configuration of services within PCCC and NHO; and resource allocation based on identified needs using national databases (disability and palliative care).

While social inclusion has traditionally focussed on the care and support needs of identified vulnerable groups, this approach is now being broadened to encompass measures aimed at enhancing the responsiveness of all services at all levels of care. Examples of initiatives which ensure a broader social inclusion agenda include the development of a health inequalities framework and implementation of the national intercultural strategy.

Supporting Service Delivery
Our corporate functions support service delivery. Key priorities for 2008 include:

- Progressing the implementation of shared service platforms for human resource management, finance, ICT and procurement.
- Establishing our ICT requirements.
- Consumer complaints investigated within 30 days (85%).
- Parliamentary questions responded to within 15 days of request.
- Estates infrastructure maximised.
- The expansion of Expert Advisory Groups (EAGs) to include Cardiovascular Health, Disability, Maternity Services and Oral Health.

Monitoring and Measuring our Performance
The NSP is supported by a business planning process to ensure its delivery by the HSE during the year. This business model also details our Performance Monitoring and Measurement Framework, together with our Control Process for 2008.

By 1st January, 2008, all managers will have received their budgets, their approved employment ceilings and their expected service delivery commitments. Managers will be held accountable for their performance against budget as well as in respect of service delivery.

In partnership with the DoHC, work has been ongoing to build on, agree and further develop the performance indicators and measures that will be used in 2008 to assess our performance.

SECTION 1
INTRODUCTION

SECTION 1 – INTRODUCTION

In this section, we set out the background and context for the National Service Plan (NSP) including our legal framework, the planning assumptions underlying the NSP, our financial resources for 2008 and our plans for controlling, monitoring and measuring our performance so that we deliver our commitments under the NSP within budget.

National Service Plan – the legal framework
Under the Health Act 2004, the HSE is required to prepare an annual Service Plan. Once adopted by the Board of the HSE, the NSP must then be submitted to the Minister for Health and Children for approval.

The Act stipulates that this should be done no later than 21 days after the publication of the Estimates. Due to the new unified budget arrangement announced by the Minister for Finance, the 21 days technically commenced from the announcement of the Pre-Budget Outlook (PBO) on 18th October, 2007. However, the Minister extended the deadline for submission of the NSP by 10 days to the 19th November 2007.

Any additional monies announced on budget day (5th December, 2007) will be managed via an addendum to the NSP, endorsed by the Board, and submitted to the Department of Health and Children (DoHC).

This NSP outlines the agreed level of health and personal social services to be provided by the Executive for 2008 within the voted allocation of the Oireachtas and in accordance with government policy on employment control within the health service. The CEO, as the Accounting Officer, is required to manage the Vote in compliance with his legal remit.

The NSP is accompanied by a statement of the Executive's estimate of income and expenditure relating to the plan, and by the Capital Plan for the year (as required under Section 31 of the Health Act, 2004).

Planning Assumptions on which the NSP has been framed
The NSP for 2008 has been framed on a number of key considerations and planning assumptions.

Considerations
- **National Policy Context and Strategic Focus.** The overall policy and strategic focus is framed on both our legislative framework (health and personal social services are delivered within the legislative framework of the Health Acts 1947 to 2004), and the context provided through national strategic and policy documents including *Quality and Fairness: A Health System For You* (2001) and on Government priorities for 2008.
- **Corporate Plan, 2005 – 2008.**
  Our Corporate Plan outlines our agenda for the period, identifies our response to the National Health Strategy *(Quality and Fairness)*, reflects the decisions of our Board and takes cognisance of other national policies and priorities. It maps out the future direction for the health and personal services which will be delivered through the annual NSP and associated business planning process. A new plan is currently being developed for the period 2008 – 2010.
- **Transformation Programme (TP).** While not the only driver for change, TP is the primary mechanism and framework for developments across the HSE (detailed further in this introduction).
- Our submission to the **Estimates process, 2008** setting out the priorities of the CEO and National Directors, and reflecting our Transformation Programme.
- **NSP 2007.** Priorities / deliverables being brought forward into 2008.
- Delivering on our commitments as set out in '**Towards 2016 Ten Year Framework Social Partnership Agreement 2006 – 2015'**.

In addition to these considerations, specific planning assumptions have been applied to both the preparation and finalisation of the NSP.

Planning Assumptions
- The principle of Existing Level of Service (ELS) has formed the basis of the setting of targets for 2008. However, in situations where an ELS would result in a budgetary overspend for 2007, Directorates have been cognisant of breakeven plans in place in 2007 in the final determination of their targets for 2008. This will ensure affordability and sustainability for 2008.
- Approved employment ceilings apply and a tight focus on employment control will continue – there are no additional resources for growth beyond 2007 outturn.

- New service developments / enhancements can only be considered in two ways, either through new development funds which may be specifically allocated to the Executive in the Budget Day package (and, therefore, not included in this plan), or through realignment of existing resources through maximising effectiveness and efficiencies and in the context of our Transformation Programme.
- Delivering better Value for Money (VFM) will continue to be a key objective.

Delivering services within Vote

The Pre-Budget Outlook (PBO) sets the context for the planning and financial assumptions adopted by us in the preparation of the NSP for 2008. The resource available to us in the PBO is intended to support the delivery of the maximum level of service feasible for 2008. There is no resource provided for new services or employment, with the exception of monies provided on a full year basis for older people and primary care services. The NSP has no capacity to incur any new expenditure on service or employment. Any proposals within the plan to incur cost on new services or employment must be funded by way of cost savings and in the context of demonstrating a balanced Vote position as the year proceeds.

We are aware of the need for sustainability and affordability in framing this NSP and have been explicit in terms of what we can achieve in 2008.

Our Estimates submission included details of additional costs arising from emerging pressures, compliance with new legislative requirements, revenue consequences of capital developments and service development priorities. Our first priority for 2008 is to ensure that adequate resources are provided to meet the true costs of providing the approved levels of service. Any new expenditure to be incurred as part of this plan, will only be undertaken following a full review of Quarter 1 performance.

The PBO has provided the resource identified in the table below to the HSE for maintenance of services. The NSP is framed in the context of this resource level.

		Pre-Budget Outlook 2008 €000	Revised Estimates Volume 2007 €000	Increase / (Decrease) €000	% Change
1	Gross Revenue	13,982,850	13,068,468	914,382	7.00%
2	Long-Stay Repayments and Dormant A / C's	150,000	363,000	-213,000	-58.68%
3	Capital less Dormant A / C's	545,950	538,950	7,000	1.30%
4	**Gross Estimate**	**14,678,800**	**13,970,418**	**708,382**	**5.07%**
5	HSE Appropriations-in-Aid	745,000	596,000	149,000	25.00%
6	Other Appropriations-in-Aid	1,896,990	1,900,009	-3,019	-0.16%
7	**Net Estimate**	**12,036,810**	**11,474,409**	**562,401**	**4.90%**
8	**Net HSE Revenue Allocation**	**13,237,850**	**12,472,468**	**765,382**	**6.14%**

The financial monitoring arrangements will be developed further during 2008, continuing work on budgeting and reporting processes that commenced in 2007.

The Minister has continued to emphasise the need to secure greater value for money and cost effectiveness from our core funding. Section 7 of this NSP sets out our strategic approaches, cost containment initiatives, value and productivity reviews and benchmarking type processes to progress the development and delivery of VFM in 2008 and beyond. An ambitious VFM programme is planned, the details of which are set out in Section 7 of this NSP. We are targeting to deliver a 2% cost reduction in 2008. This is equivalent to €280m. This target is inclusive of savings derived from drug cost savings in 2008 which are estimated at €120m. We are also targeting significant improvement in reducing waiting times for patients during 2008.

We are also committed to driving and delivering value in the planning, delivery and management of health and personal social services and acknowledge that continuing to improve productivity and value can make a significant contribution to increasing sustainability; reducing pressure on the budget in the context of an ageing and growing population; and increasing base service costs.

Human Resource Management

Control of employee numbers is critical to the successful delivery of the NSP 2008 within the Vote. There is no scope to grow the employment levels in 2008 beyond authorised levels. Any recruitment in 2008 will be subject to rigorous recruitment procedures and must be within the national employment ceiling. This means

that employment must be sustained at levels supported by allocated 2008 financial provision through the year. Development posts not filled in 2007 will only be filled based upon ceiling compliance and financial affordability. Any posts not filled on this basis during 2008 will be held for filling at a time when we are in a position to undertake the recruitment from both a ceiling and financial perspective.

Accountability and Governance
The NSP is our contract with Government for the delivery of health and personal social services for the monies Voted to us by Government. However, from a HSE perspective, the NSP is not just the contract with the Minister - it first and foremost sets out our agenda for implementation of our priorities and deliverables in 2008.

The NSP should be considered in the light of the accountability of the CEO as Accounting Officer for Vote 40, being the HSE Vote. The Accounting Officer has the obligation to take such actions as may be necessary to achieve a balanced Vote. Any such actions would be communicated through the NSP control process and as specified in legislation.

Business Model and Performance Monitoring and Measurement Framework
The NSP is supported by a business planning process which facilitates its delivery by the Executive during the year. Each element of the NSP is supported by a range of Business Plans at area, hospital network, local and unit level that translate the national deliverables into local deliverables at all levels of the system. Our business model is the tool which managers use to plan and monitor the delivery of their services and the method by which we hold our own system to account, at each level of the health delivery system, through our Performance Monitoring and Measurement Framework. This ensures that we are reporting on achievement against our objectives, within allocated resources and approved employment levels and taking the necessary corrective action as appropriate. The Business Model will be supported through a strengthened performance management approach across the system. In turn, it will ensure that implementation of the NSP is in accordance with our legal obligations in accounting to the Minister for Health and Children for the provision of services as specified in our NSP.

We are committed to the further development and promotion of a performance management culture as an integral part of the way we work. Our performance monitoring and measurement framework continues to be improved as the needs of the organisation continue to evolve. Significant work has progressed in 2007 to build further on an integrated approach towards the presentation of key activity, finance and staffing data. The ongoing development of our performance measures and indicators will assist in ensuring accountability, increased efficiency and achievement of best performance, based on national and international benchmarking. This has been managed both internally by a cross-directorate group and externally, with the involvement of the DoHC. Details of this work are further set out in Section 10. It remains a constant challenge to ensure that the data we report against is consistent, reliable, verifiable and robust and this will continue to be a primary focus for us in 2008.

Our Performance Monitoring and Measurement Framework for 2008 will enable an integrated progress review on the implementation and management of the NSP for:
- CEO, as the Accounting Officer.
- HSE Management Team.
- Managers, in meeting their governance and performance responsibilities.
- The Board.
- Minister for Health and Children and the Department of Health and Children.
- Government.

and will be supported by a strong performance management approach across the system.

Control Process
Central to success is the relationship between responsibility, authority and accountability and how this forms the basis of our governance arrangements from the Board and the CEO to National Director and throughout the system. In addition to the performance management arrangements, a Corporate Control Group was put in place in 2007 to review and validate organisational performance in the key areas of financial performance, human resource management and the achievement of targets identified in our NSP. These control mechanisms will continue in 2008 and will be further strengthened.

To ensure that these control mechanisms can operate to best effect, Business Plans to support implementation of our NSP will be fully operational from January, 2008. This will ensure that strict adherence is being applied in terms of implementing our NSP within approved employment, financial and activity targets.

Transformation Programme (TP)
Our TP is a key management tool to deliver our vision that *everyone will have easy access to high quality care and services that the public has confidence in and we are proud to provide.*

The TP focuses on six transformation priorities:

- Developing integrated services across all stages of the care journey.
- Configuring Primary, Community and Continuing Care (PCCC) services so that they deliver optimal and cost effective results.
- Configuring hospital services to deliver optimal and cost effective results.
- Improving the health of the population and implementing a model for the prevention and management of chronic illness.
- Implementing standards based performance measurement and management throughout the HSE.
- Engaging all staff in transforming health and personal social services in Ireland.

While not the only driver for change, the TP constitutes the primary mechanism and framework for developments across the HSE in the period 2007 to 2010. Specific elements of the transformation plan which will be progressed during 2008 are referenced throughout the Plan and are summarised in Appendix 1.

SECTION 2
HEALTH STATUS

SECTION 2 – HEALTH STATUS

Health Status and Social Well-being of the Population
The following sections outline in more detail the factors that can influence the health and well being of the population and, in this context, the Population Health priorities that have been used to guide the preparation of the NSP 2008.

Factors that can influence the health and well being of the population
Key factors which determine the health and well being of the population and subsequently the need for services include:

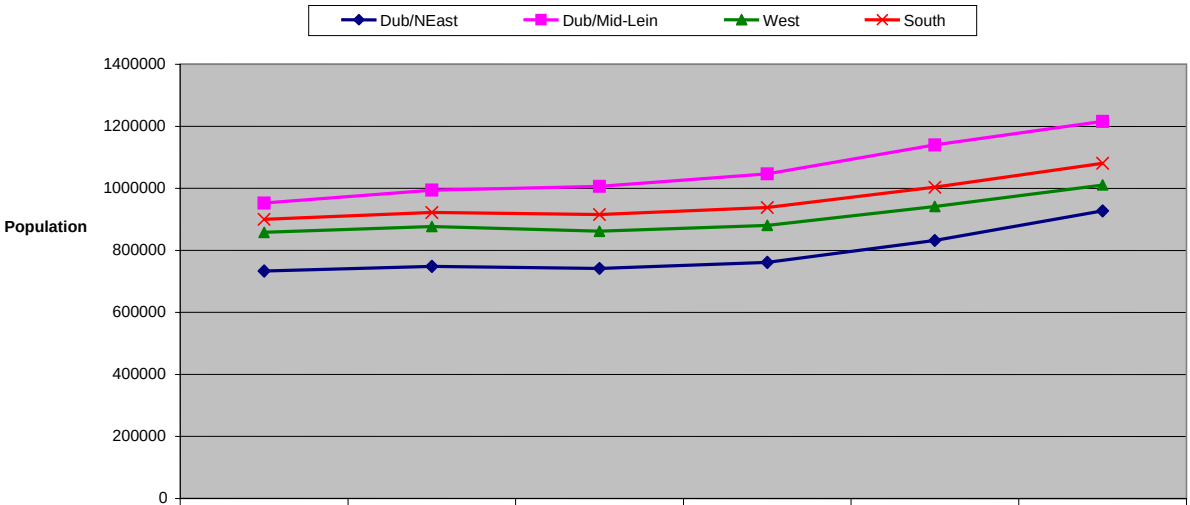
1. Demography.
2. Changing health and social status of the population.
3. The level and management of chronic illness.
4. Changing health technology.
5. Changing legislation.

1. Demography
A key factor in the demand for health and personal social services will be the structure of the population and how that is expected to change. Data outlined below are the latest available from the Central Statistics Office (CSO).

According to the 2006 census there are 4,234,925 people living in the Republic of Ireland, compared with 3,917,203 in 2002. This represents an increase of 8.1% in four years and is at an all time high since 1864. Figure 1 shows the distribution of the population by current HSE areas extrapolated back to 1981. As can be seen in the graph, most of the growth in population has occurred in the last 10 years.

- HSE Dublin Mid-Leinster has the greatest share of the population at 28.7%, followed by HSE South at 25.5%, HSE West at 23.9% and HSE Dublin North East at 21.9%.
- While the overall population has grown by 8.1% since Census 2002, the percentage growth in the population within HSE areas is as follows:
    - HSE Dublin North East + 11.5%, HSE South +7.7%, HSE West + 7.4% and HSE Mid Leinster + 6.7%.

Figure 1 HSE Area Population 1981-2006



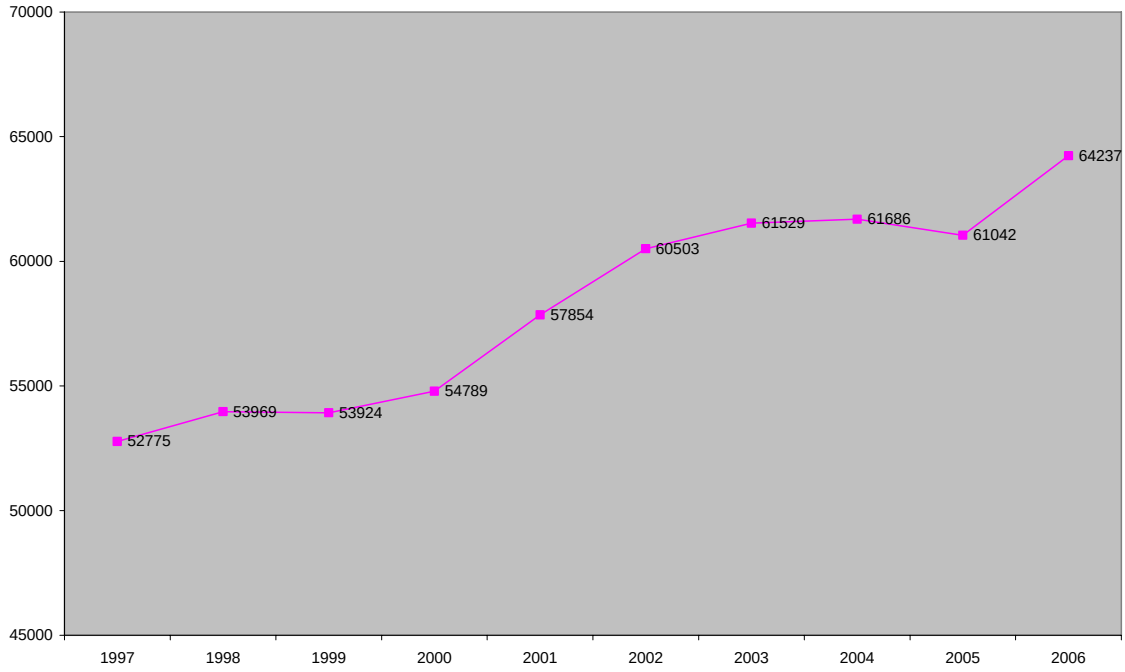
	1981	1986	1991	1996	2002	2006
Dub/NEast	733562	748328	741877	761054	831899	927525
Dub/Mid-Lein	952299	993939	1006515	1046582	1139870	1215711
West	857734	876508	861876	880294	941462	1010690
South	899810	921868	915451	938157	1003972	1080999

Years

Looked at from a ten-year perspective, as illustrated in Figure 1, Ireland's population increased at an annual average rate of 1.6% between 1996 and 2006 – the largest population growth rate in the EU.

Figure 2 shows the growth in births from 1997 to 2006. Of particular note is the increase in births over the last ten years.

Figure 2 Births in Ireland 1997-2006



Over the last ten years births have increased by on average 1,146 per year, or by 22% over the period. In addition, the proportion of births to single mothers has risen from 26% in 1997 to 33% in 2006. This rate of growth, and the nature of it, has placed significant pressure on existing maternity and personal social services.

In addition to providing census data at regular intervals, usually every five years, the CSO also provides national population projections. It provides a set of projections based on six possible permutations of fertility and migration. In addition, the Economic and Social Research Institute also compiled population projections for the period up to 2021 using its own set of assumptions, as have some private sector organisations such as NCB Stockbrokers. Figure 3 also shows how these projections compare with each other – using their high and low estimates where applicable. With the exception of the CSO low data, all the other projections seem to be following a similar growth pattern, with the population estimated to reach five million by 2019.

Figure 3 Population Projections 2005-2019

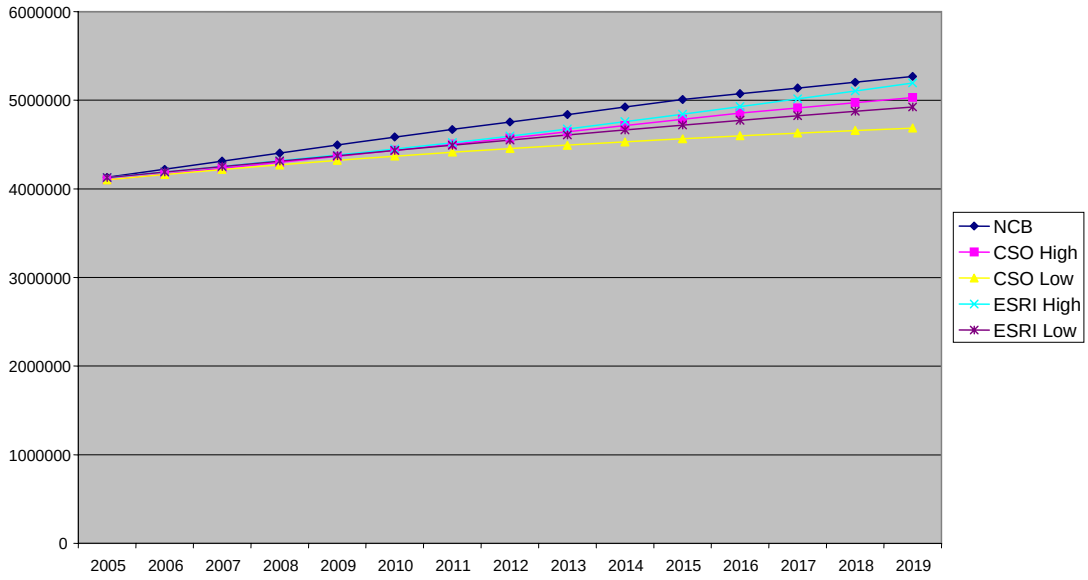
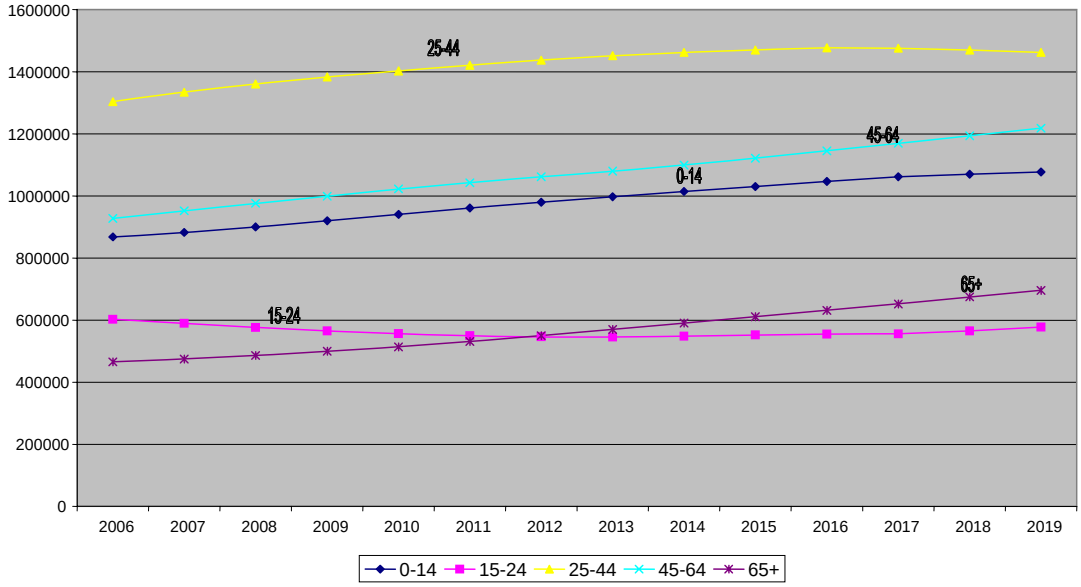


Figure 4 outlines how the age groups will change between 2006-2019.

Figure 4 Population Projections 2006-2019, CSO High, by age group



With the exception of the 15-24 year age group, all other age groups will show real growth up to approximately the year 2016. Thereafter, some of the age groups begin to plateau or fall off (0-14; 25-44), with others showing moderate growth (15-24) and others showing continued growth (45-64; 65+). From a health service perspective, the overall population will show substantial growth with demands increasing at almost every level.

There will be a continuing need to provide a more comprehensive health and personal social service as the numbers in the 0-14 age group continues to grow and likewise, for those in the middle years 45-64, where growth in numbers is also substantial, and the burden of chronic illnesses begins to emerge. However, the most significant early and continuing impact on the services will be in the 65+ year age group. The need to plan for their needs, particularly in the primary care arena, with a particular focus on chronic illness management, will be crucial.

Conclusions on these demographic trends:

- The population is at an all time high since 1864. Population growth will require an increase in services for all age groups. The continuing growth in births will require an analysis of the capacity of the existing model of maternity services to cope with this increased growth.
- Factors that influence the social well being of the population include:
  - Improvement in the quality of life for older people through support to remain at home in independence for as long as possible (please see service delivery section on older people on page 41).
  - Provision of support for the most vulnerable young people and families (please see service delivery section on children and families on page 28).
- The ageing of the population will have implications for the provision of most services.
- The increasing incidence and prevalence of chronic illness among the middle-aged and older groups will require, in particular, the development of new models of chronic illness management (please see service delivery section on chronic illness on page 60).
- We will need to engage with other relevant bodies, for example, local authorities in relation to social housing for older people (please see service delivery section on older people on page 41).
- We have the opportunity of ensuring that the current middle-aged population will be healthier and more independent when they reach old age. In order to achieve this we will need to:
  - Make a compelling case, through Health Impact Assessment, for policies which will have a positive effect on health e.g. fiscal policy on tobacco and alcohol; social and economic policies which promote equity in society.
  - Tackle significant lifestyle risk factors which currently represent a major threat to the health of Irish people e.g. alcohol, tobacco and obesity. Data from the 2006 Survey of Lifestyles Attitudes and Nutrition (SLAN) will be available in early 2008 and will give a clear indication of progress made over the last four years in all of these areas. In the interim, data from the Office of Tobacco Control (OTC) and HSE Surveys indicate that adult smoking rates are about 29%, which will impact negatively on the health status of the population. In addition data from OECD and Eurobarometer studies indicate that Ireland has one of the highest per capita consumptions of alcohol and has a particular problem with binge drinking.
  - Ensure that everyone has access to evidence based interventions such as statin drugs, treatment for high blood pressure, better treatment of chronic illness management generally, different modalities of cancer treatment through highly specialised multi disciplinary teams etc.
  - We will need to deal with the implications of a multicultural Ireland. This means, amongst other things, ensuring that our services are accessible and culturally appropriate for all groups in the population.
    (Deliverables have been identified for implementation in 2008 which support both service provision and development in these areas and are reflected in the relevant sections of this NSP).

2. Changing Social Factors

As the demographic profile of the population changes, so too does the population's health and social status. It is expected that smaller family sizes will alter the ability of nuclear families to care for each other in a way that was possible in previous times. In addition, as a result of expected net positive migration over the period, the health and personal social services will need to provide for a multi-ethnic mix of cultures in the delivery of health and personal social services. Data from the 2006 Census shows that the percentage of the population born outside of Ireland has increased to 15.8% from 6.3% in 1986. Other changes, including increased marital breakdown, the need for both partners in a marriage / relationship to be in paid employment, the need for long journeys to work etc., all affect the sense of well being of adults and children and the pressures on the health and personal social services.

3. The Level and Management of Chronic Illness

Worldwide, there is an increasing incidence and prevalence of chronic illnesses and conditions. Chronic illnesses are those diseases which can only be controlled and not, at present, cured. They include diabetes, heart failure, some cancers, chronic obstructive pulmonary disease, dementia, asthma, arthritis and a range of disabling neurological conditions. The incidence of such diseases increases with age and many older people are living with more than one chronic illness. Approximately 25% of the population has a chronic illness and 60% of deaths are as a result of a chronic illness.

Improvements achieved in our health status in recent years have given us a clear indication of the approach that is required. Heart disease is a good example, where Ireland has achieved major success in heart health status in the past 15 years, with a 40% reduction in deaths from heart disease. Only 44% of the reduction in the deaths from heart disease can be attributed to effective treatment of established heart disease. Reductions in population risk factors such as smoking, cholesterol and blood pressure have had a greater effect. The wider determinants of health will continue to have a greater impact on health than health services. This highlights the need for investment in a model of care which includes health promotion, primary care, hospital care, emergency care and rehabilitation.

Life style factors such as smoking, alcohol, diet, obesity and inactivity have led to the increase in chronic illnesses. Success in treating what were previously fatal diseases, such as heart disease, respiratory diseases and some cancers is also a factor that has led to the increase in chronic illnesses. The care of people with chronic illnesses consumes a large proportion of health and personal social services resources:

- Chronic illnesses account for 78% of all health costs (US data).
- 80% of G.P. consultations relate to chronic illness and patients with chronic illness or complications use over 60% of hospital bed days (UK data).
- 2 out of 3 patients admitted as medical emergencies have exacerbations of chronic illness.
- People with multiple chronic illnesses are extremely high users of acute services; an analysis of the Hospital Inpatient Enquiry (HIPE) System shows that in Ireland 5% of inpatients account for over 35% of all inpatient bed days.

Formal generic chronic illness management programmes which have been operational in the US for over a decade, are now spreading to health systems in Western Europe in various adapted forms. These programmes have been subject to evaluations and they have all shown positive improvements in service utilisation indicators, cost reduction indicators and improvements in quality of care indicators. For example:

- Up to 50% reduction in unplanned admissions and significant reductions in medication.
- Length of stay down by 31% and a reduction in total bed days used by older persons of 41%.
- 35% reduction in urgent care visits.
- Significant increases inpatient and family satisfaction, together with improvements in service integration, more appropriate referrals and faster response times.

One of the aims of the Transformation Programme is to reconfigure PCCC services so that multidisciplinary PCTs are in place and have the control to prevent and treat chronic illness. Acute exacerbations of chronic illness are the cause of most emergency medical admissions to hospital in Ireland and contribute significantly to the difficulties facing Emergency Departments. Chronic illness management is therefore one of the biggest challenges facing us and is a pre-requisite for a sustainable solution to the most effective use of hospital resources.

4. Changing Health Technology

The term health technology includes all health interventions including drugs, diagnostic equipment, programmes of care etc. New and highly effective health care interventions such as stents and statin drugs for heart disease, drugs for cancer, rheumatoid arthritis and metabolic diseases, diagnostic imaging techniques such as PET / CT scanning and other interventions, have added greatly to the cost of health care in Ireland in recent years. The literature suggests that health technology is a greater driver of costs than demography.

The future development of health care interventions is likely to have a significant influence in improving health outcomes for the population. These developments will require us to be clear about the benefits of the existing technologies and to be able to predict, as far as possible, the potential costs and benefits of future technologies. We will support the new Health Information and Quality Authority (HIQA) in conducting Health Technology Assessment (HTA), which is a methodology to consider the effectiveness, appropriateness and cost of technologies, and will ensure that such assessments inform the use of technology.

Some HTA can help new beneficial technology diffuse into the system more rapidly and prevent unproven technology which is highly cost inefficient from being widely used. An essential element of HTA is the development and implementation of evidence based guidelines so that those who stand to benefit most receive the benefits. Therefore, we can provide the most cost effective mix of interventions.

5. Changing Legislation

Another significant driver of services and costs is new legislation. European Union Directives and new and changing legislation have major implications across all sectors, from child care to care of older persons to tobacco control.

Population Health Priorities Used to Guide the Preparation of the NSP 2008

Increasing the emphasis on primary care and health promotion	By increasing its emphasis on primary care, we can provide high quality care, through community-based PCTs, to people with stable chronic illness, such as diabetes, heart disease and chronic obstructive airways disease within their own communities. In addition, there are greater opportunities to introduce known preventative interventions to keep people healthy.
Freeing up the hospital care system	By transferring care, where appropriate, from hospitals to the community, hospitals will be better positioned to focus on meeting acute secondary, tertiary and quaternary patient care needs, driven by international best practice and delivered through the integration of clinical practice, education and research.
Ensuring integrated care is provided in the right place, at the right time	Well integrated hospitals and primary, community and continuing care services will enable the health system to function as a single service delivery unit and make it easier for people to access the right service in the right place at the right time, through agreed care pathways, protocols for referral, joint planning for discharge etc.
Improving health outcomes *In order to integrate these major outcomes into the delivery outputs of the NSP, further detail on specific measures that support the identified focus outcomes can be found within the relevant sections of this NSP and are also summarised in Section 10.*	A significant objective for us is to improve the overall health status of the population. In order to facilitate this objective, there is constant focus on how to integrate service delivery to achieve maximum health and social gain for the population. While we can significantly impact on the health status of the population, many factors outside of our control can also impact and need to be taken into account when analysing the changing nature of the health status of the population. Work will continue in 2008 with the DoHC to set agreed targets in those areas where they do not currently exist. Key health improvement outcomes that will be monitored in 2008 include:

Focus	**2008 Target Outcome**	**Longer term Target Outcome**
Childhood Immunisation Rates The World Health Organisation recommends 95% uptake rate to ensure that herd immunity is achieved in a community and to provide individual protection.	90% at 12 months 93% at 24 months 90% (for MMR) at 24 months	a) Increase immunisation rates in all regions to that pertaining in the best region. b) Work towards 95% nationally.
Cancer Survival from cancer is dependant upon, amongst other things, stage of presentation and stage of detection. Data on the stage of presentation and survival for common cancers will be utilised to assist in assessing cancer services. The establishment of the Cancer Control Programme, Cancer Screening Programmes and the work of the National Cancer Registry will be key in reaching cancer target outcomes.	With the move to high volume surgery and treatments in 8 cancer centres outcomes are expected to improve annually.	a) Increase uptake rates in all regions to that pertaining in the best region. b) Increasing % trend year on year of early diagnosis of cancer. c) Identify best outcome in the EU and monitor progress in trend towards same.

	Tobacco Consumption Smoking is a key risk factor for cardiovascular disease, respiratory diseases, many cancers and a wide range of other debilitating conditions. Multiple strategies are required to reduce smoking prevalence, including enforcing legislation, health promotion campaigns, price increases.	Estimated that 29% of population smoke. No national target to reduce this in 2008 established by DoHC.	a) Improving trend year on year. b) Identify best outcome internationally and monitor progress in trend towards same.
	Surgical Procedure Outcomes Comparative hospital activity data on selected procedures can reflect the quality of preventative and treatment services. Procedures we will monitor include: fracture neck of femur; cataract; renal transplant; grommets; D&C and diabetes.	Identify best outcome internationally and monitor progress in trend towards same.	

SECTION 3
HUMAN RESOURCE INPUTS

SECTION 3 – HUMAN RESOURCE INPUTS

Human Resources HSE by Structure

	2007 Outturn	2008 (Estimate)
i) Primary, Community and Continuing Care	56,694	56,694
ii) National Hospitals Office	51,415	51,415
iii) Population Health	557	557
iv) Functional Directorate (e.g. HR, ICT, Finance, Office of CEO, etc.)	3,579	3,579
Total	**112,245**	**112,245**

Human Resources HSE by Staff Category

	2007 Outturn	2008 (Estimate)
i) Management / Administration	13,088	13,088
ii) Medical and Dental	5,179	5,179
iii) Nursing	26,124	26,124
iv) Health and Social Care Professionals	9,725	9,725
v) General Support Services	8,594	8,594
vi) Other Patient and Client Care	11,697	11,697
Total	**74,407**	**74,407**

Human Resources Voluntary Hospitals by Staff Category

	2007 Outturn	2008 (Estimate)
i) Management / Administration	3,898	3,898
ii) Medical and Dental	2,695	2,695
iii) Nursing	9,048	9,048
iv) Health and Social Care Professionals	3,150	3,150
v) General Support Services	3,030	3,030
vi) Other Patient and Client Care	1,290	1,290
Total	**23,111**	**23,111**

Human Resources Intellectual Disability Sector Agencies by Staff Category

	2007 Outturn	2008 (Estimate)
i) Management / Administration	1,343	1,343
ii) Medical and Dental	190	190
iii) Nursing	3,613	3,613
iv) Health and Social Care Professionals	2,811	2,811
v) General Support Services	1,664	1,664
vi) Other Patient and Client Care	5,106	5,106
Total	**14,727**	**14,727**

Note: (i) The estimated effect of statutory maternity leave on employment is c. 2,000 WTEs.
(ii) 2008 Estimate does not include WTE impact of any budget day announcements, regarding service developments.
(iii) 2008 Estimates does not include any additional development posts (included in the 2007 NSP but not approved through internal HSE systems) which may be re-activated through VFM initiatives, in 2008.
(iv) Any additional WTE impact arising from (ii) and (iii) would require concomitant ceiling adjustments during 2008.

SECTION 4
SERVICE DELIVERY

SECTION 4 – SERVICE DELIVERY

PRIMARY, COMMUNITY AND CONTINUING CARE

The Primary, Community and Continuing Care (PCCC) Directorate plans, manages and delivers a range of services to local populations. PCCC is responsible for the provision of all health and social services provided in a community setting, in partnership with the Voluntary and Community sector, including Primary Care Services, Mental Health Services, Child Care Services, Disability Services, Social Inclusion Services, Elderly / Nursing Home Services, Dental Services and Palliative Care. A range of allowances and schemes (i.e. medical cards and GP Visit) are also administered and delivered through our Local Health Offices.

Services are currently provided by a range of disciplines to multiple care groups. These are provided in the context of a single interpretation of policy, legislation, regulations and entitlements to meet population needs while advancing (as part of the Transformation Programme) realignment from the current model of fragmented service delivery to a population based model organised through multidisciplinary PCTs serving populations of approximately 8,000 people.

The areas of focus for PCCC services are presented below using a Care Group structure and highlight our range of priorities for 2008. Core service provision is articulated in the table below, where possible, and is integrated within the various care group sections to support our progress in the achievement of our priorities. Enhancing performance management is a key priority for PCCC in 2008. Central to this is the development of management information to inform decision making and priority setting.

Our priorities are to provide a local point of access for the population to a range of health and personal social services; to enhance services in the community to provide timely care in appropriate settings; to direct the provision of care away from acute and institutional / residential care and towards services in the community. These priorities are reflected in PCCC's development of Home Care Packages, its focus on Foster Care and its resourcing of community Mental Health Services etc. In line with our Vision (ease of access, public confidence and staff pride), significant emphasis is placed on maintaining and enhancing effective relationships and integration throughout PCCC and other HSE services and with other agencies. In 2008 PCCC will, within its overall framework of priorities, place a concerted focus on service reconfiguration.

PCCC core service activity levels are one of the measures of performance. These levels of activity are indicative of the breadth of health and personal social services provided in PCCC and include measures that reflect access to services, service volume, throughput and utilisation and indications of health status (such as immunisation rates). However, in themselves, they do not indicate efficiencies or effectiveness and are limited to indications for specific care groups.

PCCC Targets for elements of core service	Projected Outturn 2007	Target 2008
Primary Care		
Total no. of PCTs in place	87	187
% of Teams holding clinical meetings	45%	100% (for the 87 2007 teams)
No. of GPs in training	379	379
% of GP practices with ICT links to hospital	46% (to date based on 23 LHOs)	This will be examined in the context of the ICT requirements of the PCTs.
Schemes		
Medical Cards / GP Visit Cards	73,644 (to Oct 07)	Continue to promote uptake within eligibility criteria
Medical Cards	1,264,434 (to Oct 07)	
Long Term Illness Claims	530,000	543,000
DPS Claims	3,700,000	4,240,000
Hi-Tech Claims	275,000	309,000
Orthodontics – numbers treated	Processing transition from DoHC to HSE. Will monitor on a quarterly basis commencing Q4 2007.	Will monitor on a quarterly basis.
Hospital in the Home – clients treated	1,174	400 (contract ends Q12008)
Contacts with Out of Hours services	801,000	801,000

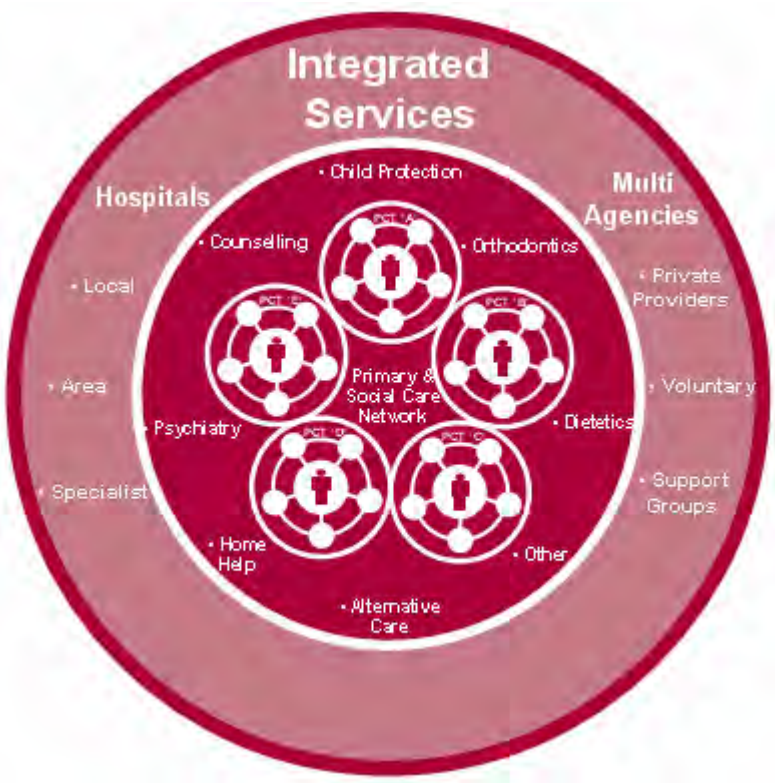
PCCC Targets for elements of core service	Projected Outturn 2007	Target 2008
Children and Families		
Children in Residential Care	426	426
Children in Foster Care	3,327	3,327
Children in Foster Care with Relatives	1,530	1,530
Children in 'Other' types of care	191	191
% of children in Residential Care with an allocated Social Worker	90%	95%
% of children coming into care that had a written care plan in place	20.3%	40%
Family Support Services		
No. of Family Welfare Conferences held	216	227
Total no. of referrals	423	444
No. of Springboard Projects in place	30	30
Total No. of referrals (Families)	786	786
Pre-School Inspections		
No. and % of pre-school inspections carried out	2,258 (49.5%)	2,145 (-5%)
High-Support / Special Care		
Special Care Bed Nights Used (monthly)	930	930
Special Care Occupancy levels	84%	84%
High-Support Bed Nights Used (monthly)	2,635	2,899
High-support Occupancy levels	58%	68%
Teen Parent Support – number of clients supported	1,200	1,200
No. of staff training days executed	150	150
No. of calls to National Information Line	70,000	-
Child Health		
Immunisation Uptake Rates – at 24 months	91%	93%
Breastfeeding (exclusively at PHN 1st visit)	33.2%	33.2%
Visits made within 48 hours	71%	71%
Mental Health		
No. of Inpatient Psychiatric Beds	30.7	30.7
No. of CAMHTs	47	55
Admissions to Inpatients Beds	96.7	96.7
Re-admissions to Inpatient Beds	70.3	70.3
Older People		
Home / Community Supports		
No. of Home Help Hours	11,780,000	11,780,000
No. of HCPs to be provided	4,350 equivalents	4,350 equivalent
No. of Clients to benefit from HCPs	8,500	8,500

PCCC Targets for elements of core service	Projected Outturn 2007	Target 2008
No. of Day Care Places	21,300	21,300
% uptake of Flu Vaccine	63%	Promote uptake of vaccine
Residential Care		
No. of Persons in Receipt of Subvention	7,800 (monthly average)	A Fair Deal monitoring will replace subvention monitoring in 2008
No. of Public Nursing Home Beds	10,156	10,156 plus impact of fast track beds
No. of Nursing Homes Inspections carried out	868	100% of 1st and 2nd statutory inspection
% of Persons 75 and over in residential care	9%	Less then 10% in residential care
Palliative Care		
No. of patients treated in Specialist Inpatient units	330 (monthly average)	(330 monthly average plus impact of service developments)
No. of patients accessing Home Care Services	2,500 (monthly average)	2,500 (monthly average plus impact of service developments)
No. of patients accessing Day Care	260 (monthly average)	260 (monthly average plus impact of service developments)
Social Inclusion (Addiction)		
No. in Methadone Treatment	7,000 (monthly average)	7,000 (monthly average)
% commencing treatment within one month	84%	Increase no receiving treatment within one month
Social Inclusion (Travellers)		
% of Travellers on THU	43%	50%
Intellectual Disability		
Total no. of persons in residential care	8,262	8,262
Total no. of persons in receipt of day services	24,729	24,729
Total no. of persons in receipt of respite services	4,480	4,480
Physical and Sensory Disability		
Total no. of persons in residential care	834	834
Total no. of Home Support / PA hours	3,000,000	3,000,000
No. of persons in receipt of domiciliary Care allowance	19,600 (monthly average)	DLED scheme
No. of persons in sheltered work	2,000 (monthly average)	2,000 (monthly average) A review of adult day care services is on going and completion expected early 2008. ELS may change as a result of this review
No. of persons in rehabilitative training	2,800 (monthly average)	2,800 (monthly average) A review of adult day care services is on going and completion expected early 2008. ELS may change as a result of this review

PRIMARY CARE TEAMS AND HEALTH AND SOCIAL NETWORKS

Our Transformation objective is to ensure that by 2010 service users will be able to easily access (as close to home as possible) a broad spectrum of health and personal social services through their local PCT. The aim is that service users will experience integrated services (particularly for complex cases) across all stages of their care journey with provision of required expertise as needed.

The model is population focused, organising small populations into units of approx 8,000 people to be served by teams of multidisciplinary professionals (i.e. GPs, Nurses, Therapists, Home Care Services, Social Workers) known as PCTs. Mapping these PCTs across the country has identified that the population of 4.2 million will be served by over 520 PCTs within 5 years. These PCTs, on behalf of the service user, will navigate the system to ensure the user experiences integrated services, whether they require primary, community, continuing or acute hospital care. Agreed population health and social outcome measures will define the performance measurement of this new model of service delivery and related investment.



The availability of current services through the provision of extra health professionals, reconfiguration of existing health professionals and providing services currently restricted to hospital, will be considerably enhanced within local communities by virtue of the following:

Primary Care Team: where the vast majority (80-90%) of service users' needs will be provided by core team members, as outlined above. Teams are developing on the basis of agreed population focus and in partnership with local communities.

The Team and Network Expertise: Based on a common assessment tool, when the team forms the opinion that a patient or client has a complex set of needs requiring input from more specialised staff, these are provided to the PCT (on behalf of the client) by the Primary and Health and Social Care Network (PHSCN).

The Hospital Network: Such services are usually of an investigative, acute or emergency nature. The sharing of resources between hospitals, networks and teams is part of a local operational plan, with an emphasis on shifting appropriate services (i.e. diagnostics, rehabilitation, step down etc.) historically provided by hospitals to a community base.

Other Agencies and Service Partners: All service providers are clear about their role in meeting needs for a given population or cohort of population with particular needs, and they work in close cooperation with teams and health and social care networks.

PRIMARY CARE

Primary care services aim to support and promote the health and wellbeing of the population by providing locally based accessible services. The development of primary care services is a key priority and a cornerstone of our Transformation Programme. A significant proportion of primary care services are delivered through contractual arrangements with private contractors. This area of activity utilises some 33% of PCCC's overall annual revenue allocation. As at the 1st October 2007, 1,264,434 eligible persons were in receipt of medical cards, representing 32% of the total population. A further 73,644 were in receipt of GP Visit cards.

A review of contractual arrangements is now required to ensure that they are reflective of modern health care requirements and to ensure that the various contractual instruments are supportive of our Transformation Programme. Work will continue on the fundamental reviews of GP, Pharmacy and Dental contractual arrangements with the HSE, during 2008. The details are outlined below.

Primary Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Primary Care Reform and Integration *(TP 2.1-6)*				
Contractual framework for GMS and other publicly funded services involving GPs: *This is a key enabler to the transformation of primary care services. Our objective is to achieve improved outcomes in the management of chronic illness, greater responsiveness to vulnerable patients (i.e. older people, homeless, addiction) and increased productivity in a 24 / 7 provided service.*	Contract framework developed	New Contract framework and associated documentation finalised and signed off by management team.	Q3	PCCC
		Mechanism for engaging with relevant stakeholders, in compliance with Competition Act, 2002, defined and in progress.	Q1	
Dental Treatment Services Scheme: *A new contractual arrangement with Dental contractors to provide emergency and routine dental treatment to eligible adults.*	New contract substantially drafted.	New Contract framework and associated documentation finalised and signed off by Management Team.	Q1	PCCC
		Mechanism for engaging with relevant stakeholders, in compliance with Competition Act, 2002, defined and in progress.	Q1	
Pharmacy Contract: *A new contractual arrangement with community pharmacy contractors as a key element in the reform of the community drug schemes.*	Process for advancing review of contract, which is compliant with Competition Act, 2002, determined. Agenda for a new contractual arrangement substantially drafted.	New Contract framework and associated documentation finalised and signed off by Management Team.	Q1	PCCC
		Mechanism for engaging with relevant stakeholders, in compliance with Competition Act, 2002, defined and in progress.	Q1	
Demand Led Schemes: *The demand led schemes include the GMS, community drug schemes and the discretionary 'Hardship Scheme'. A range of allowances such as the Domiciliary Care Allowance is also included under the Demand Led Schemes.*	*Projected Outturn 07:* *GP visit cards issued: 73,644* *Medical Card recipients: 1,264,434* *Drug Payment Scheme claims: 3,700,000* *Long Term Illness claims: 530,000* *Hi-Tech claims: 275,000*	A review of the Demand Led Schemes will be carried out addressing areas such as: • Procurement for non drug items. • Hardship Scheme. • Oral nutritional supplements.	Q1-Q4	PCCC

Primary Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Develop and implement PCCC Configuration Framework *(TP 2.1, 2.4)* *Development of additional PCTs.* *PCTs are the unit of service delivery for non-acute care and will be assigned to populations of approximately 8,000 people. They will be made up of a number of health professionals working alongside GPs.* *Their development involves both the recruitment of additional staff and the re-organisation of existing PCCC staff. Fully functioning teams are those who are holding clinical meetings concerning patients and the achievement of this stage of development is key.*	Re-configuration framework of existing Community Care Services and Staff commenced in all Areas. Engagement Workshops held in each LHO.	Existing PCCC services will continue to be re-orientated to facilitate their re-configuration into PCT and Health and Social Care Networks (HSCN).	Q1-Q4	PCCC
		Each area to develop a plan for reconfiguration of existing staff.	Q2	
	2006 Teams Development of 87 teams progressed. Business Process / Toolkit rolled-out to support PCTs' move to full functionality. Spatial mapping work completed. Commencement of roll-out of National Framework for team-building and development for PCTs. Communication and Engagement workshops completed in Local Health Offices.	**2006 Teams** The 87 (2006) PCTs will be progressed from development phase to fully functioning teams, delivering services to defined populations.	Q2	
	Projected Outturn 07: 45% of PCTs holding clinical meetings.	*Performance Target: 100% of 2006 PCTs holding clinical meetings.*	Q4	
	189.5 staff recruited to support development of 87 teams.	Progress recruitment of 110.5 staff to support development of 2006 teams.	Q4	
	2007 Teams Additional sites for 07 phase of PCT development identified.	**2007 Teams** Progress development of 100 Primary Care Teams.	Q1-Q4	
	Additional staffing requirements of 07 Primary Care Teams identified.	Progress recruitment of 300 posts identified to support development of 100 PCTs.	Q1-Q4	
	Recommendations from the review of the 10 Pilot PCTs were disseminated to teams.	Complete definition of HSCNs through: • Alignment of care groups to PCTs and HSCN. • Progressing Staff Reconfiguration Plan at LHO and Area level. • Completion of geographic mapping process. • Addressing LHO Organisational Structure.	Q2	
		Review of PCT development completed, in line with 'Towards 2016' commitment.	Q4	

Primary Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Use of Information Technology: *ICT is a key enabler of integrated care. (TP 2.1 and 2.4)*	ICT Council working group established a Cross-Directorate working group to scope out the business needs of PCTs and HSCNs. *Projected Outturn 07: 46% of GP practices nationally had ICT links with hospitals (based on 23 LHOs).*	ICT requirements identified for PCTs and HSCNs.	Q2	PCCC
		Framework agreed for the use of a shared record within PCTs and HSCNs.	Q4	
		Work with ICGP and PCCC in relation to computerisation and the development of the shared record.	Q1-Q4	
		Performance Target: This will be examined in the context of the ICT Requirements of the Primary Care Teams.	Q3	
Out of Hours GP services / GP Co-operatives *(TP 2.5: Out of hours GP services are provided through a number of different co-operative models.*	*Projected Outturn 07: 801,000 contacts (see Section 10 for additional activity)*	*Performance Target: 801,000 contacts.*	Q4	PCCC
		A National Review of G.P. Out of Hours Services to standardise Service Level Agreements arrangements will be conducted.	Q4	
HSE National Information Line	*Projected Outturn 07: 70,000.*	*Performance Target: 70,000 (Est) calls dealt with.*	Q4	PCCC
	Existing information lines consolidated into National Information Line (1850-24-1850).	Satisfaction surveys executed periodically to support quality assurance of the service.	Q1-Q4	
GP Vocational training (in partnership with the ICGP) *(TP 2.5)*	*Projected Outturn 07: Total of 379 GPs in training (July 1st 2007).*	*Performance Target: 379 GP training places provided.*	Q1-Q4	Office of CEO / PCCC
	Joint HSE / ICGP National Steering Committee continued to meet during 07.	A review of GP Training undertaken.	Q3	
	10 additional GP Vocational Training places established on 1st July 2007.	Report from Interim National HSE / ICGP Steering Group completed.	Q4	
	Discussions concerning a revised Terms of Reference for the Interim National HSE / ICGP Steering Group GP Vocational Training took place.	Work with the Irish Medical Council and Irish College of General Practitioners in meeting our requirements under the Medical Practitioners Act 2007.	Q1-Q4	
Development of the Hospital in the Home Service (HITH)*. (TP 2.5) HITH is a consultant led community service, treating conditions such as Chronic Obstructive Airways Disease available to patients of DATHs and Connolly Hospitals and the patients of General Practitioners in the greater Dublin area.*	Contract for service provision awarded to Tara Healthcare. Interim Evaluation of the programme completed. *Projected Outturn 07: 1,174 Clients.*	Service will continue until at least Contract completion in March 08.	Q1	PCCC
		Performance Target: 400 Clients (in respect of Jan-March 08).	Q1	

Primary Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
National Schemes Modernisation Project *(TP 2.8)*				
Implement recommendations of Community Ophthalmic Services Medical Pilot Scheme: *This will enable the cost effective delivery of a range of medical and surgical interventions in the primary care setting, which would otherwise have to be delivered in the acute hospital setting.*	Review completed with recommendation that pilot service be rolled out nationally. Review highlighted the cost effectiveness of providing a range of interventions in the primary care setting that would otherwise be provided in the acute hospital setting. It also highlighted the benefits to patients in terms of local and timely access to treatment.	Contract agreed with providers. Implement roll out to an additional 10 (WTE) contractors, thereby ensuring equitable geographical availability of service to medical card holders and provision of additional treatments.	Q4	PCCC
The Application / Assessment process for Medical / GP Visit Cards to be streamlined and made more 'customer friendly'.	Not applicable.	A self-assessment system piloted in one LHO Area.	Q4	PCCC
		On-line application process for persons aged 70 years piloted.	Q4	
		Standard National Medical Card / GP Visit Card Review Form developed.	Q4	
Development and enhancement of competency and knowledge base within HSE (PCCC) on EU Health regulations.	Integration of EU Health Regulations into Schemes Modernisation programme. Transitional arrangements in respect of the European Health Insurance Card Registration process successfully completed.	One central repository for all EU regulations queries and points of information established.	Q4	PCCC
		Information manual on 'Completion of EU forms' compiled.	Q4	
		Mechanism established to identify the numbers and cost of providing services under regulations.	Q4	
		Position clarified regarding costs, notional costs and waiver systems between EU countries.	Q4	
Review of the Indicative Drug Target Saving Scheme: *A review of the Indicative Drug Target Savings scheme was carried out by the National Pharmo-economic Unit to establish if the scheme was meeting its original objectives of promoting cost effective prescribing.*	Review completed.	Recommendations of review prioritised and action plan drawn-up.	Q1	PCCC
Oral Health *(TP 2.8): Oral health services are delivered by Dentists and Orthodontists within PCCC. They include the school screening programmes and services to adults who are medical card holders. Some services are provided by independent practitioners not contracted to the HSE.*				
Complete review of Dental Treatment Services Scheme	Review commenced Q2 2006 (including such areas as probity, new contract, treatment items etc).	Implementation plan for the DTSS Review to be agreed following advice from Attorney General.	Q1	PCCC

Primary Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
	Development of plan for implementation is awaiting legal advice on the setting of fees with contracted providers, having regard to the provisions of the Competition Act, 2002.			
National Review Group on Orthodontic Service	Group established to review and prioritise recommendations of the national review. Workplan for implementation developed. Roll-out of the revised eligibility guidelines across the majority of HSE areas initiated.	Impact of revised guidelines will be monitored on an ongoing basis in 2008.	Q1-Q4	PCCC
Development of Orthodontic Services	Not Applicable.	Appointment of Consultant Orthodontist for Cork / Kerry area completed.	Q4	PCCC
		4 Orthodontic training places at Cork Dental School implemented.		
Development of action plan to address oral health needs of patients with special needs / patients in long-term residences.	Action plan for oral health needs of patients with special needs completed.	Recommendations of action-plan prioritised.	Q1	PCCC / OCEO
		Action plan developed to address oral health needs of patients in long-term residences, in line with the findings of DoHC Oral Health Policy Review Group.	Q2	
Hepatitis C Services: *Health Amendment Act (HAA) Cardholders (i.e. those infected with Hepatitis C through administration of contaminated blood and blood products)*	Eligibility criteria for HAA card extended.	Service provided within existing eligibility criteria.	Q1-Q4	PCCC
	National Hepatitis C Forum established to monitor planning and delivery of services across primary and secondary care.	National Hep C Forum will monitor planning and delivery of service.	Q1-Q4	
		Provide HAA cardholders with up to date guide to services available under the HAA scheme.	Commence Q1	

MEASURING PERFORMANCE IN PRIMARY CARE

Measurement	Projected Outturn 2007	Target 2008
Primary Care		
% of GP practices with links to hospitals	46% (23 LHOs)	To be examined in the context of PCTs ICT requirements
No. of GMS GPs involved in GP co-operatives as a % of all GMS GPs.	77% (26 LHOs)	Provide existing levels of service
GMS population covered by GP co-operatives as a % of the total GMS population.	58% (24 LHOs)	Provide existing levels of service
No of GPS in training	379	379
GP visit cards	73,644	Promote update within eligibility criteria
Medical Cards	1,264,434	Promote update within eligibility criteria
No of contacts with GPs out-of-hours	801,000	801,000
No of Primary Care Teams (PCTs)	87	187
% of PCTs holding a clinical meeting	45%	100% (for 87 teams)
Long term illness claimants	530,000	543,000
DPS claims	3,700,000	4,240,000
High tech claims	275,000	309,000
Hospital in the Home - No. clients treated	1,174	400 (contracts end Q1)
Dental Services		
% of school children in designated classes who receive screening.	70% approx	>70% nationally
Waiting times in orthodontics for treatment and assessment (category A: category B)	Processing transition from DoHC to HSE.	Monitor quarterly 08
No. of water fluoridation schemes inspected	251 inspected (29 LHOs)	251
% within statutory limits	49% (20 LHOs)	- (% will be monitored on quarterly basis)

CHILDREN AND FAMILIES

Services for children and families aim to promote and protect the health and wellbeing of children and families, particularly those at risk of abuse or neglect.

Service provision is guided by the HSE Children and Family Services Strategic Objectives, which seek to assure to children the right to express views freely in all matters affecting them; to ensure that decision making in regard to the planning and delivery of all Children and Family services is informed by an evaluated approach based on empirical data from evidence based research; to reorient supports and services so that they are fully integrated and easily accessible, that they emphasise prevention and early intervention, with a strong community based response; and to emphasise professional development and supervision to attract, retain and develop staff to support quality, child centred service delivery.

The focus for development in the coming years is on preventive, community-based services which provide early intervention within a Primary Care context. The development of alternative care services will, over time, impact on the numbers of children in residential and foster care.

Children and Families Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Rights of the Child in line with National Children's Strategy 'Our Children, Their Lives'.	Not Applicable	Awareness of complaints procedures by all children in care.	Q3	PCCC
		National Association of Young People in Care supported to ensure we meet our obligations under national policy to support and advocate for service users.	Q1-Q4	
Children in Care	**Provision for Children in Care**	**Provision for Children in Care**	Q1-Q4	PCCC
	Residential: 426 (7.8%)	*Residential: 426 (7.8%)*		
	Foster Care: 3,327 (60.8%)	*Foster Care: 3,327 (60.8%)*		
	Foster Care with relatives: 1,530 (28%)	*Foster Care with relatives: 1,530 (28%)*		
	Other: 191 (3.5%)	*Other: 191 (3.5%)*		
***Care planning** is seen as a vital element of the quality provision of children in our care. Care planning and review ensure compliance with the 1995 Child Care Regulations.*	Performance improved incrementally. *Projected Outturn 07: No and % of children who came into care during Q3 who had a written care plan drawn up prior to placement;* *Overall (Residential, Foster Care, FCWR, Other) %: 20.3%* *Residential: 14 (20.3%)* *Foster Care: 49 (23.3%)* *FCWR: 12 (17.1%)* *Other: 11 (73.3%)* Discussions held with HIQA regarding input into format development and education issues in context of new organisation and structures to achieve implementation of a consistent format and approach across the HSE.	*Performance Target: 40% Children coming into care with written care plans, drawn up prior to placement.*	Q4	PCCC
		Standardised care plan developed following completion of discussions with HIQA.	Q2	
		Ensure implementation of standard plan across system.	Q2 09	
	Projected Outturn 07: 90% Children in residential care with an allocated Social Worker	*Performance Target: 91% of children in residential care with an allocated Social Worker.*	Q4	

Children and Families Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Development of 'Agenda for Children's Services' National Child Care Policy. *In compliance with 'Towards 2016'*	Not Applicable	*Agenda for Children* disseminated and implementation process commenced.	Q4	PCCC
Residential Care: *To ensure best practice in child care and that children are placed appropriately*		Current placements reviewed of children aged 12 and under and single occupancy placements.	Commencing Q1	PCCC
		Review will be ongoing to ensure that children are placed appropriately.	Q1-Q4	
Child Protection Assessments *Standardised child protection process to be implemented in all areas*		Implementation of standardised initial assessment process in four designated areas (Cork, Louth, Mayo and Donegal / Leitrim / Sligo) as part of development of National Childcare Information System.	Q2	PCCC
Special Care				
The pending enactment of the Special Care Orders *will require implementation in order to comply with legislation.*	Format for applications standardised, agreed and enshrined in court judgements. Heads of bills and legislation in relation to putting Special care on a statutory footing to be brought to Government by year end.	Work with the Courts and the Children's Act Advisory Board (CAAB) in relation to the development of Special Care Orders.	Q4	PCCC
High-Support and Special Care Units: *We are committed to addressing the occupancy levels of high-support and special care units as well as standardising admission criteria through the development of an improved management structure.*	Single structure for Special Care agreed and implemented (one method of making application through National Admissions / Discharge Panel administered through office of National Manager). Audit of resource and staffing completed and under consideration by national management team. Schedule in place to maximise occupancy levels of units. Capacity managed in a flexible and effective way to meet the needs of children. Criteria for appropriate use of Special Care Units developed and applied across LHOs. First and second rounds of nation-wide education tours concluded to disseminate use of criteria. St. Joseph's, Clonmel, transferred successfully on 1st March 07 from Dept. of Education.	Completion of strategic review of High Support and Special Care.	Q2	PCCC
		Implementation of recommendations to be examined.	Q3	
		Development of performance measures.	Q4	

Children and Families Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
	Projected Outturn 07: 2,635 (58%) High Support Occupancy	*Performance Target: High Support Occupancy 2,899 (68%)*	Q4	
	Projected Outturn 07: 930 (84%) Special Care Occupancy	*Performance Target: Special Care Occupancy 930 (84%)*		
Improving quality in Foster Care	Protocol on Foster Care Standards agreed in relation to HSE engagement / interaction with Voluntary Bodies and other Agencies. Formal Communications with Irish Foster Care Association (IFCA) improved. Service Level Agreement in place.	All placements subject to protocol.	Q1	PCCC
		Review of foster care standards completed to identify issues arising.	Q2	
		Following completion of Review, ongoing implementation of the standards on a cost-neutral basis will be considered.	From Q2	
		Publicity and promotion of fostering.	Q4	
		SLA for IFCA to be continued.	Q4	
Family Welfare Conferences *are held in accordance with the provisions of the Children's Act, 2001 to ensure optimum family involvement in child welfare outcomes.*	*Projected Outturn 07: 423 referrals to FWC* *Projected Outturn 07: 216 convened FWC*	*Performance Target: 444 referrals* *Performance Target: 227 convened*	Q4	PCCC
Springboard projects *respond to the most vulnerable children and families in their own home.*	*Projected Outturn 07: 30 Projects nationally* *Projected Outturn 07: 786 referrals*	*Performance Target: 30 projects nationally* *Performance Target: 786 referrals*		PCCC
Implement a standardised pre-school monitoring framework *These Inspections ensure that pre-school services take all reasonable measures to guarantee the health, safety and welfare of pre-school children, in accordance with the Child Care Act. ('Towards 2016' and National Development Plan)*	Implementation of results of Standardised Framework Project progressed. The following was delivered: • Standardised inspection tool inspections went live on 16th April 07. • Completion of Guidance Notes for Standard. • Inspection Outcomes Reports delivered. • National Standardised Code of Practice for Pre-school inspectors developed. • All standardised reports available to public by Q4 2007. Agreement reached on the establishment of a national partnership committee to consider further implementation. *Projected Outturn 07: 2,258 (49.5%) Inspections*	Implement inspection tool across system.	Q4	PCCC
		National child care standards for pre-schools service developed. *Performance Target: 2,145 (-5%) Pre-School Inspections.* The -5% variance in figures is forecast as it is envisaged that the new audit tool will increase the time it takes to complete an inspection, therefore reducing the number of inspections in turn. Maximise timely inspections in context of growing number of facilities, more comprehensive inspection regulation and resource availability. Roll out of national standard pre-school inspection process and reporting.	Q4	

Children and Families Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Review existing Child Protection and Welfare Structures and Services	Meetings held with Office for the Minister for Children on implications of Children First review of HSE Child Protection systems.	Revised Children First Guidelines implemented on a phased basis, on completion of review.	Q4	PCCC / Office of the CEO
Criminal Evidence Act 1992	Implementation of Section 16 (1) (b) of Criminal Evidence Act 1992 (interviewing 14 year old victims of violent and/or sexual crime	Assist and co-operate closely with an Garda Siochana in the preparations for (including training) and the interviewing of children under these provisions once commenced.	Q4	PCCC
Management Information: *The provision of good quality data on our childcare services is a priority for us.*	Initial transfer of interim data set to HSE from DoHC complete.	Interim data set transferred to HSE.	Q1	PCCC / Office of the CEO
		Additional Childcare measures identified through work of National Childcare Information System.	Q2	
	Review of Children and Families data collection and performance information completed.	Review of Interim Data Set completed.	Q2	
Children and Families Transformation Plan *(TP 2.1)*	Consultation process in place to inform development of Children and Families Transformation Plan to conclude in 2007.	Project plan developed and implemented to realign Children and Families Services with PCCC TP, in line with PCCC service reconfiguration (delivered through PCTs and HSCN).	Q2	PCCC
Towards 2016 *Local Interagency Children's Committees - To ensure inter-agency integration in the planning and delivery of child care services*	Establishment of new county committees on a pilot basis in four locations (Limerick, Donegal, Dublin South and Dublin South City) under the auspices of Towards 2016 Children's Implementation Committee. Framework document signed off. Internal network of managers established to drive continuous development. Strong Leadership by HSE to operation of committees, including chairing of all 4 pilots.	Development of County Committees in consultation with Office of the Minister for Children and stakeholders. In context of Inter-Agency planning, HSE will complete its own business plans for the delivery of children's service directly provided and funded, in each of the four pilot areas.	Q1-Q4	PCCC
Inter-Country Adoption: *Provide inter-country adoption services.*	The Performance, Monitoring and Evaluation Unit assumed the role of collating the ICA Statistics nationally from June 2007.	Review of Inter-Country Adoption business processes in order to achieve maximum efficiency in the context of impending changes in adoption legislation progressed.	Q1	PCCC
		Validation exercise of current data set undertaken.	Q1	
Develop responses to the needs of Separated Children Seeking Asylum: *Provide effective community based services for separated children seeking asylum*	Guidelines developed. Policy development Workshop convened.	Standardisation of the management of care and welfare of Separated Children seeking Asylum will continue in partnership with other stakeholders.	Q1-Q4	PCCC
		Development of plan for countrywide provision.	Q1	

Children and Families Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
		Implementation of plan on a phased basis.	Q2-Q4	
		Implementation plan developed for roll-out of guidelines.	Q4	
		Data collection process is devised in respect of users of the service.	Q2	
Youth Homeless Strategy: *Implementation of recommendations*	Not applicable	Establish group to examine recommendations of Youth Homeless Strategy.	Q1	PCCC
		Regular reports provided on progress.	Q1-Q4	
Sexual Assault Treatment Unit report	Publicity campaign completed to encourage doctors to engage in service delivery in both new and existing units. A new course - 'Sexual Assault Forensic Examination Certificate' – commenced November 2007. National implementation Committee established to oversee the implementation of SATU Report. Forensic Nurse training programme commenced through RSCI.	GP certificate course continued.	Q1-Q4	PCCC / NHO
		Nurse Training Programme continued.	Q1-Q4	
		Improve response rates to the victims of sexual and / or domestic violence seeking practical and / or emotional support by: • Completing analysis of shortfalls in current funding for a number of voluntary organisations • Improved training of GPs and other frontline staff. • Increased level of services to clients. • Developing improved responses to clients of these services. • Improved uptake on training. Commissioning of 2 new SATUs (Mullingar and Galway).	Q4	
Ferns: *Implement the findings of the Ferns Report (TP 2.6)*	Audit of practices and compliance with recommendations instigated. Research underway on legal framework for Interagency committees / confidentiality. National publicity campaign undertaken and phase 2 campaign details under consideration. Report submitted to Steering Committee on our obligations and Ferns Recommendations. Report underway on treatment needs for children and young people. Report submitted to Steering Committee and EAG Sub-Group re treatment services for persons with sexually harmful behaviour.	Identification and implementation of recommendations on a cost neutral basis.	Q1-Q4	PCCC

Children and Families Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Violence Against Women	Participation in the National Steering Committee continued.	Work with Service Providers in relation to funding allocated to ensure improved service delivery.	Q1-Q4	PCCC
	Independent report commissioned to review salaries and conditions of the workers within the Violence Against Women Services.	Standardisation of Service Level Agreements completed.	Q4	
Teen Parent Support Programme *Towards 2016* *Progress commitments in Towards 2016 to Teen Parent Support Programme*	HSE assumed funding responsibility for Dublin North / Louth Projects and for the National Coordinator of the Teen Parents Support Programme, allowing for improved integration of service with other HSE services. Mainstreamed and enhanced existing projects and established 3 new projects (Ballyfermot, Finglas and Wexford). *Projected Outturn 07: 1,200 clients in the Teen Parent Support Programme*	Work with the Teen Parent Support Programme with a view to improving outcomes for Teen Parents. *Performance Target: 1,200 clients in the Teen Parent Support Programme.*	Q1-Q4 Q4	PCCC
Community Based High Support: *National policy commitment to the development of community based high support services.*	Intensive training provided to managers and staff for the provision of alternative care in the community. (Mol an Oige service Mayo / Roscommon).	Performance measure developed to capture community based alternatives to high support.	Q1	PCCC
Continuing Professional Development of HSE Staff and Providers.	Approximately 150 training days executed in 2007.	150 training days to be delivered in 2008 for HSE staff.	Q4	PCCC
	National Fostering undertaken to promote foster care.	Children First Training delivered to Agencies delivering services.	Q1-Q4	

MEASURING PERFORMANCE IN CHILDREN AND FAMILIES

Measurement	Projected Outturn 2007	Target 2008
Pre-School *(see additional measures in Section 10)*		
No. and % of notified current operational pre-school centre where an Annual Inspection took place.	2,258 (49.5%)	2,145 (-5% reduction)
Residential and Foster Care		
No. of children in residential care	426 (7.8%)	426 (7.8%)
No. of children in Foster care	3,327 (60.8%)	3,327 (60.8%)
No. of children in Foster care with relatives.	1,530 (28%)	1,530 (28%)

Measurement	Projected Outturn 2007	Target 2008
No. of children in Other Care Placements / At Home under Care Order.	191 (3.5%)	191 (3.5%)
% of children in care who have an allocated named social worker	90%	91%
% with a care plan	20.3%	40%
Family Welfare *(see additional measures in Section 10)*		
Total no. of referrals to Family Welfare Conferences	423	444
Total no. of Family Welfare Conferences convened	216	227
Child Abuse		
No. of notifications	2006 Section 8 reports in process of completion – outturn 07 not available at time of report.	Target to be developed in 2008
No. of assessments		
No. on waiting list for assessments		
Average time spent on waiting list		
Springboard Project		
No. of projects in place	30	30
No. of families referrals	786	786
High Support and Special Care Units *(see additional measures in Section 10)*		
Bed nights used	S / C 930 H / S 2,635	S / C 930 H / S 2,899
% occupancy levels	S / C 84% H / S 58%	S / C 84% H / S 68
Teen parent support programme	1,200	1,200

CHILD HEALTH

Ireland has the highest percentage in the EU of children and young people in its population. Evidence shows that early childhood health and development will have a significant impact on the health outcomes achieved as adults. Immunisation is one of the most cost effective ways of reducing childhood morbidity and mortality

Child Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Immunisations ***Achievement of immunisation targets:*** *identify areas of low vaccine uptake and put in place strategies to increase uptake by 5%*	*Projected Outturn 07:* • *Percentage of children 12 months of age who have received three doses of vaccine against:* *D3: 87%* *P3: 87%* *T3: 87%* *Hib3: 87%* *Polio3: 87%* *MenC3: 86%* • *Percentage of children 24 months of age who have received three doses of vaccine against:* *D3: 91%* *P3: 91%* *T3: 91%* *Hib3: 91%* *Polio3: 91%* *MenC3: 91%*	*Performance Target: 90% national uptake at 12 months.* *Performance Target: 93% national uptake at 24 months.*		PCCC / Pop Health
		Review current implementation model to maximise efficiencies towards achieving a 95% national uptake rate, at 24 months.	Q4	
	Percentage of children 24 months of age who have received MMR: 87%	*Performance Target: 90% national uptake at 24 months.*		
Undertake audit to support 'European Strategy for Child and Adolescent Health and Development'.	Project team established.	Self audit using WHO tools completed.	Q4	Pop Health / Office of CEO
PHN visits to new born babies *PHNs play a very important role in supporting parents and their newborn baby. A visit by the PHN in the early post natal period involves alleviating any parental concerns, support around infant feeding, immunisation, accident prevention, and post natal depression.*	*Projected Outturn 07: 71% of newborn babies visited by a PHN within 48 hours of discharge*	*Performance Target: 71% of newborn babies visited by a PHN within 48 hours of discharge.*	Q1-Q4	PCCC

Child Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
The WHO Global Strategy for Infant and Young Child Feeding recommends that: "to achieve optimal growth, development and health, infants should be exclusively breastfed for the first six months of life. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years and beyond".	*Projected Outturn 07: 33.2% of babies are breastfed at PHN first visit* *Projected Outturn 07: 19.5% of babies are breastfed at 3 months*	Support new mothers to continue breastfeeding. *Performance Target: 33.2% of babies breastfed at PHN first visit.* *Performance Target: 20% of babies breastfed at 3 months.*	Q1-Q4	PCCC
Adolescent Friendly Services	Quality assessment tools for measuring adolescent friendly services disseminated and put onto website.	Training in use of assessment tools rolled out in locations delivering services to young people.	Q3	Pop Health / Office of the CEO
Child Health Surveillance	Parenting Support Manuals updated and National roll out plan developed. Plan for national roll-out of Parent Held Record (PHR) developed.	Evaluation of developmental surveillance tool for children in Ireland complete.	Q4	PCCC / Pop Health / Office of CEO
		Translation of Child Health Information Support for Parents (CHISP) materials into languages of ethnic groups in Ireland undertaken.	Q2	
		Training plan developed.	Q4	
Promote a strategic approach to child health research *(TP 1.3)*	Guidelines for carrying out research with children completed. Specific research studies contracted.	Specific research studies contracted in relation to youth participation, injury prevention, and Universal Neonatal Hearing Screening.	Q4	Pop Health / Office of the CEO
Emotional well being of children	Training model for Public Health Nurses (PHN) delivered. Action plan developed.	Training programme and development of training needs assessment for working with adolescents reviewed.	Q3	PCCC / Office of the CEO
Universal Neonatal Hearing Screening	Project Manager sourced. Implementation Group established. Implementation plan devised.	Current pilot sites to be developed to full screening standard.	Q4	NHO / PCCC / Pop Health
		Develop additional pilot site in Dublin.	Q3	
Growth Measurement	Tendering process for re-equipment of PHNs with modern growth measurement tools completed.	Implication of new WHO charts considered and recommendations made. Tendering for new Irish Growth Chart completed.	Q2	Pop Health
Obesity in Children and Young People	Community Management Guidelines disseminated.	Training in prevention and management guidelines for primary professionals rolled out.	Q3	PCCC / Pop Health

Child Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Preventing Injury to Children and Young People	Eurosafe project joined. Seminar held on injury prevention.	Injury Prevention Activity reviewed and action plan developed.	Q3	Pop Health / Office of the CEO
		Participation in European Child Safety Alliance.	Q1	
Screening Newborns for Cystic Fibrosis	Proposal developed for implementation of screening programme.	Implementation of plan with commencement of screening.	Q4	NHO / PCCC / Pop Health
Irish Association for Adolescent Health and Development *This is an umbrella organisation for service providers and youth organisations concerned with improving the health and well being of adolescents.*	Business plan developed about model for Irish Association.	Business Plans further developed and implemented.	Q2	Pop Health / Office of the CEO
Developmental Screening ***Best Health for Children***		Audit of HSE performance against standards outlined in 'Best Health for Children' completed.	Q3	Pop Health / PCCC / NHO / OCEO

MEASURING PERFORMANCE IN CHILD HEALTH

Measurement	Projected Outturn 2007	Target 2008
PHN Visits		
No. and % of babies visited by PHN within 48 hours of discharge	34,137 (71%)	34,137 (71%)
Developmental Screening		
The percentage uptake of developmental screening at seven to nine months	-	To begin reporting in 08
% of boys with undescended testes undergoing orchidopexy as a % of all boys	58%	70%
Immunisation *(see additional measures in Section 10)*		
Uptake rates at 24 months	91%	93% (95% by 2010)
Breast Feeding		
% of babies breast fed at first PHN visit	33.2%	33.2%
% of babies breast fed at 3 months	19.5%	20%

MENTAL HEALTH

Mental Health services span all life stages and include services for Children and Adolescents, Adults, and Older Persons. Considerable changes are currently taking place in Mental Health Services with the adoption by the HSE in May 2006 of The Report of the Expert Group on **Mental Health Policy – A Vision for Change**, the commencement in November 2006 of Part 2 of the Mental Health Act, 2001 and the role for Mental Health Services within PCTs. All of these have significant implications for the manner in which Mental Health Services are planned and delivered.

Part 2 of the Mental Health Act was enacted on 1st November 2006 and represents the largest change in the rights of people with Mental Health illnesses for over a century.

Mental Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Implementation of Vision for Change, *which has been adopted by the HSE as policy for mental health services. (TP 2.6)*	Implementation of the recommendations of *A Vision for Change* commenced through the Transformation Programme 2007 – 2010. Implementation plan for 'Vision for Change' finalised.	Progress implementation plan for '*A Vision for Change'.*	Q1-Q4	PCCC
General Adult Psychiatry: *The establishment of multidisciplinary mental health teams to deliver core mental health service for sector populations of 50,000, with two consultant led teams per sector. (TP 2.6)*	16 Consultant Adult Psychiatrist posts advertised with most filled on a temporary basis. 2006 - Multi Disciplinary Teams: • 135.5 of the 189.5 allocated WTEs were in place to complete the initial development of 18 MDTs and 14 Team enhancements.	Reconfiguration of mental health services to community based settings in line with PCCC Transformation Reconfiguration Programme (Primary Care Teams and Health and Social Care Networks) supported.	Q1-Q4	PCCC
		Filling of the Consultant Adult Psychiatrist posts progressed, subject to agreement on Consultant Contract talks.	Pending Agreement	
Old Age Psychiatry	3 Consultant Psychiatrists appointed in a locum capacity.	Filling of the Consultant Adult Psychiatrist posts progressed, subject to agreement on Consultant Contract talks.	Pending Agreement	PCCC
Eating Disorder Services	Service developed through both Adult and Child and Adolescent psychiatry services.	Service will be progressed as part of development of Child and Adolescent Psychiatry Teams in Dublin Mid-Leinster and the South.	Q4	PCCC
National Forensic Mental Health Services	24 additional WTE appointed in Central Mental Hospital. Locking of patient's bedrooms has ceased in unit 7 and will cease in unit 3 by end of November. Unit 1 opened to provide an additional 10 beds to assist CMH in their response to the legal requirements of the Criminal Law Insanity Act.	Recruitment of 12 WTE in Central Mental Hospital completed.	Q4	PCCC
		Planning and design for relocation to Thornton Hall progressed.	Q1-Q4	

Mental Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
	As an interim measure, the CMH established a courts liaison service (7 WTE) which has assisted in the referral of 60 individuals to more appropriate assessment centres. Project Team for the development of a 120 bed New Forensic Mental Health Facility at Thornton Hall established. Draft proposal of the redevelopment of the CMH presented to the steering group. Terms of reference for an international Peer Review of the proposed models of care at Thornton Hall prepared and submitted to the Steering Group.			
Develop additional Child and Adolescent Mental Health Teams (CAMHTs): *In line with Vision for Change and the Forum on Child and Adolescent Psychiatry, we are committed to the development and enhancement of child and adolescent mental health teams and the development of additional inpatient facilities. (TP 2.6)*	Primary Notification received to support the development of 8 CAMH teams. Final agreement reached on the allocation and location of posts with relevant stakeholders.	Completed 8 x 7 Person Child and Adolescent Mental Health teams.	Q4	PCCC
	St Anne's Relocation Project – Galway. Four additional beds identified at St Anne's. Project design submitted to the local authority. Tender for construction expected to issue in Q4.	4 additional beds at St. Anne's commissioned.	Q1	
		Construction of the new 20 bedded unit commenced.	Q2	
	Cork Inpatient unit Preconstruction phase commenced in September 2007 on 20 bed unit in Bessboro, Cork. Work on development of the necessary infrastructural and human resources staff for interim solution in Glanmire, Co. Cork progressed.	Construction of the new unit commenced.	Q1	
		8 beds in St. Stephens Hospital, Glanmire commissioned as an interim solution in advance of the completion of the Bessboro Unit.	Q4	
	St Vincent's Fairview Tender for interim 6-bedded inpatient unit at St. Vincent's developed. Building work commenced.	1st Phase – a 6 Bed Adolescent Inpatient Unit commissioned at St. Vincent's Hospital, Fairview.	Q3	
		2nd Phase: Development of an additional 6 Beds in the Adolescent Inpatient Unit, St. Vincent's Hospital, Fairview progressed.	Q1-Q4	
		Service provision at Warrenstown House increased from 5 to 7 days per week.	Q1	

Mental Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Implementation of Mental Health Act: *Section 9 (1) (a) of the Mental Health Act 2001 provides for an application to be made by an authorised officer to a registered medical practitioner where it is proposed to have a person (other than a child) involuntarily admitted to an approved centre.*				
Development of role of Authorised Officers	Interim arrangements in place to deliver the Authorised Officer Service under Mental Health Act 2001. Discussions to agree arrangements to deliver the full Authorised Officer service ongoing with the relevant unions. Development of a 5 day training course for authorised officers completed in September, 2007.	Negotiations advanced through Partnership to primarily deliver service through our staff.	Q1-Q4	PCCC
Arrangements for Second Medical Opinion	Recommendations of the Working Group commenced implementation and all second opinions sought from the panel provided.	Second Opinions provided as required.	Q1-Q4	PCCC
Meet legal obligations in providing for Assisted Admissions	Demand for Assisted Admissions met through our Staff and a contact service provider.	Meet legal obligations in providing for assisted admissions.	Q1-Q4	PCCC
Management Information *The development of information is a key priority for PCCC Mental Health Services*	National Minimum Dataset for Mental Health developed by Mental Health Commission in collaboration with the HRB. Discussions on its ongoing development have taken place between the HSE, the Mental Health Commission, the HRB and the DoHC.	Interim data set (derived from the suite identified in 2007) to meet the accountability requirements of the main stakeholders developed and implemented. Development of a comprehensive information system for Mental Health commenced.	Q1 Commencing Q1	PCCC
National Service User Council (NSEU)	Interim NSEU established. Launch of Strategic Plan.	NSEU established and elections to the Board supported.	Q1-Q4	PCCC

MEASURING PERFORMANCE IN MENTAL HEALTH

Measurement	Projected Outturn 2007	Target 2008
Inpatient Units *(see additional measures in Section 10)*		
Admission rates to acute units	96.7	96.7
Readmission rates	70.3	70.3
Community Mental Health Teams		
No. of CMHTs in place	47	55

OLDER PEOPLE

Services for Older People aim to support older people to remain at home in independence for as long as is possible or, where this is not possible, in an alternative appropriate residential setting. A range of services is provided in partnership with older people themselves, their families, carers, statutory, non-statutory, voluntary and community groups. The principles of person-centeredness and empowerment of service users underpin service delivery.

Older People Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Development of home and community based services and supports *(TP 2.5 and 2.6) Government policy states that Community and home based care should be developed to maintain older people in their own communities for as long as possible and to support the important role of the family and informal carer.* ***The Home Help service*** *and the provision of Home Care Packages (HCPs) are at the core of these community and home based services.*	Home Help Hours *Projected Outturn 07: 11,780,000 Home Help Hours provided*, i.e. an additional 350,000 hours above 2006 levels. Estimated 53,000 persons availing of Home Help service at year end. Agreement reached through High Level Partnership Group on introduction of a new standardised Home Help Delivery Structure in 2008 to ensure high quality and safe provision.	*Performance Target: 11,780,000 home help hours per annum.*		PCCC
		Conclude the implementation of the National Home Help Agreement.	Q2	
Home Care Packages (HCPs) *are an additional support over and above existing mainstream community services and are used to support and maintain the older person at home via additional home supports and therapy services. They are designed to be flexible and are particularly targeted at those at risk of admission to long term care, inappropriate admission to acute hospital or requiring discharge to home from acute hospital. (TP 2.5 and 2.6)*	*Projected Outturn 07: 8,500 clients in receipt of Home Care Packages (4,350 equivalent) with a throughput in excess of 10,500 clients in 2007.* HCPs consisted of home help and home support type services, for example, respite care in 07. Work completed in 2007 for the employment of additional Allied Health Professionals for the delivery of HCPs to more complex cases. Evaluation of the effectiveness of Home Care commenced in conjunction with the DoHC.	*Performance Target: 8,500 clients in receipt of Home Care Packages (4,350 equivalent) with a throughput in excess of 10,500.*		PCCC
		Clients with more complex level of needs to benefit from Home Care Packages. (The input of additional allied health professionals and related community staff as part of the provision of Home Care Packages will meet the needs of more complex cases. They will enhance the support of early discharges from the acute sector and prevent inappropriate admission.)	Q1-Q4	
		HCP Evaluation completed.	Q1	
		Outcome of evaluation considered in National Guidelines.	Commencing Q4	
Flu Vaccine	*Projected Outturn 07: 63% uptake of flu vaccine*	*Performance Target: Promote continued uptake of vaccine. Achieve target of 75% by 2010.*	Q1-Q4	PCCC

Older People Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Public Fast Track Beds: *Beds developed to support the provision of extended care, rehabilitation and respite to patients. This initiative is key to the timely discharge of patients who have completed the acute phase of their care (delayed discharge). (TP 2.5 and 2.6)*	Public Fast Track Initiatives provided an additional 254 beds.	Provide an additional 606 beds bringing the implementation of the total fast track initiative to 860 as approved by Government.	Q4	PCCC
Day / Respite Care Older persons *(TP 2.5 and 2.6)*	*Projected Outturn 07: 300 Additional Day Care places provided (bringing the total to 21,300 places).*	*Performance Target: 21,300 Day Care places provided per annum.*	Q1-Q4	PCCC
Sheltered Housing *schemes play an important role in supporting older people to remain living in the community, in independence and dignity. Sheltered housing provides secure accommodation for older people who do not require 24 hour nursing care.*	Work progressed on an agreed approach with voluntary groups providing social support services and sheltered housing within resources available. This work will be used to inform 2008 developments.	Pilot, initiative using the housing with care model, established.	Q4	PCCC
Elder Abuse	26 of 32 Elder Abuse Officers appointed. Two national recruitment campaigns completed. Remaining 6 posts being filled through local recruitment campaigns. Extensive training programme in detecting and reporting Elder Abuse for staff in public and private settings was put in place. 4,000 personnel have received training to date. Comprehensive training relating to legislation and Elder Abuse held in October. Tender process to establish a National Research Centre for Elder Abuse ongoing. Selection of a suitable host institution will take place in early 2008.	Data on Elder Abuse analysed.	Q1	PCCC
		Core dataset refined.	Q2	
		Review of data collection process underway.	Q2	
		Collaboration with other stakeholders to develop Public Awareness programmes.	Q1-Q4	
		Best practice guidelines for the Voluntary and Private sector developed.	Q4	
		Collaboration with development of a national Vulnerable Adult's Policy.	Q1-Q4	
		Evaluation of Elder Abuse Awareness DVD in relation to HIQA standards on Elder Abuse.	Q4	
		Examination of merits of producing similar training materials for community services and acute settings.	Q4	
		National Research Centre for Elder Abuse establishment progressed.	Q3	

Older People Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
A Fair Deal and Associated Work: *From January 1, 2008, the current nursing home subvention will be replaced by a new nursing home care support scheme, to be known as 'A Fair Deal'. The new scheme is designed to ensure that everyone that enters a nursing home in either the public or private sector has their needs assessed through a common process and pays a fair portion of their income as a contribution towards the cost of their care. (TP 2.5)*	National Guidelines for the Standardised Implementation of the Nursing Home Subvention Scheme 2007 were issued and implemented. New procedures and protocols for financial assessments being finalised as part the requirements for implementation of 'A Fair Deal' from January 2008. (see Section 10 for measures relating to 'A Fair Deal')	Implementation progressed of 'A Fair Deal' and all its components i.e. Financial Assessments, National Needs Analysis of Long Stay Residential Care, Common Assessment Process and Clinical Pathways for Long term Care, development of Geriatrician-led Teams in the Community, Standards, Nursing Home Inspections.	Q1-Q4	PCCC
		National standardised financial procedures and protocols in place to replace subvention processes.	Q1-Q4	
		National Guidelines implemented from 1st January 2008 and monitored to ensure implementation on an equitable basis nationally.	Commencing Q1	
		IT system in place to capture performance and management information required in the context of 'A Fair Deal' linking with existing IT systems in Nursing Home Units across the service.	Commencing Q1	
Financial Assessment to encompass existing subvention arrangements and new provision. ***Common Assessment Process and Clinical Pathways for Long term Care:*** *In the overall context of the significant investment in, and development of, community based, acute and residential care services for older people, there is a growing requirement to ensure effective clinical co-ordination of services across these domains. (TP 2.5)*	Policy document on 'PCCC Clinical Pathways for Older People' - setting out a common pathway for admission of older people developed. Implementation of a paper based Common Assessment Summary complete for 01.01.08, and policies for Common Assessment Process.	Assessment of resources required to implement PCCC Clinical Pathways for Older People completed, with a focus on the introduction of : • Continuing care referral procedures and processes • Establishment of Placement panels for residential care. • Appraisal and development of ICT based care needs assessment systems and identification of capacity building requirements.	Q1	PCCC, NHO
Develop Geriatrician-led Teams in Community: *Develop the capacity of community services in order to meet the more complex needs of older people and to support implementation of 'A Fair Deal' (TP 2.5)*	Preparatory work undertaken for development of 4 Consultant Led Geriatrician Teams (5 WTEs per team)	Consultant Led Geriatrician teams implemented.	Q4	PCCC

Older People Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Long Stay Charges Reimbursement Scheme	Contract awarded to external company to make payments under this scheme. (see Section 10 for measures relating to long stay charges)	Payment schedule continued as laid out in contract, within the level of funding available.	Q1-Q4	PCCC
Service and Standards Improvement	Developed Draft Standards for Residential Care and the nursing home inspection process with HIQA. Steering Group established to oversee the implementation of the standards.	Work with HIQA and the DoHC on the implementation of standards, in line with legislation.	Q1-Q4	PCCC, HIQA
Nursing Home Inspection and Registration	National standardised approach implemented. Inspection reports available to the public on our website as of July 2007, in line with agreed protocols.	Appointment of dedicated inspection teams progressed.	Q4	PCCC
		Inspection and registration function transferred to HIQA, with stakeholders in place to facilitate transfer	Q4	
		Nursing Homes inspections undertaken pending transfer to HIQA.	Q4	
	Projected Outturn 07: 100% of nursing homes received 1st and 2nd inspection in 2007	*Performance Target: 100% of 1st and 2nd statutory inspections to be completed.*	Q4	

MEASURING PERFORMANCE IN OLDER PEOPLE

Measurement	Projected Outturn 2007	Target 2008
Waiting Lists		
Patients over 65 waiting for cataract surgery / ENT / orthopaedic	N/A	N/A (for discussion with DoHC)
Influenza		
% uptake of influenza vaccine	63%	Promote uptake - 75% by 2010
Home Help Hours *(see additional measure in Section 10)*		
No. of hours	11,780,000	11,780,000
No. of clients	53,000	53,000
Home Care Packages *(see additional measures in Section 10)*		
No. of packages	4,350 equivalent	4,350 equivalent
Day Care		
No. of day care places	21,300	21,300
Meals on Wheels		Reporting will begin in 2008
Nursing Home Subvention		
No. in receipt of subvention	7,800	Dependent upon impact of 'A Fair Deal'
No. in receipt of enhanced subvention	4,300	Dependent upon impact of 'A Fair Deal'
Implementation of 'A Fair Deal' *(see additional measures in Section 10)*		Reporting will begin in 2008
Nursing Home Inspections		
% of inspections carried out	100%	100%
Residential Care		
No. of public beds	10,156	10,156 (plus impact of public fast track beds)
% of persons 75 and over in residential care	9%	< 10%
Sheltered Housing *(see additional measures in Section 10)*		Reporting will begin in 2008
Long Stay Charges *(see additional measures in Section 10)*		Reporting will begin in 2008

PALLIATIVE CARE

Palliative Care is defined as the active total care of patients whose disease is no longer responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for patients and their families. The current delivery of palliative care services in the HSE varies from and within each Primary, Community and Continuing Care LHO area and Hospital Network, both directly provided by the HSE or in partnership with the non-statutory sector.

Palliative Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
National Palliative Care Report 2001 ***Baseline Palliative Care Study (published eEnd 2005).***	Work continued to address inequalities identified in Baseline Study through the development of Area Level action plans in line with area development committees' reports. Baseline initiated under auspices of Area Development Committees.	Work of Area Development Committees supported.	Q1-Q4	PCCC
		National needs plan reviewed and examined in association with DoHC and other stakeholders.	Q3	
		Implementation plan 2009 -2013 developed, following national needs assessment.	Q4	
Development of Plan for Paediatric Palliative Care	Work undertaken with DoHC in development of policy on Paediatric Palliative Care.	Plan developed following finalisation of policy.	Q4	PCCC
Developments 2007 *These developments include provision for additional medical, nursing and allied health professionals to support the delivery of palliative care services.*	Additional service developed and signed off by Palliative Care Steering Group (March 2007). Primary notifications issued May 2007.	Completion of developments agreed in 2007 in the following areas: • Specialist Inpatient Palliative care Services. • Specialist services in the Community / Home Care. • Specialist care in Acute General Hospitals. • Core statutory funding for services provided by voluntary agencies. • Data management and improvement. • Development of database and service intelligence capacity. Additional medical, nursing and paramedical staff to support key service developments in palliative care have been identified for 2008. The impact of these appointments on current levels of service provision will be monitored through our service plan reporting.	Q4	PCCC
Provision of palliative care services for non-malignant conditions.	Joint study with Irish Hospice Foundation (Extending Access), to explore aspects of palliative care extending to patients with non-malignant conditions, was completed.	Study examined with view to phased implementation.	Q3	Office of CEO
Provision of care pathways for specialist palliative care services	Development of integrated care pathways for specialist services continued. Development of care pathways models in two LHOs initiated, to act as case study for national approach.	National approach developed (based on outcome of study in HSE South, linking to Transformation Programme delivery system – PCTs).	Q4	PCCC / Office of CEO

Palliative Care Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Minimum data-set for Palliative Care	Steering Group set up to oversee implementation.	Minimum Data Set rolled out subject to agreement on ICT platform.	Q4	PCCC / Office of CEO
Specialist Inpatient Units	*Projected Outturn 07: 330 (monthly average)*	*Performance Target: 330 (monthly average)*	Q1-Q4	PCCC
Home Care Services	*Projected Outturn 07: 2,500 (monthly average)*	*Performance Target: 2,500 (monthly average)*	Q1-Q4	PCCC
Intermediate Care	*Projected Outturn 07: 80 (monthly average)*	*Performance Target: 80 (monthly average)*	Q1-Q4	PCCC
Day Care	*Projected Outturn 07: 260 (monthly average)*	*Performance Target: 260 (monthly average)*	Q1-Q4	PCCC

MEASURING PERFORMANCE IN PALLIATIVE CARE

Measurement	Projected Outturn 2007	Target 2008
Specialist Services		
No. of patients treated in specialist inpatient units	330	330 (plus impact of new developments)
No. of patients accessing homecare	2,500	2,500 (plus impact of new developments)
No. of patients accessing intermediate care	80	80 (plus impact of new developments)
No. of patients accessing day care	260	260 (plus impact of new developments)

SOCIAL INCLUSION

The aim of Social Inclusion Services is to address inequalities in health between social groups by targeting services, improving access to mainstream services and enhancing the participation and involvement of socially excluded groups and local communities in the planning, design, delivery, monitoring and evaluation of health services. Social Inclusion services are significantly underpinned by the National Anti Poverty Strategy (NAPS), the National Health Strategy and equality legislation.

Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Traveller Health: *The Traveller Community are a minority cultural group in Irish society. They have ''particular vulnerabilities; including significantly inferior health outcomes compared to the population generally' '[National Action Plan for Social Inclusion 2007-2116]. Health interventions aim to improve the general health standards in the Community and to improve life expectancy in line with the settled population.*				
Traveller Health Units	National mapping of existing traveller services completed. Consultation process completed with Traveller Health Units (THU) on development of effective linkages with new HSE structure. *Projected Outturn 07: 43% of THUs had Traveller representation.*	National Health Advisory Forum established to facilitate effective communication and information exchange with Traveller Representatives. *Performance Target: 50% of THUs to have Traveller representation.*	Q1	PCCC
Traveller Health Study	First All Ireland Traveller Health Study, commissioned by the DOHC, underway. Establish structure and working protocols to support the All Ireland National Traveller Health Study.	First phase complete. Operational structure to support study in place.	Q1 Q2	PCCC
Primary Healthcare Projects	New Traveller Primary Care Healthcare Projects developed in 4 locations: Kildare, Cavan, Bunclody, Dungarvan.	Recruitment of staff for Traveller Primary Healthcare Projects completed.	Q4	PCCC
Ethnic Minority Services: *Ethnic and cultural diversity in Irish society has been rapidly increasing. With Census 2006 reporting that 10% of the population are non-Irish, new challenges exist for the HSE in developing appropriate, effective mechanisms of providing health services to a diverse group of service users, many of whom have unique and distinctive health and support needs.*				
Learning, Training and Support Framework for HSE staff.	8 pilot sites in acute and PCCC settings implemented intercultural training programmes and initiatives. Evaluation of sites completed. (End 07) 381 staff participated in training.	Evaluation of Learning, Training and Support Framework reviewed. Promote ongoing training of staff.	Q1	Office of CEO / PCCC

Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
RAPID, CLÁR and Development Boards ***Rapid:*** *The RAPID Programme is a Government initiative, which targets 46 of the most disadvantaged areas in the country. The Programme requires Government Departments and State Agencies to bring about better co-ordination and closer integration in the delivery of services.* ***CLÁR:*** *The CLÁR programme is a targeted investment programme in rural areas. CLÁR provides funding and co-funding to Government Departments, State Agencies and Local Authorities in accelerating investment in selected priority developments.* ***Development Boards:*** *County / City Development Boards (CDBs) exist in each of the 34 County / City Councils, as a government response to the challenge of better integration of public and local service delivery. They comprise representatives from the four key sectors of local government, local development, the social partners and state agencies. The main function of the Boards is to bring about the more coordinated delivery of public and local development services at local level. The HSE is represented on each CDB.*				
Implement new HSE Structure for RAPID	HSE RAPID Structure developed to define and structure HSE engagement with the RAPID programme at national, regional and local level.	Populate HSE RAPID Structure.	Q1	PCCC
The RAPID leverage fund *is a series of capital health projects in RAPID areas that are co-funded by the HSE and the Department of Community, Rural and Gaelteacht Affairs.*	Current round of HSE RAPID Leverage Fund concluded. HSE RAPID action plan finalised (November 2007)	New round of RAPID Leverage Fund developed.	Q2	PCCC
		RAPID Leverage Fund Financial Processes operationalised.	Q1	
		RAPID action plan implemented.	Q4	
Implement new HSE Structure for CLÁR Programme	Current round of HSE CLAR Funding concluded.	CLAR Fund Financial Processes operationalised.	Q1	PCCC
	Projects for new round of HSE CLAR Funding finalised.	CLAR Project Funding commenced.	Q1	
Development Boards	HSE represented on each Development Board.	Engagement in County / City Development Boards reviewed.	Q1	PCCC
Community Development: *Our Community Development Service supports communities in developing an awareness of and assisting in the identification of social need; promoting, maintaining and developing the potential of voluntary organisations; developing and maintaining liaison between relevant voluntary organisations and relevant statutory agencies; promoting and evaluating standards and quality of service; and working with other agencies providing health and social services in the area.*	Community Development Position Paper completed with recommendations on structure of Community Development within the HSE.	Action plan developed to review the structure of community development	Q1	PCCC

Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Report on Lesbian, Gay, Bisexual, Transsexual, Transgender Services	Position paper completed on Services for Lesbian, Gay, Bisexual, Transsexual, Transgender clients.	Action plan developed for review of services.	Q1	PCCC
Community Welfare Services: *The Community Welfare Service is currently in the process of being transferred from the HSE to the Department of Social and Family Affairs.*	Working Paper on the role of CWOs in Primary Care Teams and Social Care Networks developed. Process underway to validate the numbers of staff currently employed in the Community Welfare Service both in respect of Supplementary Welfare Allowance work and HSE work. Process for implementation of core functions report commenced, including partnership approach with Trade Unions.	Support the transfer of PCCC Schemes to the Department of Social and Family Affairs (DSFA).	Q1-Q4	PCCC
		Progress implementation of the core functions report in conjunction with the DoHC, DFSA, DoF, and stakeholder representatives.	Q1-Q4	
		Reconfiguration of arrangements for delivery of health and social service elements of Community Welfare Services implemented.	Q1-Q4	
		Special Housing Aid for the Elderly Scheme transferred to the Department of the Environment supported.	Q1-Q4	
		Administrative processes and procedures examined after the transfer of the Community Welfare Service: • Nursing Home Subvention. • Hardship Scheme. • Homecare Package. • Inpatient Charges Assessment. • Home Help Over 70s. • Disabled Persons Rehab Allowance.	Q1-Q4	
HIV / STD: *These services provide a range of supports and interventions for people with HIV and STDs provided directly and also through a number of voluntary and community groups.*	Funded part of Stamp Out Stigma campaign which is a national campaign, to combat stigma and discrimination against people infected with HIV in Ireland. Review is underway of funding to Voluntary Organisations that provide services in relation to HIV / STD to determine the distribution of the available resource from the 2007 Development Funding.	HIV / STD Services mapped.	Q1	PCCC
		Position Paper in relation to HIV / STD services developed.	Q4	
National Drugs Rehabilitation Strategy**:** *Rehabilitation is a key priority for us in 2008.*	National Drug Strategy Report on Rehabilitation completed.	National Drug Rehabilitation Implementation Committee developed.	Q2	PCCC

Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Addiction Services ***National Drugs Strategy:*** *The National Drugs Strategy, which is the context for the delivery of addiction services, comes to an end in 2008 and is being reviewed. The lead Department, the Department of Community, Rural and Gaeltacht Affairs, is currently establishing a structure for this review. The HSE will have a critical role to play in this.*	See Section 10 for measures on addiction services.	Participate in review of the National Drugs Strategy.	Q1-Q4	Office of CEO / PCCC
Cocaine Treatment	National Co-ordinator employed to lead the National Addiction Training Programme, with initial emphasis on cocaine training.	Implementation of the National Addiction Training Programme progressed.	Q1-Q4	PCCC
Development of Under 18's Treatment Services	Primary Notification in place for multidisciplinary team enhancement and developments.	Development of multidisciplinary team enhancements and related services.	Q4	PCCC
Data collection: *The provision of robust information to underpin service planning in Drug and Alcohol services is a priority for Social Inclusion services.*	Glossary agreed with the Health Research Board (HRB). Mapping completed and gaps identified in data collection systems from treatment services.	Examination and reconfiguration of Performance Indicators for drug and alcohol.	Q1	PCCC
		Mapping of data collection systems	Q1	PCCC
Health Atlas: *The Health Atlas aims to enable web-based mapping of health related data on a national basis.*	Mapping services complete and framing of 4-tier model progressed to Health Atlas.	Drug and alcohol information input to Health Atlas.	Q2	PCCC
Quality initiatives / standards: *Quality in alcohol and drug services or QUADS and Drug and Alcohol Occupational Standards (DANOS) are benchmarking standards for the drug and alcohol service. (TP 2.6)*	QUADS / DANOS accepted as the benchmarking standards.	Use of QUADS mapped around the country. Ramifications for implementing DANOS explored.	Q3	PCCC
Drug Task Force Mainstreaming: *The Department for Community, Rural and Gaelteacht Affairs and has funded a number of drugs task force pilot projects.*	Working group established to plan mainstreaming of Drug Task Force projects. Mainstreaming Proposal document developed. Review underway of the list of projects to ensure they are in line with HSE policy.	Mainstreaming process agreed with DCRAGA and DOHC to manage the mainstreaming of the National Drugs Strategy projects that have been evaluated.	Q1	PCCC
		Project by project analysis undertaken of Drug Task Force.	Q4	
		Projects mainstreamed.	Q4	

Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Links to HSE Working Group on Alcohol	Cross directorate process established with Office of the CEO with PCCC and NHO.	Cross directorate strategic focus on alcohol developed.	Q2	PCCC / Office of CEO
		Best practice guidelines for the alcohol services developed.	Q3	
Homeless Services: *Homeless Services provide a wide ranging and comprehensive response to the health needs of Homeless Service users. This service is provided both directly and also through the services of Non-Governmental Organisations (NGOs).*				
The National Homeless Strategy*. This will require significant HSE operational planning and significant development in training, quality and standards.*	Homeless Strategy launched at the end of 2007.	Operational plan for the new Homeless Strategy prepared, to include a new National Preventative Strategy.	Q4	PCCC
Local Authority Capital Developments: *HSE funding of homeless services is largely based on the care and welfare dimension of clients' needs, with capital funding primarily coming from the Department of the Environment and the many NGOs engaged in this area of provision.*	Capital developments initiated in 2007 were brought on stream by local authorities, with support from HSE staff.	Completion of developments initiated in 2007.	Q1-Q4	PCCC
National Protocols for Discharge	Draft Protocol for Acute Services completed and being progressed with NHO. Draft protocol for Mental Health Services to be finalised by the end of 2007.	Agreed protocols implemented.	Q2	PCCC
	Projected Outturn 07: 25 (67%) of hospitals operating a formal discharge policy for homeless people from acute hospitals. (31 LHOs)	*Performance Target: 100% discharge policies.*		
	Projected Outturn 07: 29 (71%) of acute mental health units operating a formal discharge policy.	*Performance Target: 100% discharge policies.*		
	Projected Outturn 07: 23 (72%) of community service areas operating a formal aftercare service for young people leaving care (Q3).	*Performance Target: 100% discharge policies.*		
Homeless Services Mapping	Mapping of Homeless Services completed.	Mapping of Homeless Services to Health Atlas stage completed.	Q1	Office of CEO / PCCC
Data Collection	Data set for homeless services completed and piloted.	Data set to collect accurate information on the uptake of health services by residents in homeless	Q4	Office of CEO

Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
		facilities rolled out on a 6 monthly basis.		

MEASURING PERFORMANCE IN SOCIAL INCLUSION

Measurement	Projected Outturn 2007	Target 2008
Addiction Services		
% of substance misusers for whom treatment commenced within one month	84% clients seen within one month	Increase %
Average no. of clients in methadone treatment	7,000	7,000
Traveller Health		
No. of HSE staff who have completed training programmes	381	381
% of travellers on THU	43%	50%
Asylum Seekers		
No. of HSE staff who have completed training programmes	476	476
Homeless Services		
No. and % of acute hospitals that operate discharge policy	25 (67%)	100%
No. and % of acute mental hospitals that operate discharge policy	29 (71%)	100%
No. and % of community service areas that operate discharge policy	23 (72%)	100%

DISABILITY SERVICES

Services for persons with disabilities seek to enable each individual with a disability to achieve his / her full potential and maximise independence, including living as independently as possible.

The development of services for persons with disabilities is informed by the National Disability Strategy (2004), which provides a framework of new supports for people with disabilities. The strategy builds on a strong equality framework, which is reflected in several pieces of equality legislation. It puts the policy of mainstreaming of services for people with disabilities on a legal footing.

The prevalence of disability increases significantly with age, from a 2% prevalence rate in young people (aged 0-17 years), to a 7% rate in the 18-64 years group, to a 31% rate in the 65 years and over group.

The needs of people with an intellectual disability are identified and planned for through the National Intellectual Disability Database. This database details the existing level of specialised health service provision and an assessment of need for the upcoming five-year period. The 2007 Annual Report of the National Intellectual Disability Database Committee shows a total register of 25,613 – an increase of 0.4% from the 25,518 persons identified in 2006. Of the 25,613 persons registered on the National Intellectual Disability Databases, 97% are receiving a service. One percent (305) of those registered, who are without services at present, are identified as requiring appropriate services in the period 2008 – 2012. A further 2% (410) who are not availing of services have no identified requirement for services during the planning period 2008 – 2012. Forty five percent of these (186) are in the mild or not verified range of intellectual disability.

In June 2006, there were 27,056 persons registered on the national physical and sensory database, representing 65.6% of the estimated target national coverage.

Disability Services Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Services for Persons with Intellectual Disability and Autism *(TP 2)*				
Residential Care: *Residential care provision for persons with an intellectual disability*	New places provided: 175.34 (Q3) Enhanced places provided: 113.91 (Q3)	198 posts to support service developments (initiated in 2006) completed, together with a further 145 from 2007.	Q4	PCCC
	Projected Outturn 07: 8,262 residential care places provided.	*Performance Target: 8,262 residential care places provided.*	Q4	
Day Care: *Cay care provision for persons with an intellectual disability*	New places provided: 419.58 (Q3) Enhanced places provided: 63 (Q3) *Projected Outturn 07: 24,729 day care places provided.*	*Performance Target: 24,729 day care places provided.*	Q4	PCCC
Respite Care: *Respite care provision for persons with an intellectual disability*	New places provided: 63.77 (Q3) Enhanced places provided: 11.37 (Q3) *Projected Outturn 07: 4,480 respite care places provided.*	*Performance Target: 4,480 respite care places provided.*	Q4	PCCC

Disability Services Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Transfer of clients inappropriately placed: *A number of people with Intellectual Disability continue to be accommodated in inappropriate settings, including psychiatric hospitals. Services need to be developed to facilitate the accommodation of these persons in Intellectual Disabilities services.*	Business cases focused on the transfer of clients inappropriately placed in psychiatric settings finalised.	Number to be transferred identified and prioritised in line with need and circumstances.	Q1-Q4	PCCC
Services for Persons with Physical and Sensory Disability *(TP 2.) The 2005-2009 Multi-annual Investment Programme, under the Disability Strategy, provided for the creation of 80 additional residential places per year and 250,000 additional hours of personal assistant / home support.*	Residential Places *Projected Outturn 07: 834 (approx.) residential places provided.* New residential places: 37 (Q3) Enhanced residential places: 11 (Q3)	*Performance Target: 834 residential places provided (approx.)*		PCCC
	Personal Assistants / Home Support Hours *Projected Outturn 07: 3,000,000 hours of personal assistance / home supports provided.*	*Performance Target: 3,000,000 PA / Home Support Hours provided.*		
Complete the Strategic Review of HSE funded Adult Day Services, *with a view to reconfiguring adult day service provision to ensure compliance with the Disability Act 2005 and Equality Legislation.*	Review process commenced.	Strategic review of HSE funded adult day services completed.	Q3	PCCC
Review models of service provision to reflect revised Primary Care structures. *Review models of service provision to reflect the revised Primary Care structures (TP 2.6)* *Review congregated settings.*	A Framework Document for the delivery of reconfigured services to children aged 0–5 years with complex developmental needs and children 6-18 years was completed and agreed.	Framework document for children aged 0 -5 years implemented within available resources.	Q2	PCCC
		Review congregated settings through development of project plan to provide more appropriate community based accommodation for 3,000 individuals with an intellectual and / or physical and sensory disability who currently live in large residential units.	Commencing Q4	

Disability Services Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Implementation of the Disability Act *(TP 2.6): Part II of the Disability Act 2005, establishes a system for the assessment of individual health service needs and, where appropriate, educational needs. The Act provides a statutory entitlement to:* • *An independent assessment of health and educational needs* • *A statement of the services (Service Statement) which it is proposed to provide, within available resources* • *To pursue a complaint through an independent redress mechanism if there is a failure to provide these entitlements* *Part II of the Disability Act was implemented from 01/06/2007 for children under 5 years of age.*	Regulations to support the implementation of the statutory framework of the Disability Act developed by the DoHC in consultation with the HSE and issued appropriately. Standards for assessment adopted by HIQA and signed-off by the Minister for Health and Children and issued appropriately. Meet commitments arising from the Disability Act, 2005 in respect of 0-5 year olds. 32 Assessment Officers were recruited. Thirty one are in post and 1 is in process. Training programme delivered. 32 Case Manager posts (liaison function) advertised and 27 case managers recruited. Two are in post. Training for Case Managers undertaken in September, 2007. Information leaflet published. Information notices in relation to the Act appeared in national and local press. Assessment of need and service statement for 0-5 year olds prepared. Protocols to guide the assessment of need finalised and circulated to Assessment Officers for implementation. Approximately 400 applications for assessment of need received (End August, 2007). Work commenced on the format of service statements and consultations are ongoing with voluntary service providers. **Complaints Procedure** Agreement reached nationally that the Complaints Procedure outlined in the Disability Act will be accommodated within the overall HSE Complaints Procedure. Two additional staff assigned to Consumer Affairs to facilitate this.	Children aged 0-5 years qualifying under the Disability Act to have independent assessment of need undertaken. Service statement specifying the health or education services, to be provided to an applicant as a result of their completed assessment furnished by liaison officers. Recruitment of Case Managers as part of reconfiguration of PCCC services delivered through PCTS and HSCNs. Information disseminated in relation to the entitlements of 0-5 year old children under the Act. Work in partnership with the DoHC and other stakeholders to review the sectoral plan for Disabilities. The following data items will be reported against in 2008: (a) The no. of requests for assessments received. (b) The no. of assessments commenced as provided for in the regulations. (c) The no. of assessments commenced within the timelines as provided for in the regulations. (d) The no of assessments not commenced within the stated timelines. (e) The no. of assessment completed within the timelines as provided for in the regulations. (f) The no of assessments not completed within the stated timelines. (g) The no. of service statements completed. (h) The no of service statements completed within the timelines as provided for in the regulations. (i) The no of service statements not completed within the stated timelines. (j) The number of assessments refused. (k) The aggregate unmet need.	Q1-Q4	PCCC

Disability Services Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Work with the DoHC, Dept of Education and Science and the National Council for Special Education to plan the implementation of the EPSEN Act 2004 *(TP 2.6)*	Discussions undertaken with the DoHC, DoES, National Council for Special Education and the HSE on the development of a framework to meet our mutual obligations arising from the provisions of the EPSEN Act.	Project plan developed to deliver increased capacity for children aged 5-18 years.	Q4	PCCC
		Implementation roadmap and costed action plans defined.	Q4	
Rehabilitation Training	Increase in the Rehabilitation Training Capitation Rate to maintain parity with increases in FAS training rates. Appropriate distribution funding agreed.	Increased rehabilitation training capitation rate implemented in line with the approved FÁS rates.	Commencing Q1	PCCC
Minimum Data Set	**Develop a Minimum Data Set** Working group established to comprehensively review existing information systems and arrangements for data collection. Interim ICT solution went live in August.	Completion of development of minimum data set.	Q4	PCCC
		Progress the reconfiguration of the ID and PS databases, in partnership with other key stakeholders, having regard to the requirement of the Disability Act.	Q2	
		Work in partnership with HIQA to develop standards for the inspection of ID facilities.	Q1-Q4	

MEASURING PERFORMANCE IN DISABILITY SERVICES

Measurement	Projected Outturn 2007	Target 2008
Intellectual Disability *(see additional measures in Section 10)*		
% of clients assessed and receiving residential services	99.7%	99.7%
% of clients assessed and receiving day services	99%	99%
Institutional Transfers		
% and no. transferred from psychiatric hospitals	0	-
Under 5's *(see additional measures in Section 10)*	-	Reporting will begin in 2008
Domiciliary Care Allowance		
No. of persons in receipt	19,600	DLED scheme
Sheltered Work		
No. of persons in sheltered work	2,000	2,000
No. in rehabilitation training	2,800	2,800
Physical and Sensory Disability		
No. of residential places	834	834
No. of home support / PA hours	3,000,000	3,000,000

POPULATION HEALTH

The Population Health Directorate has developed in a manner that promotes strong inter-directorate working, particularly with the NHO and PCCC. Key areas of collaboration include cancer services, the chronic illness framework, hospital configuration, emergency management, healthcare-associated infection and in progressing the priorities of the wider Transformation Programme. The Directorate is structured into six key areas: health intelligence; strategic health planning; health promotion; emergency management; health protection and environmental health and each of these are set out below.

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Health Intelligence (HI) *supports the use and development of knowledge to improve the health of the population. It supports the work of the HSE by promoting evidence based healthcare information and practice. Through supporting research and development, planning and evaluation will be further informed.*				
Management of population health related data and information resources *(TP 4.7)* *HI will focus on key outputs in particular through the Health Atlas Ireland in support of national, regional and local health development matters.*	Breadth and depth of the health related data and information resources progressed.	Consolidation of population health information speciality, within the context of full establishment of the national Health Intelligence function for the HSE: • Firmly defined role in supporting planning and decision-making processes.	Q1	Pop Health
		• Addition of further data resources (through the Health Atlas Ireland programme).	Q4	
		• Conduct specific pieces of analysis to inform policy and planning decision-making.	Q4	
		• Health Atlas further progressed.	Q4	
The use and development of the evidence base of health *(Part of TP 4.7)* *The Horizon Scanning Unit will lead the HSE on activities to distil new and novel ideas, derived from sources both nationally and internationally, to inform direction and decision making.*	Capacity for examination of evidence base of health provided. Tailored access through further enhancement of the HI website provided.	Priority review and dissemination of evidence (including through the Horizon-Scanning Unit) to support decision-making.	Q4	Pop Health
		Provision of some extension and improvements to web-based resources through new HSE internet and intranet platforms, including www.healthintelligence.ie, intranet based resources, and www.factfile.ie.	Q1	
		Provision and progress on basic parts of Knowledge Exchange programme. Applying Network Analysis to example knowledge networks, conduct review and inventory of existing knowledge channels, develop knowledge broker resources.	Q4	
		'Contact, Help, Advise and Information Network' (CHAIN) programme to raise awareness of services through email based 'mail-shots' and articles in professional journals progressed.	Q1	

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Research and Development Strategy	Strategy developed and implemented.	Implementation of further actions by Health Intelligence in the context of the wider HSE context. Continuing to support research grant applications.	Q4	Pop Health
Health Technology Assessment (HTA)	Development of Health Technology Assessment framework in consultation with HIQA commenced.	Completion of Health Technology Assessment framework with HIQA.	Q3	Pop Health
		Completion of actions for 2008 identified as agreed together with HIQA.	Q4	
		Progress the work of Drug Utilisation Group.	Q2	
HSE Information Governance Framework *(TP 1.9)*	Steering Group formed. Clarification of scope and urgent tasks concluded. Liaison link with DoHC established.	Trans-agency liaison on policy issues (with HIQA, DoHC and Data Protection Commissioner) and internal practice review improvement planned and progressed.	Q2	Pop Health
Implement National Client Index *(TP 1.10)*	Steering Group formed. High level scope and plan agreed. Business case and costed project plan commissioned.	Trans-agency liaison on policy issues (with HIQA, DoHC and Data Protection Commissioner) and some internal process improvement progressed.	Q4	Pop Health
National Registry of Congenital Anomalies	Preparation work further progressed.	Extension of existing congenital anomaly surveillance coverage to an additional four counties in the northeast of the country.	Q4	Pop Health
CEMACH - (Confidential Enquiry into Maternal and Child Health) *(TP 4.7)*	Project group chaired by the Institute of Obstetricians established. Project plan to link with CEMACH initiated.	Participation by HSE in the CEMACH process and the implementation of recommendations – Preliminary work on processes and protocols completed.	Q4	Pop Health
Implementation of the HSE Quality and Risk Framework	Implementation of the HSE Quality and Risk framework within Population Health to support the work of service planning, delivery and review.	Implementation of Quality and Risk Framework.	Q4	Pop Health
Strategic Health Planning *involves planning for health and not just for health services; adopting a formal needs assessment approach to identify gaps in services; re-orientating the health system from hospital to primary care, particularly in the management of chronic illnesses; promoting equity as a strong value in the health system; and working with other sectors to improve health.*				
Review of donor organ procurement services	The National Audit of Potential Organ Donors commenced at the end of August with 34 of 36 acute hospitals participating.	Final report on audit completed.	Q4	Pop Health
		Work with stakeholders in relation to an external review of transplant services nationally.	Q1-Q4	

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Work in collaboration with NHO and PCCC in relation to monitoring and implementation of the various elements of the Winter Initiative.	Report completed. Influenza immunisation monitored. Media campaign completed.	Work in collaboration with NHO and PCCC in ensuring that all the health and personal social services required to address the particular demands of the winter season are in place and operating optimally.	Q1-Q4	Pop Health
Renal review report	Renal review progressed.	Renal review finalised.	Q4	Pop Health
Chronic Illness *is defined as long term conditions which can be treated but not cured. These illnesses include diabetes, heart failure, chronic obstructive pulmonary illness, dementia, asthma, arthritis and a range of disabling neurological conditions, many of which are preventable. The nature of illness in western society has changed; chronic illness is now the greatest cause of ill health for the population and hence is the greatest cause of health service usage.*				
Framework for Prevention and Management of Chronic Illness: *The purpose of the framework is to identify the way forward so as to prevent chronic illness where possible and to detect, minimise and manage the impact of chronic illness on individuals and the population. (TP4.1)*	Preparatory work on developing the framework completed.	Further developments in relation to the Chronic Illness Framework progressed.	Q4	Pop Health
Chronic Illness Patient Support Programme ***Implement a pilot project for chronic illness patient support.*** *(TP 4.2.1)*	Successful procurement of an international expert company to provide the chronic illness patient support programme in the pilot areas. Successful procurement of a prestigious University to carry out the external evaluation of the programme. Engagement of stakeholders and staff associations in both pilot areas. Commencement of service provider contract and implementation of programme delayed due to further staff association consultation.	Conclusion of service contract negotiation with service providers and external evaluator.	Q1	Pop Health
Implementation of the national framework for diabetes. *(TP 1.2 and 4.2.2)*	Initial scoping document prepared in relation to recommendations on the information needs of a national diabetic service.	Establish the governance arrangements and quality assurance standards required for the national programme.	Q4	Office of the CEO / Pop Health / PCCC / NHO
Develop the management of Chronic Obstructive Airways Disease (COPD) *(TP 4.2.3)*	A National Strategy Group was convened and as part of the Transformation Programme development of a strategy commenced.	Complete Strategy for the management of COPD.	Q4	PCCC / Pop Health

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Health Promotion: *Health promotion provides individuals and communities with opportunities to achieve and maintain good health. It also means addressing factors and conditions that have an influence on health that are generally outside the control of the individual. These include environmental, economic and social conditions. An important element of this work is the creation of relationships with other sectors. Health promotion also involves re-orientation of health services from a curative focus towards preventing ill health and promotion of positive health. A community development approach is an essential element in ensuring that communities are empowered to improve their health collectively.*				
Provision of Schools Training	*Projected Outturn 07:* *Primary 1,120 hrs* *Post Primary 186 hrs* *SPHE 2,220 hrs*	*Performance Target:* *Primary 1,400 hrs* *Post Primary 200 hrs* *SPHE 2,200 hrs*	Q3	Pop Health
Provision of Training to Health Care Workers, Management / Administration	*Health Promotion 2,768 hrs* *Accredited HP 2,465 hrs* *Number of persons trained:* *Medical / Dental 396* *Nursing 1,796* *Allied Health Professionals 760* *Management / Admin 327* *Support Staff 704* *GPs 50* *Practice Nurses 111* *Pharmacists 40* *Others 512*	*Health Promotion 4,350 hrs* *Accredited HP 2,000 hrs* *Number of persons trained:* *Medical / Dental 100* *Nursing 2,400* *Allied Health Professionals 800* *Management / Administration 400* *Support Staff 1,000* *GPs 10* *Practice Nurses 100* *Pharmacists 85* *Others 300*	Q3	Pop Health
Provision of training to other sectors	*Statutory bodies 676* *Private Sector 89* *Community / Voluntary 2,364* *Other 431*	*Statutory bodies 900* *Private Sector 450* *Community / Voluntary 3,500* *Other 1,100*	Q3	Pop Health
Participation in Health Promoting Hospital Network	*a) Members of the Promoting Hospitals Network. No and %: 41 (69%)* *b) With a written Health Promotion policy No and %: 59 (100%)* *c) Engaged in Health Promotion Initiatives No and % 41 (69%)*	*a) Members of the Promoting Hospitals Network. No and %: 41 (69%)* *b) With a written Health Promotion policy No and %: 59 (100%)* *c) Engaged in Health Promotion Initiatives No and % 41 (69%)*	Q3	Pop Health
Provision of support to Workplaces	*HSE Worksites 163* *Non HSE worksites* *Small 22* *Medium 21* *Large 16*	*HSE Worksites 150* *Non HSE worksites* *Small 55* *Medium 10* *Large 30*	Q3	Pop Health

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Development of community based Health Promotion Partnerships	*Based on community development approach* 302 *Organised by HP services* 89 *Clinical Dietetics* - *Smoking Cessation* - *Health Promotion / Public Campaigns* 6	*Based on community development approach* 300 *Organised by HP services* 150 *Clinical Dietetics* - *Smoking Cessation* - *Health Promotion / Public Campaigns* 6	Q3	Pop Health
Health Promotion Strategy and Policy				
Development of strategic health promotion policy in partnership with DoHC	'Towards 2016' commitment. Initial discussions held with DoHC.	Scope strategy and agree with DOHC, who have proposed the establishment of an Inter-departmental forum which will support the development of the Health Promotion Policy.	Q4	Pop Health
Development of Population Health Strategy *(TP 4.8)*	Population health vision developed based on consultation held with 250 staff. Scoping for strategy commenced.	Framework for Population Health Strategy completed. Consultation commenced with key stakeholders. Strategic priorities identified.	Q3	Pop Health
Development of a National Sexual Health Strategy and Action Plan *(TP 4.8)*	Audit of services commenced. Consultation meetings held with DoHC.	Consultation held with key stakeholders. Outline strategy developed.	Q4	
Social Marketing				
Health Promotion Campaigns	Campaigns on Flu Vaccines, Sexual Health, Breastfeeding and Tobacco delivered. Social marketing framework completed.	Campaigns on Flu Vaccines, Alcohol, Obesity, Tobacco, Breastfeeding and Sexual Health delivered.	Q4	Pop Health
National Health Promotion Programmes	Progressed nNational programmes including Social Personal and Health Education (SPHE), National Youth Health Programme, Health Promoting Hospitals (HPH) and Healthy Food Made Easy.	Key priorities identified and progressed. In conjunction with the Dept of Education and Science and DOHC, the delivery of SPHE further developed.	Q4	Pop Health
Health Promotion Research and Development				
Support the roll out of SLÁN *(Survey of Lifestyle, Attitudes and Nutrition), HBSC (The Health Behaviour in School-Aged Children) and ESPAD (The European School Survey Project on Alcohol and Drugs) surveys which are commissioned by the DoHC*.	Lifestyle trends monitored.	Lifestyle trends continue to be monitored. Research disseminated to key stakeholders.	Q2	Pop Health

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Health behaviours and risk factors				
Alcohol	Further implementation of the recommendations of the Task Force Reports on Alcohol continued. Research study on consumption trends completed. Alcohol Campaign deferred.	Further research and education initiatives developed on alcohol in pregnancy. HIA project on off-sales commenced. Continue joint working with DoHC on advertising, off sales, etc.	Q4	Pop Health
Obesity	Action plan on obesity developed and work progressed work on research, health promotion nutrition / physical activity. Development of a National Database to monitor prevalence trends of growth, overweight and obesity commenced (TP 4.7) Campaign deferred.	North / South conference held. Research progressed in key areas. Health promotion programmes undertaken in key settings. Framework for database developed. Campaign delivered.	Q2 Q4 Q3	Pop Health
Physical Activity	Training in GP Exercise Referral commenced. Development of physical activity guidelines commenced.	Roll out of national training programme on GP Exercise Referral with ICGP. Guidelines progressed with external partners	Q4	
Nutrition	Contributed to development of National Food Dietary Guidelines. Facilitated sub committee of National Folic Acid Implementation Committee and social marketing plan developed.	Contributed to development of guidelines. Contribute to the roll out of the National Folic Acid Policy.	Q4	
Tobacco	Development of a National Tobacco Framework progressed. Project Group established. National campaign delivered.	Action plan completed and framework in implementation phase.	Q2	Pop Health
Breastfeeding	National committee established. Campaign on supports delivered.	Area committees established and key actions of Strategic Action Plan delivered in partnership with statutory and voluntary organisations. Key research undertaken. National campaign facilitated.	Q4	Pop Health

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Health Promotion Settings and Population Groups	Further developed Health Promotion in key settings such as workplaces, schools, communities, prisons and among priority population groups.	Key priorities implemented across all areas.	Q4	Pop Health
Service Reform	Progressed Change Management Programmes. First phase of structures agreed at joint working group.	New structures in place.	Q4	Pop Health
		Projects underway in priority areas such as development of key competencies and skills in health promotion.		
		Communication strategy developed for health promotion.		
Working with the Voluntary Sector	Governance arrangements developed to manage funding and service level agreements.	Effective governance processes in place for management and funding of voluntary agencies in line with current national work.	Q3	Pop Health
Health Inequalities	National Steering group established. Proposal agreed.	Literature review on best practice in health inequalities completed.	Q2	Pop Health
		Draft HSE Framework developed.		

MEASURING PERFORMANCE IN HEALTH PROMOTION

Measurement	Projected Outturn 2007	Target 2008
Training *(See Section 10 for detailed breakdown on all HP measures)*		
Schools Training	3,506 hours	3,800 hours
Provision of Training to Health Care Workers, Management / Administration on Health Promotion and Accredited HP	5,233 hours	6,350 hours
No. of persons trained	4,696	5,195
Provision of training to other sectors	3,560	5,950
Participation in Health Promoting Hospital Network	41 (69%)	41 (69%)
Provision of support to Workplaces	236	245
Development of community based Health Promotion Partnerships	397	456

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
***Health Protection** plays a critical role in protecting people from infectious diseases and in preventing harm when environmental hazards are involved. The prevention and control of healthcare-associated infection (HCAI) is a priority issue for the HSE both in terms of the health and safety of patients and staff, and the resources consumed by potentially avoidable infections. Implementation of appropriate governance structures and enhanced surveillance systems will reduce the incidence of HCAI.*				
***Undertake surveillance on infectious diseases** in accordance with the infectious disease legislation (TP 4.10)*	Guidelines for optimum surveillance of each notifiable disease prepared. Outbreaks of infectious disease detected and managed. Guidelines for the management of infectious disease cases and outbreaks implemented. Management of the control of selected infectious diseases audited. Coordination of 'Report on the Prevention of the Transmission of Blood Borne Viruses' implemented. Roll out of CIDR continued. Outbreak / cluster surveillance continued.	Outbreaks of infectious disease detected and managed.	Q4	Pop Health
		Implement guidelines for the management of infectious disease cases and outbreaks.	Q4	
		Outbreak / cluster surveillance.	Q1-Q4	
		Implementation of recommendations of Report on the prevention of the transmission of Blood Borne Viruses.	Q1-Q4	
		Review and implement public health TB Controls.	Q4	
		Surveillance of new vaccine preventable diseases. Invasive pneumoccoccal disease and Hep B (especially children born to positive mothers).	Q4	
		Implementation of STD surveillance report.	Q1-Q4	
		Roll out of CIDR in West.	Q4	
		TB implementation on CIDR in all areas.	Q4	
Immunisation ***Flu vaccine campaign:** The WHO recommends vaccination coverage of all people at high risk – "at least 50% of elderly people by 2006 and 75% by 2010".*	Expansion of the flu vaccination campaign to include all those over 60 years of age did not commence in 2007. The focus will now be placed on strategies to increase the uptake rates for the over 65s.	Increased update rate for over 65 years achieved.	Q4	Pop Health
***Primary Childhood Immunisation Programme** (PCIP)*	Work in relation to ensuring 95% uptake of essential childhood vaccines continued.	Completion of plan to introduce Pneumococcal conjugate vaccine into PCIP.	Q4	Pop Health
		Completion of plan to introduce Hepatitis B vaccine into PCIP.	Q4	
		Completion of plan to eliminate Measles, Mumps and Rubella.	Q4	
Immunisation Education	Training Immunisation manual drafted. Health Protection Surveillance Centre (HPSC) involved in ongoing work disseminating information, lectures and participation in the national immunisation implementation group.	Roll-out of immunisation staff training programmes.	Q4	Pop Health

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Cold chain delivery	New contract of Cold Chain delivery service implemented.	Maintain National Cold Chain Vaccine Delivery service.	Q1-Q4	Pop Health
Develop a national environment / public health strategy	Establishment of a national Environment and Public Health Unit/Centre explored and action plan developed. Surveillance and management of environmental hazards developed	Develop National Unit or interim focus / centre to strengthen networking / sharing of information and resources.	Q4	Pop Health
		Surveillance and management of environmental hazards.	Q1-Q4	
		Define role regarding implementation of new Drinking Water Regulations and standardise existing practices.	Q4	
		Clarify and define working relationships with other disciplines and agencies, for example, Environmental Health Officers.	Q1-Q4	
Targeted campaigns at specific Health Care Associated Infection (HCAI) *(TP 4.10)*	Surveillance of HCAI continued. Data now available from hospitals on 4 key areas. Governance structures established through Local Implementation Teams (LITs). 5 Year Infection Control Action Plan put in place. Public education programme on Hand Hygiene completed. e-learning centre progressed.	Surveillance of HCAIs.	Q1-Q4	Pop Health
		Implement key elements of Action Plan.	Q4	
		Provide education and training for all health care workers.	Q3	
		Set up MRSA helpline for public.	Q2	
		Identify additional Infection Control Staff.	Q4	
Suicide Prevention: *2008 will see the continued implementation of 'Reach Out' the Government's National Strategy for suicide prevention. The National Office for Suicide Prevention (NOSP,) responsible for the implementation of the strategy, will continue to engage in partnership with both statutory and non statutory organisations to ensure that the 96 actions are implemented and evaluated.*				
Implementation of 2007 research project recommendations. *The NOSP will continue to engage with research projects that are in line with the objectives of the Suicide Prevention Research Strategy.*	Research projects progressed.	The NOSP will continue to engage with research projects that are in line with the objectives of the Suicide Prevention Research Strategy (Reach Out, Action 26.1)	Q1	Pop Health
Mental Health Awareness Campaigns	Mental Health Awareness Campaigns to promote positive mental health through various media outlets progressed and developed.	Implementation of the Mental Health Awareness campaign / Social Marketing (launched in October 2007) continued.	Q4	Pop Health
		Targeted campaigns developed, for example young men.		
Development of Deliberate Self Harm (DSH) Liaison Nurses *through partnership with Hospital Networks and PCCC.*	Deliberate Self Harm (DSH) Liaison Nurses through partnership with Hospital Networks and PCCC supported.	Continue to improve the availability of nurses fully trained to deal with the needs of patients presenting with DSH.	Q2	Pop Health / NHO / PCCC

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Implement outstanding actions from Phase 1 of Reach Out. *Phase I has 30 Actions of which 7 require significant action.*	Implementation of outstanding actions from Phase 1 of Reach Out progressed.	Remaining deliverables from Phase 1 of Reach Out implemented. • Media training of volunteers. • Bereavement support. • Primary care referrals for self harm. • Suicide amongst older people. • Information / data links.	Q4	Pop Health
Continued Support of Voluntary and Community initiatives *which will facilitate implementation of agreed actions in the Reach Out strategy thus providing a stable base for these organisations to operate and manage existing levels of service.*	Support for voluntary organisations providing suicide prevention and bereavement support services continued.	Network of voluntary organisations providing suicide prevention and bereavement support services sustained and developed.	Q4	Pop Health
Provision of Regional Resource Officers *Resource Officers provide training and support in their area for individuals and organisations.*	Local initiatives as identified by Resource Officers supported	Local initiatives responding to local needs as identified by Resource Officers supported.	Q4	Pop Health
Implementation of national training programme on suicide prevention	National training programmes progressed.	National database relating to training packages, qualifications, courses, units of competency and registered training organisations developed, including: • Community education. • Work with religious groups. • Training for primary care / hospital staff. • Work with Gardaí. • Work with Coroner service – develop pilot scheme.	Q4	Pop Health
Environmental Health: *The environmental health service protects, enhances and promotes the environmental health needs of the population. Environmental health refers to the theory and practice of assessing, correcting and preventing factors in the environment that can potentially adversely affect the public health of the present population and future generations. The environmental health concept and approach integrates controls on all these factors in the environment that threaten public health, many of which are subject to control by statutory agencies. The fostering of relationships between the statutory and voluntary agencies and communities is an integral part of this process.*				
Implementation of the Environmental Health Service Review	Implementation of the EH Service Review Report commenced.	Structures established to ensure a smooth transition from PCCC to Population Health and ensure continuity of service delivery.	Q1	Pop Health
		Implementation of the recommendations outlined in the report commenced, in conjunction with the various stakeholders.	Q1	

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Develop a National Environmental and Health Action Plan	NEHAP strategy in conjunction with the DoHC launched Implementation plan for HSE agreed.	Local Environment and Health Action Plans (LEHAPs) developed based on all inclusive local partnership arrangements and plans piloted.	Q3	Pop Health / DoHC
Co-ordination of activities within the HSE in relation to public water supplies in the context of the Drinking Water Directive (SI 106 and 278 of 2007)	Engagement with the Environmental Protection Agency (EPA) to agree requirements and measures in relation to the new directive progressed.	Protocols developed with Local Authorities and EPA in relation to risk management.	Q2	Pop Health
		Procedures agreed pertaining to contaminated supplies.	Q3	
Co-ordination of activities in relation to fluoridation of water supplies within the HSE (S.I. 42 of 2007)	Monitoring of schemes to ensure compliance with the regulations continued. (See Section 10 for measures in relation to water fluoridation)	Compliance with new legislation.	Q1-Q4	Pop Health
		National Steering Group to support and advise the Local Monitoring Committees established.	Q1-Q4	
		National audit of treatment plants progressed.	Q3	
		5 year capital development plan prepared.	Q3	
		Procurement arrangements for the supply and independent testing of Hydrofluosilicic Acid (HFSA) completed.	Q1	
Develop an integrated national strategy to prevent falls in older people *(TP 4.2.6)*		Scope out the extent of the environmental hazards that give rise to falls in older people.	Q2	Pop Health / Local Authorities
		Agree a programme to implement an action plan.	Q4	
Health Impact Assessment *(TP 4.6)*	Framework document prepared.	Health impact assessment designed to integrate health in public policy and public formation.		Pop Health / other relevant agencies
		Intersectoral collaboration developed.		
		Review and evaluate the impact on public policy and publications.	Q2	
		Identify pilot projects and sites.	Q3	
Food Safety / Control	Current service contract (2006 – 2008) with Food Safety Authority of Ireland reviewed	Current contract implemented and proposal for new service contract with the FSAI finalised.	Q1-Q4	Pop Health / PCCC

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
	and implemented. *Projected Outturn 07: 47,142 inspections of food premises carried out*	Develop the capacity to meet the additional legal obligations arising under the EU Hygiene Package including the obligations of a competent authority under EC Regulation 882 of 2004: • Internal Audit / Quality Management System • ICT • Training	Q2	
		National Food Business Register (EU Regulation 852) established.	Q1	
		Import controls, surveillance and sampling programmes, on foods of non-animal origin developed and implemented.	Q2	
		Port Health infectious disease controls required by the International Health Regulations 2005 developed and implemented. *Performance Target: 45,000 Inspections to be carried out.*	Q1	
Tobacco Control	Memorandum of Understanding with Office of Tobacco Control (OTC) agreed. HSE / OTC business plan agreed.	HSE / OTC business plan 2008 implemented.	Q1-Q4	Pop Health / PCCC
		Capacity to implement additional legal provisions on point of sale secured.		
	Projected Outturn 07: 30,012 inspections carried out (2006 figure)	*Performance Target: 32,012 inspections to be carried out*	Q2	
	Database for HSE established.	National Tobacco Control Database rolled-out.		
Control of Cosmetic Products	Study on baseline levels published	In co-operation with the DoHC and the Irish Medicines Board (IMB), develop and implement a National programme for the effective implementation of the Cosmetic Products Legislation.	Q3	Pop Health
Improvements in Radiation Exposures and Dose levels for Population (SI478)	HSE Task Force on SI478 final report produced. Report on baseline audit completed.	Commence and implement recommendations of HSE Task Force on SI478.	Q1	Pop Health / Quality and Risk
		First annual report of Medical Exposure Radiation Committee (MERC) prepared.	Q4	

Population Health Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
		Baseline audit complete.		
Improvements in Road Safety for the Population	Action Plan from Road Safety Steering Group prepared. National Road Safety Strategy produced.	Management approval for action plan sought.	Q1	Pop Health / PCCC / NHO / HR
		Implementation of plan agreed.	Q2	
		Implementation of action plan commenced.	Q3	
Networking with key stakeholders outside of the HSE	Necessary arrangements to ensure links with relevant agencies implemented.	Memorandum of Understanding and Service Level Agreement with HIQA, Health and Safety Authority (HAS), Environmental Protection Agency (EPA), Office of Tobacco Control (OTC), Radiological Protection Institute of Ireland (RPII) agreed.	Q1-Q4	Pop Health

MEASURING PERFORMANCE IN ENVIRONMENTAL HEALTH

Measurement	Projected Outturn 2007	Target 2008
Tobacco		
No. of inspections to ensure compliance with Public Health Tobacco Act	32,012	32,012
Food Inspections		
No. of inspections of food premises	47,142	45,000

ACUTE HOSPITAL AND PRE-HOSPITAL EMERGENCY CARE

The National Hospitals Office Directorate plans, manages and delivers acute services in fifty-two hospitals. These are grouped into eight hospital networks.

2007 continued to be a challenging year for acute hospitals services. The ongoing demographic changes (population growth, rising birth rate, diversity in the population base and an increase in the elderly population) and the acknowledged relative underdevelopment of pre and post hospital services, continued to place significant demands on acute hospital services nationally.

This was borne out by the findings of the Acute Hospital Bed Utilisation Review published in May 2007. Key findings included:

- 65% of acute hospital patients were 65 or older, a high proportion (71%) presented with co-morbidity.
- At national level, 13% of patients admitted to hospital could potentially have been treated outside an acute setting.
- On the day of care, 39% of patients surveyed could potentially have been treated in an alternative setting if appropriate alternatives were available.

This historical overdependence on the acute sector is reflected in increased activity levels, with hospitals reporting an overall trend of increasing levels of emergency admissions impacting on scheduled elective workload. The issues are being addressed by the HSE both strategically and operationally and this will continue in 2008 under the Transformation Programme and the Winter Initiative. The Transformation Programme will encourage and support the move to enhanced primary care delivery and the development of models of chronic illness prevention and care, enabling acute hospitals to focus on acute care.

The acute services deliverables for 2008 are derived from the TP objectives. The work underway now and in 2008 in the NHO in stabilising acute service activity against a backdrop of population growth and ageing is in line with the transformation of the system to provide care in the community where possible and reduce the over-dependence on the acute sector. Key priorities for NHO under Transformation are a targeted programme focusing on improving hospital performance and reconfiguration of hospital services to deliver optimal and cost-effective results, in line with best national and international practice.

The NHO is committed to developing services in line with international best practice, to provide the full range of secondary, tertiary and quaternary services and national specialties that fit appropriately into the integrated care model and are evidence-based, efficiently run and quality-assured. Decisions regarding the operation and configuration of services are supported by evidence and objective service reviews. The service reviews committed to by the NHO are an essential component of planning for a future model of service based on evidence. The reviews incorporate benchmarking against international best practice in relation to organisation of hospital services and workforce within a range of health system models, in terms of clinical practice, emerging clinical trends and emerging technology.

The reconfiguration will be reflected in a redeveloped hospital governance / management construct and in specific service transformation projects in areas such as cancer, paediatrics, maternity services and emergency departments. The Transformation Programme will encourage and support the move to enhanced primary care delivery and the development of models of chronic illness prevention and care. The NHO is also committed to ensuring continuation of acute services to the population over the period of implementation of the wider Transformation Programme.

The use of shared services and common processes, the embedding of ICT, the development of extensive planning and control programmes, and substantial improvements in estates management will support improvements in service efficiency, effectiveness and quality in acute hospital services.

2008 Activity Targets

Acute Hospital services activity levels are but one of the measures of performance for the acute sector. Levels of activity are an indication of hospital throughput, but in themselves do not tell much about the efficiency or effectiveness of the hospital system. These volume measures have to be considered in conjunction with the other measures and indicators for our hospital system detailed in Section 10 – Monitoring and Measuring Our Performance.

In reconfiguring the health system, the HSE can deliver better service, better outcomes and better value by shifting the delivery of services to day cases and community based services. It is, therefore, logical and desirable that over time the activity also shifts in this direction.

The activity targets for 2008 are set within this strategic context of the gradual transformation of the system to improve performance and reduce historic overdependence on the acute sector. Consequently, inpatient activity levels are expected to be less than actual 2007 levels as efficiency in bed use improves further and more services are provided for patients without requiring access to an inpatient bed.

In providing an appropriate response for patients, the NHO has a concerted and targeted programme focusing on improving our hospital performance in line with best national and international practice. Effective bed utilisation, discharge planning, reducing length of stay and increasing use of day surgery are key enablers to providing an appropriate service response to demand, supported by hospital specific action plans and robust health intelligence / information.

The volume / type of services set out here can be delivered within resources available. As there are a number of key service areas where there is limited capacity to control activity levels in 2008, the activity targets for some specific activity areas are higher than 2007 targets.

The best use of resources and strict control of activity profile will be achieved through the application of a strong performance management approach focussing on:

- The application of different incentive systems to reward positive hospital performance. This will be done in conjunction with hospital specific performance targets.
- Strict monitoring of activity levels through the HSE control process.
- The development of service and process improvement programmes across hospitals.
- The further application of casemix in performance monitoring.
- The development of performance frameworks for other hospital categories (e.g. maternity and paediatric services).
- Better integration of hospital and community services.
- Rebalancing care towards the community.

Inpatient and Day Case Activity

Inpatient admissions in the public acute system are predominantly determined by emergency admissions (>65% nationally) and there is limited scope in a one year period to reduce emergency admission levels. However, in managing overall volume of inpatient activity in 2008, focus will be on managing elective workloads, encouraging provision of care on a day case basis where appropriate and on performance improvements, such as day of surgery admission and minimising length of stay.

National Total	Target 2007	Projected Outturn 2007	Target 2008
Inpatient Discharges	597,135	609,646	597,135
Day Case Attendances	564,819	574,229	586,740
Total	1,161,954	1,183,875	1,183,875

In this context, the thrust of our plans for next year will be to move inpatient activity downwards while moving day case activity upwards in relative terms as efficiency in bed use improves further and more services are provided for patients without requiring access to an inpatient bed.

Our objective for 2008 is to further move from inpatient to day case activity where that is appropriate, thus increasing the ratio of day case:inpatient by 10% by the end of 2008 for those specific procedures where patients should be treated on a day case basis. In managing overall activity levels within financial resource, the further volume shift to day case activity will be in the non high cost areas. This change in practice will be reflected in our performance reporting in this area in 2008.

Emergency Presentations

While there is very limited capacity for NHO to control numbers presenting at Emergency Departments (EDs) real growth here is not expected in 2008. The stabilisation of Emergency presentations is expected as a number of viable alternatives are developed to deal with cases that could be treated in alternative settings, so reducing the dependency on use of EDs as service access points. Our commitment for 2008 is that no patient will wait in an ED for more than 12 hours following the decision to admit. The need to cope with demand within existing capacity presents a challenge in simultaneously improving patient experience and waiting times and this will be managed closely throughout 2008.

National Totals	Target 2007	Projected Outturn 2007	Target 2008
Emergency Presentations	1,131,054	1,168,412	1,168,412
Emergency Admissions	358,770	369,368	369,368

The emergency admission rates are linked to numbers presenting at ED. The bed utilisation review pointed up the number of admissions that could be potentially avoided when a number of appropriate services are developed in alternative settings. In the interim, the 2008 focus will be on minimising avoidable admissions where possible through performance improvements in areas such as access to diagnostics and enhanced senior decision making presence within EDs.

Targets in this NSP are based on Emergency "presentations" rather than ED "attendances" in respect of the 34 hospitals with acute adult ED functions. Emergency presentations more correctly reflect the number of emergency demands placed on a hospital and comprise attendances at Medical Assessment Units and emergencies that present directly to wards (e.g. most usually in cases of paediatric and maternity cases) in addition to attendances at the EDs.

Outpatient Department (OPD) Attendances

An objective for the NHO is to improve access for public patients for OPD consultations. In order to maximise OPD effectiveness in 2008, the focus will be on reducing the number of return OPD visits through increased senior decision making and prompt discharge of patients back to community services where appropriate. This has the potential to improve the new / return attendance ratio and reduce waiting times for appointments, while managing overall attendance levels.

National Totals	Target 2007	Projected Outturn 2007	Target 2008
OPD Attendances	2,770,851	3,076,442	2,770,851

Births

The projected birth-rate for public hospitals in 2008 is derived from CSO projections, plus information available from hospitals on known 2008 booking levels. As detailed in the Health Status Section of this NSP (see page 9), births have increased by 22% over the last ten years, and this rate of increase has greatly accelerated in 2006 and 2007.

National Totals	Target 2007	Projected Outturn 2007	Target 2008
Births	65,068	67,742	72,653

Pre-Hospital Emergency Care

Community Transport is a budgeted service. To date, provision has developed in different ways across the country. To ensure that resources are used appropriately in 2008, policy will be developed that patients will only be provided with transport where there is an identified medical need that prevents or precludes the use of conventional transport.

National Totals	Target 2007	Projected Outturn 2007	Target 2008
Emergency Calls	205,000	206,000	214,000
Urgent Calls	66,000	62,706	63,000
Non Urgent Calls	192,000	211,000	192,000
Community Transport*	234,000	420,000	188,000

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
A National Acute Bed Capacity Review (ABCR) was commissioned**, to identify the acute bed capacity needs to the year 2020 and to identify, at HSE Administrative Area level, the required type and location of acute beds. (TP 3.1)* ***Acute Hospital Inpatient Bed Utilisation Review	Acute Bed Capacity Review completed and presented to the Minister for Health and Children. Review Completed and published.	The findings of both the Acute Bed Capacity and the Bed Utilisation Reviews will form the basis for the development of performance improvements as they apply to practices in acute hospitals i.e.: • Implement formal bed management procedures across all hospitals. • Increase day case rates. • Implement performance improvements over time, such as reducing average length of stay and admission on day of surgery, in a continuous improvement environment.	Q1-Q4	NHO

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
		A performance improvement culture will be driven on the ground via the eight Local Implementation Teams that have worked effectively in addressing the ED waiting time issues as part of the Winter Initiative.		
Acute Hospital Configuration *Joint HSE / Department of Health and Children Group (TP 3.1)*	HSE established a Joint HSE / Department of Health and Children Group to oversee the steps being taken to plan for, and progress, the optimum configuration of acute hospital services. Inaugural meeting was held.	Progress on individual regional reviews tracked Ensure that plans emerging in one area, or for one service, are integrated with each other and are consistent with overall national / government policy and the TP.	Q1-Q4	NHO
Reconfiguration of Mid-West and Southern Hospital Groups	Reviews of the Mid-West and Southern Hospital groups commissioned.	Implementation plan developed to take forward the findings of the reviews.	Q1	NHO
		Responsibilities assigned to relevant people to action specific findings.	Q1	
		Progress priority actions.	Q2-Q4	
Reviews of acute hospital services in greater Dublin area and Midlands		Review of acute hospital services in Greater Dublin Area completed.	Q4	
		Implementation plan developed to take forward the findings of the reviews.	Q4	
		Review of acute hospital services in Midlands completed.	Q4	
		Implementation plan developed to take forward the findings of the reviews.	Q4	
Critical Care Planning *(TP 3.1)*	Tender issued for an external consultancy to undertake a review of future critical care requirements, in line with international best practice.	Review of critical care services undertaken.	Q2	NHO
		Implementation plan developed in line with recommendations forthcoming from this review.	Q3	
		Responsibilities assigned to relevant people to action specific findings.	Q4	
		Progress priority actions.	Q4	
Management of Emergency Patients *(TP 1.1 and 3.4). A key priority is to reduce the numbers waiting in Emergency Departments (ED). Hospitals assessed against 3 goals in relation to ED performance:*	Hospitals were measured against 3 goals in relation to ED performance. Eight Local Implementation Teams (LITs) have been formed around Local Health Offices and Hospital Groups to address the issues that cause problems in ED.	*Performance Target: Waiting time from decision to admit (DTA) to admission <12 hours.*	Q1 – Q4	NHO
		Performance Target: Accommodation in admission lounge <24hrs.	Q1 – Q4	

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
▪ *Reduce the numbers waiting in EDs.* ▪ *Reduce the length of time that patients wait.* ▪ *Improve the overall patient experience.*	*Projected Outturn 07:* • *Average number of patients on trolleys in Emergency Departments (ED) nationally per day was 93.5.* • *Average number of patients waiting in EDs nationally per day, from DTA to admission, was:* • *<6 hrs: 37.1, 6-12hrs: 21.8, 12-24hrs: 27.9, >24hrs: 4.6* (based on census at 14.00 daily).	Measurement of total patient time from attendance to discharge at an ED commenced, dependent on stakeholder agreement on standardised process in EDs.	Q1	
Implementation of 100+ consultant post scheme *to reward hospitals that are maintaining high performing Emergency Departments (TP 3.4)*	This scheme, supported by the DoHC, was introduced last year as a reward for hospitals with EDs operating in line with established performance targets. In August the appointment of an additional 60 consultant posts in hospitals that had EDs which were performing well, was supported. These consultant posts were distributed across 24 hospitals and include posts in Emergency Medicine, Radiology, General Medicine, General Surgery and Geriatric Medicine. In September the announcement was made of progressing Phase 2 of the scheme (with up to 40 further new consultant posts).	Progress applications submitted to Consultant Appointments Unit for the recommended posts, in line with the level of development funding available for this scheme in 2008. Track recruitment process for the approved posts. Monitor hospital performance to ensure outcomes and ED targets are in line with hospital undertakings.	Q1 – Q4	NHO
Transformation of National Paediatric Services *(TP 3.5)* ***Development of the new National Paediatric Hospital***	The Joint HSE / DoHC Transition Group established to take forward the recommendations of 'Children's Health First', progressed the development of a high level framework brief for the new national paediatric hospital and the establishment of the Development Board.	HSE representatives participate on the Development Board. Appropriate structures in place to progress the recommendations in the High Level Framework Brief report that are directly relevant for NHO.	Q1 – Q4	NHO
Establish a single network approach *to all services currently provided in the three children's hospitals*	Agreement was reached on the restructuring of paediatric consultant surgeon posts in Dublin, across the three children's hospitals.	Progress appointment of vacant paediatric surgeon posts. Joint department of paediatric surgery established in Dublin.	Q2	NHO

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Appropriate arrangements for delivery of specialist paediatric services in non paediatric hospitals	**Paediatric Neurosurgery** Established project group to address some immediate issues of concern as well as plan for the development of the service pending the opening of the new paediatric hospital. External expertise tender process undertaken.	Tertiary Paediatric Neurosurgery Review completed. Implementation plan to take forward the findings of the review in place.	Q1	NHO
		Immediate issues of service concern addressed in line with review recommendations.	Q2-Q4	
		Review of ENT services provision for children in Beaumont conducted.	Q3	
		Responsibilities assigned to relevant people to action specific findings.	Q4	
		Progress priority actions.	Q4	
	Paediatric Cochlear Implants. Meeting convened in July to discuss the requirements of the Cochlear Implantation programme in Beaumont and the potential to plan for move of appropriate element of the service to a paediatric setting in 2008.	Development of the paediatric component of the National Cochlear Implant Programme commenced in line with the recommendations of the Paediatric Cochlear Implantation Review 2005 and 'Children's Health First' 2006.	Q1-Q4	
Secondary Paediatrics outside Dublin	Consultation process with relevant stakeholders to address delivery of best practice paediatric surgery outside Dublin initiated. Proposal drafted to undertake review of secondary paediatric services nationally.	Review undertaken of paediatric services outside Dublin.	Q2	NHO
		Implementation plan developed to take forward the findings of the review.	Q3	
		Responsibilities assigned to relevant people to action specific findings.	Q3	
		Progress priority actions.	Q3	
		Implementation of High Level Framework Brief recommendations that are directly relevant to HSE commenced.	Q1 – Q4	
National Paediatric Transport programme	Steering committee established to oversee the planning of the National Paediatric Transport Programme.	National Paediatric Transport Programme operational.	Q3	NHO
Transformation of maternity Services *(TP 3.6)*	Review of maternity services in the greater Dublin area initiated. Short term action plan to address priority areas of concern produced.	Implementation plan developed to take forward the findings of the review on a phased basis.	Q1-Q4	NHO
		Responsibilities assigned to relevant people to action specific findings.	Q1-Q4	

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
	Service development funding allocated to the three Dublin maternity hospitals to address priority recommendations from the Short Term Action Plan.	Progress priority actions.	Q1-Q4	
Development of Governance Arrangements in the Acute Sector *(TP 3.3)*	Review of international best practice relating to hospital governance provisions commissioned.	Proposals for the governance of public hospitals in the Irish health services further developed.	Q1-Q4	NHO
New consultant contract is a core element of the Government's Health Reform Programme. *Our key objective regarding a new consultant contract is to achieve greater equity and increase productivity in a consultant-provided 24 / 7 hospital service.*	Negotiations with the IHCA and IMO continued during 2007. New contractual framework agreed that includes: the introduction of clinical directorates and related systems of clinical leadership; team-working; flexible rostering arrangements over the 24 / 7 period; associated changes to consultant work practices; and a restructuring of the extent to which consultants can engage in private practice.	New contract agreed following outcome of negotiations. Establishment of contract implementation group. Progress implementation of new contract.	Q1-Q4	Office of CEO / NHO / HR / PCCC
Hospital Performance Management *(TP 3.8)*	A number of performance projects were initiated. These were specifically designed to target areas where no previous performance frameworks have been introduced.	Maternity Services Performance Framework in place. Paediatric Services Performance Framework in place.	Q3 Q3	NHO
Process improvement	Scoping projects undertaken to identify possible support service improvement projects that could be undertaken in 2008.	OPD service improvement project within the 2 hospital networks of the Dublin Midlands Area.	Q3	NHO
Conduct a review of radiology services nationally *to determine the most appropriate structure and arrangements for the delivery of radiology services required by the HSE for both acute and community requirements.*	Baseline review of radiology facilities nationally, detailing the WTEs, equipment and associated costs conducted.	Commission an external review of radiology services to determine the optimum configuration of radiology services nationally to provide services across the continuum of care. Responsibilities assigned to relevant people to action specific findings. Progress priority actions.	Q2 Q3-Q4 Q3-Q4	NHO
National Specialist Services: *There are a number of dedicated national specialist services in the acute sector such as Liver Transplant Programme, Cochlear Implant Programme and Heart / Lung Transplant Programme.*	Review meetings held with national specialist service providers to review activity and outcomes and to plan for national specialist service development.	Bi-annual reviews held with the services.	Q2 & Q4	NHO

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Collaboration with UK Transplant *In line with the expansion and development of transplant programmes nationally the HSE now intends to renegotiate the Irish national contract with UK Transplant.*	Meetings held with UKT to clarify the existing relationship and information requirements for all solid organ transplants.	Agreement on a new service level agreement with UKT.	Q2	NHO
Heart Lung Programme Mater Hospital	Revised SLA agreed with Freeman Hospital in Newcastle.	New contract agreed with Freeman Hospital reflecting the development of a national programme at the Mater Hospital.	Q3	NHO
		Formal external review of Mater programme completed.	Q4	
Neurosurgical Services: *Comhairle Report (September 2006) recommended establishment of National Committee for Neurosurgical Services.*		National Neurosurgical Committee established to oversee implementation of Neurosurgical Service developments.	Q2	NHO
Arthritis and related conditions	At request of DoHC, the HSE established a working group on arthritis and related conditions. Development plan for arthritis and related conditions completed.	Alignment of arthritis model of care with HSE chronic illness model of care for existing rheumatology sites (restructuring / integration of acute services with PCCC).	Q1-Q4	NHO / PCCC
Metabolic Disorders	Decision to establish national group to oversee the development of metabolic disorder service for adolescence and adults.	Steering Group to be established to make recommendations on model of care, infrastructural and resource requirements and arrangements for administration of therapies.	Q1-Q4	NHO
PET CT Services	HSE steering committee established to commission PET CT in Cork University Hospital and St. James's Hospital. Capital funding secured and tender awarded for the scanners.	PET CT Services available in St. James's within existing resource level.	Q2	NHO
		PET CT Services available in CUH within existing resource level.	Q4	
Laboratory review *to determine the most appropriate structure and arrangements for the delivery of laboratory medicine services required by the HSE across the full continuum of care including primary, community, secondary, and tertiary care. (TP 1.11)*	National laboratory review commissioned. The review has provided recommendations in the context of current resource constraints, on the timeliness, reliability, capacity and efficiency of current laboratory medicine services provided by or for the HSE, benchmarked against leading international practice and standards.	Implementation plan developed for the recommendations of the Laboratory Report.	Q1	NHO
		Consultation process undertaken to agree the implementation stages. This will be conducted through the Partnership Forum.	Q2	
		Priority will be the development of 'cold laboratories'.	Q1-Q4	

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Co-Location Private Hospitals *to provide additional capacity with the transfer of private activity to those hospitals, thereby freeing up capacity for public patients in public hospitals.*	Under the procurement process seven consortiums were selected to build co-located hospitals adjacent to public hospital sites. Project implementation plans have been agreed with the companies.	Implementation plans continued for the seven hospitals and a co-located hospital award progressed for the remaining public hospital.	Q1-Q4	NHO
		Contractors to achieve planning approval and complete financial due diligence.	Q4	
		Financial close for at least 6 of the co-located hospitals reached.		
Madden Reports on Post Mortems *(TP 3.7)*	Audit of retained organs commenced Commencement of work on the standards with IHSAB / HIQA deferred pending completion of the Audit.	Audit is to be completed with the report sent to the DOHC.	Q2	NHO
		Standards for organ retention and related issues developed in line with the outcome of the Audit. This will be undertaken in conjunction with HIQA.	Q3	
Pre-Hospital Emergency Care				
Estate Strategy	Commenced work on the development of an estates strategy for the ambulance service in conjunction with the national Director of Estates.	Estate strategy completed.	Q2	NHO / Estates
ICT Strategy	A number of ICT projects were commenced within the ambulance service in conjunction with the National Director of ICT.	ICT strategy for the ambulance service developed	Q2	NHO / ICT
Staff Development – Training: *The Ambulance Service must ensure that all staff involved in emergency planning, delivery and monitoring are suitably trained to conduct these functions.*	Major Incident Medical Management System and decontamination interagency exercises (MIMMS) were conducted during the year. MIMMS training was completed for 150 new recruits.	Training strategy will be developed in line with nationally agreed standards.	Q1-Q4	NHO
		MIMMS training for an additional 150 staff will be completed.	Q4	
National Human Resource (HR) structure	Work commenced for the national HR structure for the ambulance service.	National HR structure for the ambulance service further developed to provide consistent support in areas such as change management, selection and recruitment, employee relations, and staff development and training.	Q4	NHO
Appointment of a National Medical Director for Ambulance Services	Proposals developed for the creation of a function of National Medical Director, previously carried out separately and independently within the former regions.	National Ambulance Service Medical Director appointed.	Q1	NHO

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Appointment of a Clinic Performance Manager for Ambulance Services	Proposals developed for the creation of a function of Clinical Audit / Clinical Performance Manager.	Clinical Performance Manager appointed.	Q3	NHO
System for effective clinical audit for Pre-hospital emergency care.	System developed and piloted in two locations: Dublin and the North East.	System rolled out nationally subject to approval of Department of Finance CMOD.	Q1-Q4	NHO
Fast Response Units	The roll out of fast response units commenced in 2006. Seven units were established during 2007.	7 additional fast response units commissioned.	Q2	NHO
Ambulance Fleet management	An in-house project team was appointed to develop a new national fleet management system to improve national coordination and standardisation of fleet management.	National fleet management system introduced.	Q3	NHO
National ambulance fleet upgrade and replacement programme	National ambulance fleet upgrade and replacement programme in line with National and European Standards established and the target set for new fleets have been achieved. 67 new ambulances ordered and delivered.	65 new ambulances purchased through an existing contract.	Q1-Q4	NHO
Major Emergency Management	The National Ambulance Service participated in the national Emergency Management Team. Area major emergency plans were developed in conjunction with Population Health.	Senior manager with responsibility for emergency and management in the ambulance service appointed.	Q2	NHO – Ambulance Services
Patient Transport Service	Tendered for external consultant to conduct a Patient Transportation Needs Analysis.	National policy, qualifying criteria and needs analysis reviewed.	Q2 / Q3	NHO
		Recommendations considered by review group and a framework for the provision of Patient Transport Services prepared on a national basis.	Q3 / Q4	
Service Developments from 2006 / 2007				
Cystic Fibrosis (CF) service *(developments initiated in 2006 and 2007)*	The 58 posts approved in 2006 are in place or at an advanced recruitment stage, with the exception of the Mid-West CF Consultant post and second Consultant post in St Vincent's University Hospital. Approval was given in 2007 for 26 additional medical, nursing and clinical support staff, in line with the recommendations of the CF Working Group.	These developments will be progressed further in 2008.	Q1-Q4	NHO

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
New Unit service developments initiated in 2006 and 2007.	**Southern Hospitals Group** CUH maternity service opened in April 07, with the exception of gynaecology services.	Full year gynaecology and maternity services delivered.	Q1-Q4	NHO
	CUH Day Procedures Unit partially opened in 2007.	CUH Day Procedures Unit opened on a phased basis.		
	New ED completed in Mercy University Hospital (MUH).	Commence the opening of the ED in MUH.		
	Mid-Western Hospitals Group General theatre in Limerick Regional Hospital opening deferred from 07 to 08.	Theatre opened.	Q1-Q4	NHO
	Opening of 3rd delivery suite in Limerick Regional Maternity Hospital was delayed.	3rd delivery suite opened on a phased basis.		
	South Eastern Hospitals Group Kilkenny Stroke Unit partially opened in 2007.	Kilkenny Stroke Unit fully operational.	Q1-Q4	NHO
	North East Hospitals Group Planned ED development in Our Lady of Lourdes Hospital (OLOL) Drogheda delayed.	Our Lady of Lourdes Hospital ED development completed by October.	Q1-Q4	NHO
	Navan TSSD opened in 07.	Navan TSSD will be sustained in 2008.	Q1-Q4	
	Dublin Mid Leinster Hospitals Group Mullingar Phase 1, stage 2B, of capital project completed in 07.	Services to transfer to new Mullingar facility, on an existing service level basis.	Q4	NHO
	Tullamore moved some services into new facility in 07 (OPD, Ambulatory Care Dialysis).	Further services (main wards, ED, theatre) to be transferred to new facility, with existing staff complement.	Q1-Q4	
	Portlaoise new ED opening deferred.	Commence the opening of the new Portlaoise ED within existing levels.	Q1-Q4	
Neurology service developments initiated in 2006 and 2007.	**Neurology / Neurophysiology** CUH / South Infirmary-Victoria University Hospital (SIVUH) Consultant Neurology post deferred in 2007.	**Neurology / Neurophysiology** CUH / SIVUH Consultant Neurology post will be progressed in 2008.	Q1-Q4	NHO
	Recruitment of neurologist posts for Sligo and Limerick progressed.	Neurologists in place in Sligo and Limerick.	Q1	
	Neurophysiology posts approved for Beaumont, Tallaght and St. James's Hospitals.	Commence recruitment of Neurophysiologists in Beaumont, Tallaght and St. James's Hospitals.		

Acute Hospital Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Renal service developments initiated in 2006 and 2007 *The annual growth in incidence and prevalence of Renal Disease continues to present challenges in meeting demand for dialysis treatments*	**Dialysis** Existing contract with a private dialysis provider in South Dublin continued. An EU tender was undertaken to establish a list of suitably qualified providers of haemodialysis, where the need for additional capacity is identified. Additional short term contracts were put in place during 2007, with the private sector in North Dublin (32 patients) and Kilkenny (48 patients). A contract was awarded for a satellite unit in Limerick. In Galway, an interim arrangement was put in place for up to 20 patients from Limerick.	**Dialysis** Continue service provision in public units. There is limited expansion capacity as units are currently running at full capacity nationally. Formalise existing contracts in Dublin and in Kilkenny within the Dialysis tender framework. The Limerick satellite dialysis unit will be operational by the Autumn of 2008. Requirements for additional tenders will be considered in the context of funding available and the expansion capacity in the public system.	Q1-Q4	NHO
Patient Safety	Dublin maternity services commenced. Recruitment of posts required for the implementation of agreed priorities from the Short Term Action Plan.	These essential maternity service posts to be progressed further in 2008.	Q1-Q4	NHO
	Drogheda: an additional 11 midwives in place and locum anaesthetists progressed as part of planned recruitment of an additional 25 staff for maternity service.	North East will continue this development further in 2008.	Q1-Q4	
Tissue and Cells development funding *(TP 3.7)*	Approval given for quality managers to implement and oversee the quality process. There was a delay in the full implementation of the developments, arising from the need to ensure financial breakeven.	Progress compliance with EU Directive.	Q1-Q4	NHO
Sexual Assault Treatment Unit (SATU) Funding	Locum Consultant Obstetrician / Gynaecologist commenced in Rotunda service. A review of existing units was undertaken. Requirements for new units to be established were identified.	Facilitate release of 8 nurses for forensic training. Progress recruitment of permanent Consultant post. Progress establishment of 2 new units (Midlands and West).	Q1-Q4	NHO

MEASURING PERFORMANCE IN ACUTE HOSPITAL AND PRE-HOSPITAL EMERGENCY CARE

Measurement	Projected Outturn 2007	Target 2008
Length of Stay *(see additional measures in Section 10)*		
Average length of stay for specific DRGs	See Section 10 for detailed information	5% reduction in mean length of stay
Day Case *(see additional measures in Section 10)*		
% of patients treated as day cases for specific procedures	See Section 10 for detailed information	10% increase in overall inpatient / day case activity ratio for specific procedures
Discharge and Procedure Rates for specific DRGs *(see additional measures in Section 10)*	See Section 10 for detailed information	Identify best outcome internationally and monitor progress in trend toward same
Public Inpatient and Day Case Waiting List	See Section 10 for detailed information	No adult waiting over 6 months No child waiting over 3 months
Emergency Department Waiting Times *(see additional measures in Section 10)*		
Average no. patients on trolleys following decision to admit	93.5 per day	No one waiting more than 12 hours from decision to admit
Public / private mix	75:25 ratio	80:20 ratio
Emergency / elective split	65:35 ratio	65:35 ratio
Activity		
No. of inpatient discharges	609,646	597,135
No. of day case attendances	574,229	586,740
No. of Emergency presentations	1,168,412	1,168,412 (expected activity)
No. of Emergency admissions	369,368	369,368 (expected activity)
No. of outpatient attendances	3,076,442	2,770,851
No. of births	67,742	72,653
Day of Surgery (Winter Initiative)		
Overall rate of patients being admitted on their day of surgery	-	To begin reporting in 08
Appropriate Use of Beds (Winter Initiative)		
% of admissions and inpatients on day of care by hospital	-	To begin reporting in 08
Ambulance response times		
No. of emergency calls	206,000	214,000
No. of urgent calls	62,706	63,000
No. of non urgent calls	211,000	192,000
Community transport	420,000	188,000

CANCER CONTROL PROGRAMME

The next two years will see the transition phase of the National Cancer Control Programme, which has full Government Approval. This is an ambitious programme that is a cross cutting platform that transcends all the directorates of the existing HSE structure. It is the fist national programmatic approach focused on a single disease process within the Irish Health System. As such it is at the leading edge of the health reform process and embodies all of the stated Transformation priorities of our Transformation Programme.

After diseases of the vascular system, cancer is one of the leading causes of death in Ireland, currently accounting for 7,500 deaths and approximately 22,000 new cancer cases each year. In 2006 the National Cancer Registry (NCR) predicted that by 2020 cancer incidence will increase to 42,000-43,000 per year in Ireland. In 2005 there were almost 88,000 hospital discharges and over 56,000 day cases with a principal diagnosis of cancer (Public Health Information System V8 (PHISV8)).

Cancer incidence in those under 65 years in Ireland is lower than the rest of Europe, but for those over 65 years it is greater than in the rest of Europe.

Life style changes, together with increases in, and the ageing of, population mean that cancer incidence is still continuing to rise. The World Health Organisation (WHO) estimates that by 2020 the number of new cases of cancer will rise to 20 million each year. Despite this, mortality from certain cancers is declining. Early detection and improved treatment are beginning to have a demonstrable effect on cancer survival. In Ireland, between 1995-1997 and 1998-2000, overall relative survival from cancer (excluding non-melanoma skin cancer) increased from 48% to 50% for women and 38% to 44% for men (NCR).

It is difficult to estimate the effect of the different treatment modalities on cancer outcome. Previous estimates have suggested that 49% of those cancer patients that are cured, are cured by surgery in high volume surgical institutions, 40% by radiation therapy alone or combined with other modalities and 11% by chemotherapy alone or combined with other modalities. Radiation therapy and chemotherapy are also effective options for palliation and symptom control in many cases of advanced or recurrent cancer.

The Cancer Control Strategy for Ireland of 2006 indicated, with data from the NCR, that outcomes for cancer patients were generally lower in Ireland than the rest of Europe, and suggested that these rates were due to a number of factors including; limited screening services, low volume surgery and limited access to radiation therapy treatments. This document recommended a National Cancer Control Programme with 4 Cancer Control Networks, each with 2 Cancer Centres, delivering high volume specialised oncology surgery, with equitable access to all other cancer modalities based on population needs. See Section 10 for detailed measures and indicators for cancer services.

Cancer Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
National Cancer Control Programme (NCCP) *(TP 3.9)*	Organisational Design – Ministerial decision made in 2007 to progress cancer to a Programmatic Structure within the HSE, and a key appointment of Programme Director was announced in September 2007.	Establishment of the Cancer Control Programme with transfer of all budgetary funding, WTE and other resources under the direct control of the Cancer Programme Director.	Q2	HSE / Cancer Programme Director
Key appointments into the NCCP *(e.g. National head of systemic therapy, radiation oncology, oncology surgery).*	As part of the Programmatic Structure, key appointments of national heads of subsections of cancer services were agreed.	Appointments of head of systemic therapy, radiation oncology and oncology surgery as 0.5 WTE appointments.	Q1	HSE / Cancer Programme Director
		Consideration of other leadership roles.	Q4	
Establishment of 4 cancer control networks, with 2 cancers centres per network: *Based on recommendations of the 2006 Cancer Control Strategy the NCCP Advisory group established the evidence to support 8 cancer centres, 2 per network, with some cancer surgeries being delivered in less than the 8 centres.*	Ministerial and HSE announcement in September '07 supported these findings and named the 8 Cancer Centre Hospitals.	With a target of 90% of surgeries transferred to the 8 centres by the end of 2009, the programme will endeavour to transfer assets into each centre, work with each network to relocate other services and establish a plan for any capital, infrastructural or service expansion required to support this realignment of cancer surgeries.	Q1-Q4 with a target of 90% transfer by end 2009	HSE / Cancer Programme Director

Cancer Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Symptomatic Breast Disease services: *This is an essential element of the quality agenda set out in the National Cancer Control Strategy. The aim is to provide equal opportunities for women, to be managed in a centre capable of delivering the best possible outcome. Volume and Outcome is the most important determinate of survival for people who develop breast cancer. Centres will be developed within the QA standards aimed at a managed population, minimum case load of 150 per year, and have at least two each nominated breast surgeons, radiologists and histopathologists.*	The Minister for Health and Children approved National Quality Assurance standards for Symptomatic Breast Disease under the Health Act 2007.	Hospitals carrying out less that 20 new breast surgeries per year (ceased in September 2007) to continue.	Q1-Q4	HSE / Cancer Programme Director
		Ceasing and transferring services rolled out for those hospitals providing less that 50 new breast surgeries per year.	Q2	
		Full transfer of breast surgery services into the 8 designated cancer centres.	Target end of 2009.	
National Standards: *The existence of the NCCP provides a mechanism to implement national standards and to report on compliance with these standards. A range of international standards exist that link compliance with standards to improve cancer outcomes.*		Development and implementation of national standards for access to, and quality of, diagnostic and treatment services for cancer patients, and implementation of a process to report on a compliance of these standards.	Q4	Cancer Programme Director / NCCP / HIQA
National Plan For Radiation Oncology (NPRO) To 2010 *Well established plan from 2005 for 4 main radiation oncology developments within a National Structure, with 2 smaller linked centres to be delivered by a combination of capital development and Public Private Partnership (PPP).*	Ministerial decision for capital funded delivered phase 1 radiation services in Beaumont and St James's hospitals, with some temporary expansion in St Luke's hospital and a temporary service level agreement in Waterford. This will deliver the required National Capacity by 2010 for the population.	Continue the service level agreement in Waterford.	Q1-Q4	HSE / Cancer Programme Director / NPRO
		Clinical increase in services in St Luke's by 20%.	Q3	
		Capital development plan in Beaumont and St James's Hospitals as part of the National HSE Radiation Oncology Network.	Q1-Q4 (target date for clinical service 2010)	
NPRO To 2014: *Phase 2 developments in St James's and Beaumont hospitals, and transfer of services from St Luke's hospital, expansion of services at Cork University Hospital with a networked new department in Waterford, expansion of services at University College Hospital Galway and Limerick Regional.*	Ministerial decision to complete the remainder of the National Radiation Network - fully delivered by PPP by 2014.	Governance structure established with the HSE and the National Development Finance Agency for this PPP project.	Q1-Q4	HSE / Cancer Programme Director / NPRO
		Prepare for public sector benchmarking.	Q4	
		Prepare for tendering process for PPP Advisors.	Q4	

Cancer Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
NPRO Education and Training Strategy	An HR workforce plan commenced in 2007 to expand and develop training schemes for heath professionals required to populate the expansion of radiation oncology service in Ireland into 2010 and 2014.	Workforce Strategy continued.	Q1-Q4 to make provision for 2010 and 2014	HSE / Cancer Programme Director / NPRO / Universities
National Plan for Medical Oncology (NPMO)*: A national plan for medical oncology needs to be developed using similar methodology to the NPRO.*		Commenced development of National Plan for Medical Oncology.	Q1	Cancer Programme Director / NCCP Advisory Group
National Plan for Surgical Oncology: *A national plan for surgical oncology needs to be developed using similar methodology to the NPRO.*		Commenced development of National Plan for Surgical Oncology.	Q1	Cancer Programme Director / NCCP Advisory Group
Communications	As result of the cancer developments announced in 2007 there is recognition that a communication strategy is required.	Communication strategy for patients. Communication strategy for staff. Development of a website for NCCP.	Q1-Q4	Communications / Cancer Programme Director / NCCP advisory group
Information Strategy (TP 1.10): *The development of systems to support cancer control activities and gather cancer data are an important component for the development of the NCCP.*	A vision and strategy agreed to develop and support NCCP.	Development of a high level outline specification developed for an oncology ICT network which will provide a common identifier for oncology, provide cancer data, and enable treatment across all sections of cancer within national standard guidelines and care pathways.	Q1-Q4	Cancer Programme Director / Cancer Registry / NPRO / NCCP advisory group / National ICT
Cancer Financial Model	Work commenced to establish a financial model for the NCCP.	Transfer of resources and funding into the NCCP.	Q2	DOHC / HSE / Cancer Programme Director
Impact on HSE services of National Screening services	2007 saw the formation of the national Screening service, with the commencement of a National Cervical Screening service and the opening of static breast screening units in the South and West both planned for late 2007.	Opening of the static breast screening units in the HSE South and West Dec'07, and commencement of the Cervical Screening service will impact into the symptomatic services. In 2008 a review of this impact will be carried out. Review to be carried out of symptomatic services.	Q4 Q1	HSE / Symptomatic Services

Cancer Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
National Cancer Registry (NCR)	A decision to align the NCR into the NCCP was indicated in 2006 / 2007.	Alignment of the NCR into the NCCP, thus creating the foundation stone of a cancer surveillance system.	Q2-Q3	HSE / Cancer Programme Director / National Cancer Registry.
Ensure an evidence based approach to developments of the Cancer Control Programme	Needs assessment complete which prioritised the development of acute cancer services according to the National Strategy.	Ensure an evidence based approach to the developments of the NCCP.	Q4	Pop Health

MEASURING PERFORMANCE IN CANCER SERVICES

Measurement	Projected Outturn 2007	Target 2008
Cancer Registry	See Section 10 for detailed information	See Section 10 for detailed information
Smoking		
% of population smoking	29% (OTC interim data)	No national target set by DoHC. Improve trend year on year.
Breast Cancer Procedures	See Section 10 for detailed information	See Section 10 for detailed information

CARDIOVASCULAR HEALTH

Diseases of the vascular system, be it coronary (heart), cerebral (stroke) or peripheral vascular (limbs) account for four out of every ten deaths in Ireland. Furthermore, for premature mortality from heart disease (under 65 years), Ireland remains at the top of the league table among the EU15.

Ireland, like most developed countries, has experienced a declining death rate from coronary heart disease (CHD) with 5,417 deaths in 2004 (123.8 per 100,000) compared with 8,326 in 1980 (244.8 per 100,000). Males accounted for 56.2% of deaths in 2004. The trend in mortality decline has been unequal; mortality rates in unskilled male workers are now almost three times higher than professional counterparts.

An analysis of the declining trend in mortality from cardiovascular diseases in Ireland shows that half of the decline is due to a decrease in risk factors, especially smoking, and the remainder is accounted for by improved treatments.

With decreased mortality, the pattern has shifted to increasing survival, with increasing numbers who have a high risk of recurrence of symptoms, and an increase in those with heart failure. This presents an increasing burden on primary and secondary care services. This, along with an increase in obesity, an ageing population and raised prevalence of diabetes, presents major challenges in bringing Irish death rates and the burden of cardiovascular illness into line with our European neighbours.

CVD Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Acute Myocardial Infarction (AMI) Improvement	The AMI / Institute of Health Improvement (IHI) pilot in the 5 national pilot sites continued moving towards evaluation of results from data collection in order to determine success prior to any roll out of the programme.	Action plan for roll out of programme in conjunction with the NHO prepared.	Q1-Q4	NHO (Quality and Risk) / Pop Health
Cardiovascular Strategy *(TP 4.2.4)*	Audit of Building Healthier Hearts Ireland 'Take Heart' completed.	The service gaps outlined in the audit will be reviewed by the Cardiovascular Expert Advisory Group (EAG).	Q4	Office of CEO
		Heart health service development action plans prepared.	Q4	Pop Health / PCCC
Sudden Cardiac Death (SCD)	Implementation of the recommendations from the SCD task force report commenced. Support provided to the UCD MERIT programme supplying Automated External Defibrillators (AEDs). Training of GPs and GP practices in CPR and AED use throughout Ireland commenced.	Continue implementation of the report's recommendations, specifically: a) Implementation of comprehensive first response programmes on a phased basis across the country. b) Development of protocols for follow up of people with positive risk assessment and assessment of need for cardiology referral. c) Monitoring of resuscitation ability in community.	Q1-Q4	Pop Health / NHO
CVD Policy Framework: *A DoHC Policy Group has been established to develop a policy framework for CVD.*	Agreed HSE participation on the group. Terms of Reference have been agreed.	The Minister has asked the group to report in Spring 2008.	Q2	Pop Health / NHO
Heart Failure: *Roll out programme development to targeted sites*	5 hospitals and 2 community programmes funded for initiation.	Initiate services in the 5 sites.	Q4	NHO / Pop Health

CVD Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
nationally.		Heart Failure Action Plan to be developed in association with the Cardiovascular EAG.	Q4	Office of CEO
Stroke: *The death rates from stroke have decreased steadily in Ireland since the mid-1970s. There were 2,029 deaths from stroke in 2005 (7% of all deaths). This compares with over 4,000 deaths in 1980 (12% of deaths).*	Preparations for a Stroke Strategy progressed in collaboration with the DoHC. Consultation to support the preparation of the Strategy was publicly advertised, with information also on the HSE website. An audit of the stroke services by the RCSI quantified the deficiencies in emergency and acute care and in services for rehabilitation and continuing care of stroke. Continued liaison with the Steering Committee to identify priority recommendations for the development of services arising from the audit.	Analysis of report on trends in mortality and hospital statistics completed to support health care planning.	Q1	Pop Health
		Analysis and dissemination of implications of Irish National Audit of Stroke Care (2006 / 2007) for HSE prepared.	Q1	
		Rehabilitation and long-stay post-stroke care, current provision and future need reviewed.	Q2	
		Study on 'The Patient Journey' progressed at selected locations.	Q4	
		Work in collaboration with the Cardiovascular EAG progressed.	Q4	

EMERGENCY MANAGEMENT

Emergency Management (EM) is about the planning for, and management of, major events of a scale beyond the normal capacity of the health services to respond to. These can range from a single accident to multi site accidents, or events on a national scale. These could be major flooding, release of radiological, biological or chemical substances, or major Infectious Disease outbreaks such as an influenza pandemic. The new national office for EM will provide for the standardisation and coordination of emergency plans across all parts of the Health Service and with the fire service and the Garda. Responsibility for implementation of emergency plans in each Area of the HSE rests with the lead Network Manager.

Emergency Management Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Co-ordination / standardisation and improvement of generic emergency plans *across NHO / PCCC and Pop Health at national, area and local levels.*	Strategic agenda for emergency management across all parts of the HSE established	Develop clear emergency management work programmes / business plans across all directorates and functions of the HSE.	Q1	Pop Health / NHO / PCCC / ICT / HR / Procurement
Development and implementation of generic emergency plans	Progress on updating generic emergency plans for the NHO, PCCC and Pop Health delayed due to postponement in the employment of dedicated support staff.	Draft a template for HSE emergency plans at: a) National level. b) Area level. c) Local level i.e. hospitals, local health offices, public health departments and ambulance local administrative areas.	Q1	Pop Health / NHO / PCCC /
		Draft emergency plans in accordance with the agreed template at: a) National level. b) Area level. c) Local level i.e. hospitals, local health offices, public health departments and ambulance local administrative areas.	Q2	Pop Health / NHO / PCCC
		Develop a planned programme of exercises to test the above suite of plans.	Q3	Pop Health / NHO / PCCC
Develop and implement the intersectoral framework *for emergency management with the Garda and the Local Authorities*	Guidance documents produced on: • Risk Assessment • Preparing a Plan • Exercises • Evacuation • Working with the Voluntary Emergency Services	Represent the HSE at the National Intersectoral Steering Group.	Q1-Q4	Pop Health
		Implement the 2008 Workplan at national level, as pertinent to the HSE.	Q1-Q4	Pop Health / NHO / PCCC
		Represent the HSE at the Regional Intersectoral Groups.	Q1-Q4	Pop Health / NHO / PCCC
		Implement the 2008 Workplan at regional level, as pertinent to the HSE.	Q1-Q4	Pop Health / NHO / PCCC

Emergency Management Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Emergency Plan for Influenza Pandemic	Action lists distributed to all directorates to assist in the development of influenza pandemic emergency plans.	Update the National Pandemic Influenza Plan as international understanding of the pandemic increases.	Q1-Q4	Pop Health / NEMO / DoHC
		Contribute to updating the Pandemic Influenza Expert Group.		Pop Health / NEMO
		Draft a template for HSE pandemic influenza plans at: a) National level. b) Area level. c) Local level i.e. hospitals, local health offices, public health departments and ambulance local administrative areas.	Q2	Pop Health / NHO / PCCC
		Draft a pandemic influenza plan in accordance with the agreed template at: a) National level. b) Area level. c) Local level i.e. hospitals, local health offices, public health departments and ambulance local administrative areas.	Q4	Pop Health / NHO / PCCC

SECTION 5
SYSTEM-WIDE SERVICE INTEGRATION INITIATIVES

SECTION 5 – SYSTEM-WIDE SERVICE INTEGRATION INITIATIVES

The population health approach underpins planning and delivery of health services within the HSE, with a focus on increasing the emphasis on primary care, freeing up the hospital system and ensuring increased provision of integrated care. Well integrated hospitals and primary, community and continuing care services will enable the health system to function as a single service delivery unit and make it easier for people to access the right service in the right place at the right time, through agreed care pathways, protocols for referral, joint planning for discharge etc.

While Section 4 of this NSP includes many initiatives which clearly demonstrate our focus on integration within and between our services, this System-Wide Service Integration Chapter includes some of the key cross directorate initiatives which have been identified as core drivers to enable significant progress in achieving service delivery that is well organised and connected across the organisation, enabling patients to move easily though the entire care system.

System-Wide Service Integration Initiatives Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
*Development of an **Integrated Model of Care** is one of the Core Driver Projects for the HSE Transformation Programme. This project will provide the overarching vision and high level framework for integrated health services across the continuum of care, the aim of which is to enable the effective planning and development of services. (TP1)*	The design and agreement of an overall HSE model for delivering integrated services.	Commence the migration of existing structures to the integrated model and the standardisation and roll out nationally of key elements of integrated care packages, e.g. implementation of healthcare record, discharge planning and shared care service packages.	Q1	Programme Lead
***A specific focus for 2008 is the North East Transformation Programme.** It is primarily an implementation programme which will allow HSE to focus its resources and change capacity in order to demonstrate achievement of accelerated service improvement for a substantial population base within a significant geographical area.* *The key drivers for service transformation in the North East are:* • *Improving the safety and quality of patient care by centralising acute and complex care so that clinical skills levels can be safeguarded through ensuring sufficient throughput of cases.* • *Recognising that the majority of care can and should be provided locally including in the community or at*	10 Clinical networks established. High level priority action plan developed. Full TP established with dedicated full time programme manager. Programme Office established in Ardee. Service focused project managers and functional leads assigned on WTE neutral basis. Programme governance structures in place, with balance achieved between NHO and PCCC input at all levels within the programme. Programme integrated with PCCC and NHO national transformation design as well as with local NHO and PCCC operational management. Initial external support procured to assist with programme establishment, capacity planning and detailed planning.	Complete detailed planning phase. Obtain sign-off and buy in to output of detailed planning which will include: • Business Case (Costs and Benefits). • Service Blueprints. • Functional Blueprints (Estates, ICT, Finance). • Workforce Plan. • Change management and communications plan. • High level implementation approach and timescales. NB – this first phase of detailed planning is focused on deliverables for 2008 and 2009 – thereafter the medium to long term deliverables for NE Transformation (i.e. period to 2012 / 2015) will be dealt with.	Q1 Q1	Programme Manager

System-Wide Service Integration Initiatives Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
home wherever practical *In 2008, 2009 and thereafter, the NE Transformation will require significant additional investment to be prioritised within overall HSE national resources. (TP 3A)*	Approach to detailed planning developed and signed off – detailed planning at this stage is focused on what can be achieved by the target deadline of Mid-2009. Target is to have acute and complex care transitioned from 5 into 2 sites by that stage with consequent enhancements to community services including progression of primary care teams and primary and social care networks. Detailed planning commenced. Change management and communication commenced including establishment of NE Transformation Partnership Forum.	Commence and complete detailed design phase.	Q2 & Q4	
		Commence implementation. It is not possible, until detailed planning phase is completed, to be definitive as to what aspects of NE Transformation can be implemented during 2008. It is also the case that progressing NE Transformation is contingent on initial additional investment. Subject to the completion of detailed planning and availability of funding, it is expected that significant service transformation can commence implementation during 2008.	Q4	
Winter Initiative: *There will be a concerted and targeted programme focusing on improving our hospital lengths of stay in line with best national and international practice. Effective bed utilisation, discharge planning and use of day surgery will be key enablers in this regard supported by robust health intelligence / information.*	Initiatives in 2007 focussed on promotion and prevention, hospital avoidance and capacity. By the end of the Winter Initiative period at the end of March 07: • The number of patients waiting in ED following decision to admit had fallen by 60%. • Waits >24hrs were almost eliminated. • Only 3 hospitals had wait times >24hrs on 20% of days. • 75% of patients surveyed were satisfied with their experience in ED.	Specific initiatives for 2008 include: Reducing average length of stay: • Action plan and implementation plan for each Hospital and LHO in place, with clear targets based on the findings of the Bed Utilisation Study.	Q1	LIT
		Discharge Planning: • Expected date of discharge set within 24 hours of arrival. • National Framework to support effective Discharge Planning in place.	Q3	NHO
		Admission avoidance – examples include: • Out of hours GP Service. • Rapid access clinic in Smithfield.	Q1-Q4	PCCC
		Increased usage of Day Case: • Increased usage of day case relative to inpatient surgery. • No patients admitted on the night before for day case procedures. • No patients kept in overnight for non-clinical reasons.	Q1-Q4	NHO

System-Wide Service Integration Initiatives Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
		Access to Diagnostics - Increase access to diagnostics and assessment, without admission to acute setting, through consideration of opportunities for:		NHO
		• Improved GP access to hospital and community diagnostics.	Q1-Q4	
		• Audit conducted on physical capacity e.g. Plain x-ray machines, ultrasounds, CT Scanners, MRI Scanners and comparison on usage and workload per machine also conducted.	Q2	
		• Spare capacity identified.	Q2	
		• Systematic approach using process redesign tools to match demand and capacity and improve patient flow through the system applied.	Q3	
		Outpatient Departments		NHO
		• Inventory of existing OP Waiting Lists for all specialties conducted.	Q1	
		• Simultaneous exercise on the availability of 'physical clinical space' conducted.	Q1	
		• Validation exercise on waiting lists conducted.	Q1	
		• Models of good practice adopted e.g. the management of Orthopaedic Waiting list in Limerick.	Q2	
		• Focus on level of DNAs by clinic and investigation of reasons for non attendance.	Q1-Q4	
		• Focus on shifting appropriate outpatient and other activity to other venues e.g. Warfarin clinics, I / V in the home / long stay institutions.	Q1-Q4	

SECTION 6
QUALITY IMPROVEMENT

SECTION 6 – QUALITY IMPROVEMENT

We are committed to delivering high quality services to all our patients and clients and to creating a quality promoting workplace for staff. This is done through constantly seeking to identify opportunities to improve our existing services and by consciously building quality into all aspects of new services we plan. While quality is implicit and embedded in the delivery of all our services and is reflected in the deliverables already identified in this NSP, this section for 2008 has focused specifically on an organisational-wide Quality and Risk agenda.

Our Corporate Plan 2005 - 2008 outlines that 'we will establish comprehensive systems of governance and risk management to ensure that we provide services that are safe, effective and of the highest quality, within resources available to us'. To support this objective a number of actions have been implemented, including the appointment of a Head of Quality and Risk in May 2006, the establishment of a Risk Committee of the Board in 2006 (chaired by a Board Member) and the establishment of a Risk Management Steering Group to ensure a standardised approach to this agenda across all Directorates, with the aim of supporting the assurance of good governance in respect of all activities in the HSE.

The following objectives have been identified to ensure that we deliver on this aim:

- To create an integrated, consistent quality and risk system in the HSE which has at its core standardised agreed processes.
- To enable the achievement of quality and safe health and personal social services.
- To enable, through good team working, effective interfaces within the HSE and between the HSE and relevant external agencies.
- To ensure that all HSE employees and service providers are responsible and accountable for the management of quality and risk.

Through its work, the Office of Quality and Risk will provide assurances to the CEO and the Board in relation to an integrated approach to Quality and Risk in the organisation. The responsibility for the implementation of quality and risk lies in each directorate through the accountability structures therein. Some of the key deliverables for 2008 are set out below.

Quality Focus	Output 07	Deliverables 08	Target Timescale	Lead Responsibility
Implementation of the 'Quality and Risk Management Framework' including the 'Quality and Risk Management Standard' throughout all directorates. *(TP 12.7)*	Quality and Risk Management Standard drafted and approved by Management Team and the Board.	Distribution of and briefing / education on the Quality and Risk Management Framework and Quality and Risk Standard in all HSE Directorates.	Q1-Q4	NHO / PCCC / Pop Health / Office of CEO (OQR)
Implementation by all directorates of the ***Corporate Risk Register****, as part of the national Quality and Risk Framework, will ensure an integrated corporate risk register, using common risk language.*		Distribution and briefing / education on use of risk register in all HSE Directorates.	Q1-Q4	Office of CEO (OQR) / All Directorates
Development of Quality and Risk Key Performance Indicators *to ensure continuous improvement through measurement of performance against standards, targets, best practice or benchmarks.*		Development of evaluation tool to measure performance.	Q2-Q4	Office of CEO (OQR) / All Directorates
Development of a reporting system and template for Quality and Risk *to ensure integration of information from all directorates*		Development of a Request for Proposal (RFP) in partnership with key stakeholders including representatives from various HSE directorates.	Q1-Q4	Office of CEO (OQR)

Quality Focus	Output 07	Deliverables 08	Target Timescale	Lead Responsibility
*Implementation by all directorates of **Incident Reporting** as part of the National Quality and Risk Standard.*	Working group commenced.	Agreement, dissemination and training in all Directorates.	Q4	Office of CEO (OQR) / All Directorates
***Code of Practice for Decontamination of Reusable Invasive Medical Devices** to ensure compliance nationally.*	Code of practice in place incorporating standards and recommended practices in hospitals and dental practices.	Implementation of e-learning programme.	Q1-Q4	NHO / PCCC / Estates / ICT / HR
		Development of national specification for decontamination equipment.		
		National guidance for the built environment in relation to decontamination facilities.		
***Healthcare Records Management Code of Practice** to ensure compliance nationally.*	Code of practice in place incorporating standards and recommended practices. E-learning foundation training programme developed in healthcare records management.	Implementation of National Hospital Chart.	Q1	NHO
		Development and implementation of national strategy.	Q1-Q4	NHO / PCCC / ICT / HR
		Roll out of e-learning programme.		
		Development of standardised ED documentation.		
		Implementation of National Maternity Chart.		
***Internal Investigation Team** to carry out independent investigations.*	Formation of Internal Incident Steering Team to develop policy, standards of practice and guidelines for investigation team.	Standards of Practice for team established and criteria agreed by Management Team.	Q1	Office of CEO (OQR) / All Directorates
		Communication, education and training in all directorates.	Q2	
Quality and Risk Strategy	Working Group established	Quality and Risk objectives met.	Q1	Office of CEO (OQR) / All Directorates
Development of Criteria and Guidance for Clinical Audit	Working Group established, Quality and Risk and Population Health.	Agreed criteria and guidance for clinical audit.	Q1	Office of CEO (OQR) / Pop Health
***Quality and Safety Awards** to promote and acknowledge high performing sites and develop culture of Quality and Safety.*		HSE Achievement Awards Feb '08	Q1	Office of CEO (OQR)
		Quality and Safety Conference Feb '08	Q1	
		Evaluations and Strategy for '08 Awards process.	Q2-Q4	
***Hospital Hygiene:** Implementation of the recommendations of the third report on hospital hygiene (October 2007)*	Completed third report on hospital hygiene.	Address the issues identified in the third report on hospital hygiene.	Q1-Q4	NHO

Quality Focus	Output 07	Deliverables 08	Target Timescale	Lead Responsibility
Hospital Acquired Infections and Healthcare Associated Infections: *Implementation of the Guidelines for the Prevention and Control of MRSA and GP antibiotic prescribing guidelines in order to control and prevent healthcare associated infections (TP 4.10).* *The prevention and control of healthcare-associated infection (HCAI) is a priority issue for us, both in terms of the health and safety of patients and staff, and the resources consumed by potentially avoidable infections. Implementation of appropriate governance structures and enhanced surveillance systems will reduce the incidence of HCAI.*	Surveillance of HCAI continued. Data now available from hospitals on 4 key areas. Governance structures established through Local Implementation Teams. 5 Year Infection Control Action Plan put in place. Public education programme on Hand Hygiene completed. E-learning centre progressed.	Continue and expand surveillance of HCAIs. Implement key elements of Action Plan. Provide education and training on HAIs for all frontline health care workers. Set up MRSA helpline for public. Identify additional Infection Control Staff.	Q1-Q4	NHO / PCCC / Pop Health
Risk Identification	Work underway to identify key indicative risks	Develop action plan to manage these risks.	Q1	All

MEASURING PERFORMANCE INPATIENT SAFETY AND QUALITY

Measurement	Projected Outturn 2007	Target 2008
Infection Control	Information not available for 2007 at time of report, due end Nov 07.	Targets will be set once baseline established early 2008. Reporting will begin in 2008
% annual progress made towards targets of		
i) 20% reduction in HCAIs,		
ii) 30% reduction in MRSA infections		
iii) 20% reduction in antibiotic consumption		
MRSA		
MRSA bacteraemia notification rate per 1,000 admissions	Information not available for 2007 at time of report, due end Nov 07.	Targets will be set once baseline established early 2008. Reporting will begin in 2008

SECTION 7
VALUE FOR MONEY

SECTION 7 – VALUE FOR MONEY

The Health Act 2004 requires the HSE to "use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public."

Value for Money (VFM) has been consistently defined as the correct balance between economy, efficiency and effectiveness – relatively low costs, high productivity and successful outcomes. While obtaining VFM is good practice and common sense, assessing VFM, particularly in the public sector where delivery of value is more challenging to measure and report, is complex. In prioritising the need to develop a means and method to drive, deliver and report value within the HSE, a VFM Unit was established during 2007 with the specific objective of demonstrating and delivering value in the use of public funds by the HSE and associated organisations. It has been tasked, under the direction of a senior Cross Directorate Steering Group, and in consultation with all Directorates, to develop a strategy for VFM with an associated multi year Action Plan. It is also recognised that, while this Unit can provide the dedicated support, the key to delivering value in the HSE will be the creating of a 'value culture' that provides leadership and encourages individual ownership throughout the service to drive and deliver value in the organisation.

Forecasts for the future health needs of our population are detailed in the introduction to this document. While we currently have a relatively young population, by 2030 it is predicted that one in four of the population in Ireland will be over 65. Given that older people are more likely to have chronic illnesses, this is significant in planning our services. Health costs increase dramatically as people get older. In the USA, 78% of health costs are used to treat people with chronic illness and in the UK, 80% of GP visits are by people with chronic illnesses. Also in the UK, patients with chronic illness, or complications, use over 60% of hospital bed days. The HSE is delivering value through meeting the health and personal social service needs of the expanding and ageing Irish population as well as the continued technological advances in medical treatment. Developing and implementing a sustainable health funding mechanism requires the HSE, along with government and agencies such as HIQA, to examine why the level of differential between cost growth and funding has occurred, and what value can be delivered in targeting focused behaviour and shifting the emphasis to driving productivity.

In the development of a VFM Strategy and Action Plan for 2007-2010, a savings target of €500m for this period has been set. Reported savings of €63m were realised during 2007 largely through Procurement and Contracts Management, in addition to the value generated (but not measured) in delivering increased levels of service at higher costs. This section sets out the strategic approaches to VFM being taken by the HSE, the cost containment initiatives, the value and productivity reviews and, finally, the benchmarking type processes which will all progress the development and delivery of VFM in 2008 and beyond. Those initiatives that are currently measurable in monetary terms, detailed in the cost containment section, amount to targeted VFM in 2008 of approximately €300m and are summarised in this table. Initiatives where it is not possible to set prospective targets for savings, will still be reported on in terms of progress towards driving and delivering value, and retrospective savings will be reported where appropriate.

Directorate	Initiative	Savings 2008 €m
All	Travel and Subsistence	10.00
	Telephony	2.50
	Overtime and Agency	55.00
Corporate Pharmaceutical Unit, Procurement and PCCC.	Supply of Medicines	120.00
Procurement	Contracts Mgt	9.33
ICT	Hardware Framework	2.00
	Licence Consolidation	0.75
PCCC	To be Specified*	64.00
NHO	To be Specified*	36.00
Total		**299.58**

**These will include a range of initiatives which may cover specifics for targeted areas such as Schemes Reviews and Modernisation, Review of Aids and Appliances, Dialysis, Laboratory, Performance Incentivisation in 2008, as well as initiatives driven from the local health areas and hospital networks and will be described in more detail in the Level 1 Business Plans.*

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Strategic Initiatives				
Implementation of Strategic Plan: Directorate VFM Group established in 2007 will continue to oversee the work on the development of a strategy for driving and delivering value in the HSE, and the associated action plan for meeting the €500m, 4 year savings target set in 2007, while also promoting the development of a culture of delivering value in all that we do.	Cross Directorate VFM Group established.	Management Team and Board approve strategy for driving and delivering value in the HSE.	Q1-Q4	Finance
		Oversee implementation of the action plan to deliver quantifiable VFM savings as well as broad productivity and value driving initiatives.	Q1-Q4	
Develop role and function of VFM Unit: *Secure additional dedicated financial and evaluation skills and expertise to facilitate and support driving and delivering value in the HSE.*	Head of VFM appointed. Structure, role and function of Unit agreed.	Appointment of General Manager with specialist financial expertise completed.	Q1	Finance
		Build relationships throughout the HSE to establish VFM priorities.	Q2	
Single Financial Management System: *Commence the procurement of a standardised national financial system in 2008. This SAP based system will enable the organisation to establish a Finance and Procurement foundation and will assist in the integration of internal financial management and control processes and information.* *(TP 7.4)*	Joint Business Case with Procurement developed. Business case submitted to CMOD.	The following processes will be enabled: ▪ Draft completion of Scope. ▪ CMOD Peer Review process begins (1st Stage is Review Business Case).	Q1	Finance
		▪ Tender for Implementation partner.	Q2	
		▪ Project Design (to be competed Q1 '09).	Q3	
		The first release of a long term programme should achieve the following: ▪ Revitalised financial controls and budgetary framework. ▪ Establish the finance function as a business partner for all directorates. ▪ Provide automated vote accounting. ▪ Provide comprehensive Capital Expenditure management. ▪ Establish the foundation for leveraging buying power based on national procurement. ▪ Benefits Realisation of a Shared Services environment.		

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Funding Arrangements: *Move to output / outcome based funding.*	A 'road map' developed for the future development of funding mechanisms. Casemix Unit transferred from DoHC to HSE.	Implementation of recommendations from 'road map' will commence in: ▪ A group of Dublin based hospitals. ▪ Specific Care Groups in PCCC.	Q1	Finance
Cost Containment Initiatives				
Supply of Medicines	New arrangements for Wholesalers which will reduce the margin from 17.66% to 8% from January 1 2008. Contract for Non Licensed Medicines will come into effect from 1/1/2008	Contract for Non Licensed Medicines to achieve substantial savings.	Q1	National Pharmaceutical Unit in association with Procurement and PCCC
		Finalise pricing for non drug products reimbursable under the Community Drugs Schemes.	Q2	
		Commence process of identifying balance of off-Patent products due for price reduction under IPHA Agreement. **The expected savings in 2008 will be approximately €120m.**	Q2	
Procurement Initiatives: *In parallel with the implementation of the Portfolio and Category management approach, a number of contract management initiatives will be implemented.* *Implementation of the new procurement operating model will deliver substantial savings in external expenditure over a 5 year period (€132.7 million) and achieve ongoing annual savings of €61.9 million thereafter.*		Pharma / Lab / Diag Portfolio and ▪ Unlicensed Drugs and Medicines. ▪ Medical Products Refunded under GMS Re-imbursement Scheme. ▪ Vaccines. Professional / Office Portfolio ▪ Implement Professional Services Finance and Audit Framework Agreement. ▪ Additional frameworks to support Transformation Programme. ▪ Framework for PCs and Laptops. ▪ Agency Recruitment. ▪ Patient Transport Services. ▪ Patient Ambulance Services. Hotel Portfolio ▪ Dry Provisions. ▪ Dairy Products. ▪ Cleaning Supplies. ▪ Contract Cleaning and Security (Select Areas). Medical / Continence Portfolio ▪ Aids and Appliances. ▪ Incontinence Products. ▪ Pandemic Requirements.	Q1-Q4	Procurement

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
		Special Projects Supporting ▪ National Paediatric Hospital. ▪ National Programme for Radiation and Oncology including Public Private Partnership and conventional procurement. ▪ Estates Facility Management Requirements. Please note that the above targets may be refined in the context of other priorities that may be identified by Directorates. **The above initiatives will realise benefits of €9.33m in 2008 in line with procurement business case.**		
Non Pay - Travel and subsistence expenses	Report completed identifying the potential for savings in the current expenditure on Travel and Subsistence.	**A target saving of €10m** with specific targets to be set for all Directorates, proportional to the current rate of expenditure.	Q4	Finance
Non Pay - Telephony costs *– national tender and utilisation review*	Report was completed identifying the potential for savings in the current expenditure on Telephony.	**A target saving of €2.5m** before the end of 2008, with specific targets to be set for each Directorate to reduce expenditure on telephony.	Q4	Finance
Pay – Non Fixed Costs e.g. Overtime, Agency etc.	Cross Directorate Group established to review expenditure on Overtime and Agency.	Implementation of findings of cross directorate group on expenditure on Overtime and Agency. **A target saving of €55m** has been set, with specific targets for each Directorate as well as guidance for the reduction of both use and cost.	Q3	Finance
ICT Hardware Framework	PC and Laptop Framework established.	**A total savings of €2m** is expected on the basis of the level of purchases in 2007.	Q4	ICT / Procurement
ICT Licence Consolidation		Replace multiple existing licences arrangements with single HSE consolidated agreement on a phased basis. **A total saving of €0.75m is expected, with further savings on other licences in future years.**	Q4	ICT
Creation and population of National HSE land and building Register	National database in place.	National database populated. Following completion, this database will allow the utilisation of HSE lands and buildings to be rationalised and can identify assets for disposal.	Q1	Estates
Central approval and negotiation of all Leases.	Negotiation of all leases centralised.	Manage, monitor, negotiate and approve all HSE Leases centrally. Each year, value will continue to be delivered by ongoing management of leases.	Q4	Estates

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Procurement of CNUs by means of Design / Build multi-site tenders	300 beds in Dublin and 200 beds in Cork procured by means of Design / Build tenders.	Invite tender for similar units. A 5% saving in total project costs per unit is expected.	Q2	Estates
The procurement of Design Teams by means of a Framework Tender for all projects under €30m	Tender process established.	Framework tenders for all Design Team Consultants completed. Competitive tendering for all Design Teams will ensure better VFM.	Q1	Estates
Centralisation of Corporate Facilities Management.	Process commenced to centralise corporate facilities management.	Centralisation of Corporate Facilities Management ensuring better VFM by coordinating office occupation, booking of meeting rooms, maintenance of facilities, etc.	Q4	Estates
Performance and Development – Collective Call for Tender: *Exploit full buying power of HSE and reduce administration time associated with less consolidated approach to training provider selection*		Collective call to tender in place (with the aim of establishing a framework agreement with a panel of providers who may be called upon to provide specific services in any or all HSE areas in the field of learning, training and development, primarily in support of primary care reform, over a period of 3-4 years). Report on current average per head training costs and prospectively report on savings resulting from tender.	Q3	HR / Procurement
Recruitment: *Consolidation of all management / administration recruitment processing on one site to streamline processing activity.*	Grade 3 national competition resulted in estimated savings circa €1,200 in cost per hire.	Transfer of all management / administration recruitment processing undertaken to National HR Services in Manorhamilton on a phased basis, leading to establishment of national panels.	Q3	HR
Mediation Panel: *International research shows that early intervention in conflict situations by support services such as Mediation has a clear cost reduction impact in terms of both lost time and motivation. This service will be a Partnership supported initiative and will be operationally supported by the P&D function.*	Development of a Mediation Panel drawn from Health sector employees, on a part time voluntary basis. Policy and Procedure document finalised.	New Panel launched. Areas / services report level and cost of Mediators used (estimated at costing in excess of €1,000 per day) to identify savings gained in the reduction in use of Mediators, following development and use of Mediation Panel.	Q1	HR
Maximise VFM in Health Promotion Social Marketing Campaigns*, by maximising discounts, impact of campaigns and availing of special deals.*	Estimated value obtained was €600,000.	Increased inter-sectoral planning and commissioning of campaigns which are publicly funded, resulting in higher impact and more integrated and cost effective campaigns.	Q1-Q4	Pop Health

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Audit of legal costs within Environmental Health Services		Audit of legal costs within environmental health conducted.	Q2	Pop Health
		Implement protocols and best practice in order to minimise the costs from this activity.	Q3	
Productivity and Value Initiatives				
Schemes Modernisation: *The potential of a unified system has presented us with a unique opportunity to streamline many of our back office processes and functions whilst at the same time driving a modernisation agenda. (TP 2.8)*	Commenced process for the modernisation and rationalisation of schemes within PCCC as detailed in Schemes Modernisation in Section 4, page 25.	The focus for 2008 will be:		PCCC
		▪ Complete the integration of local schemes systems with the National Schemes Index on a real time basis.	Q2	
		▪ Complete the process of populating schemes registration systems with verified PPSNs for the registered population.	Q2	
		▪ Implement National Data Management and Control Programme.	Q3	
		▪ Review of Community Drugs Schemes, including the establishment of cost effective mechanisms for the supply of drugs / medicines and non drug items under the 'Hardship Scheme'.	Q3	
Review of the Primary Care Reimbursement Schemes: *These Schemes have an annual approved allocation in 2008 of €2bn approx. PCCC will undertake a review of the usage of this money to establish potential savings.*	See detail in Primary Care Reform and Integration in Section 4, page 22.	Enhance probity assurance structures and processes across the range of contracted services.	Q2	PCCC
Review of the efficiency and effectiveness of Long Stay Residential Care for Adults in Mental Health Services: *This is a DoF agreed VFM and Efficiency Review for completion in 2008.*	Survey of all long term residents and facilities undertaken, with Census date 10th October 2007. Sub Group established to work on identifying the objectives of the provision of Long Stay Residential Care.	Review complete and recommendations brought forward to Management Team.	Q4	PCCC
National Review of Aids and Appliances Scheme	Review completed in Dublin Mid Leinster.	Development of a national policy in relation to the funding, allocation, storage and recycling of aids and appliances. National action plan for implementation, utilising work already completed from DML Review findings.	Q3	PCCC

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
National Integrated Medical Imaging System (NIMIS) Project (formerly PACs in 2007): *Integrated PACS / RIS systems offer well recognised benefits in relation to:* ▪ *Improved quality of patient care;* ▪ *Reduction in imaging specific patient care risk factors;* ▪ *Improved workflow and increased efficiencies for diagnostic imaging services;* ▪ *Avoidance of the need to print and manage hardcopy x-ray films.*	PACS Project Board was established and work on the business case commenced.	Process will commence in 2008: ▪ Business Case completed. ▪ Approval Process. Future years will require: Procurement Process Completion Q1 2009 Installation Commencement Q2 2009 Project Completion Q3 2011 The introduction of a standard technology will be cost effective in terms of administration, ease of use and maintenance. Standard technology offers the potential for data exchange between hospitals in regard to patient care.	Q1 Q2	NHO
Dialysis: *The establishment of a list of preferred providers nationally will result in a more cost effective procurement process for dialysis services.*	EU procurement process completed. Five suitably qualified companies identified as potential providers of additional dialysis capacity, which cannot be accommodated in the public sector.	Provide a dialysis service in Limerick city.	Q3	NHO
Laboratory review *to determine the most appropriate structure and arrangements for the delivery of laboratory medicine services required across the full continuum of care including primary, community, secondary, and tertiary care.*	National laboratory review commissioned. The Review has provided recommendations, in the context of current resource constraints, on the timeliness, reliability, capacity and efficiency of current laboratory medicine services provided by or for the HSE, benchmarked against leading international practice and standards.	Implementation plan developed for the recommendations of the Laboratory Report.	Q1	NHO
		Consultation process undertaken to agree the implementation stages. This will be conducted through the Partnership Forum.	Q2	
		Priority will be the development of 'cold laboratories'.	Q1-Q4	
Development of Health Information Project *which aims to integrate health and health related datasets, GIS and statistics in a web application. These actions will allow for greater economies of scale and savings as these services can be offered in house.*	Development of the Health Atlas Ireland system further progressed.	Promote the reduction in time spent on duplication of analytical work across the organisation. Promote the provision of geographic mapping data across the organisation.	Q4	Pop Health
National Falls Prevention Strategy *Falls account for 90% of hip fracture hospitalisations among older people. The average inpatient cost for a hip fracture in a person aged 65 years or older is estimated at €12,610.*	Draft strategy completed.	Implement the integrated strategy for the prevention of falls and effective management of osteoporosis. One of the expected outcomes would be an incremental reduction in acute care costs which currently stand at €35m a year.	Q3	Pop Health

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Cancer Control Programme *Population Health has carried out analysis of hospital utilisation and it has helped determine the location of the 8 cancer centres.*	Analysis of hospital utilisation completed.	Determine the capacity in the selected hospitals to develop services in accordance with quality and best practice. This will ultimately lead to better patient care, better outcomes, reduced inefficiency and good economic outcomes not just for the HSE but for the economy as a whole.	Q2	Pop Health
Develop Absence Management Strategy ***Introduce unitary system of absence recording.*** *Accurate standard recording of short and medium term absences can in itself lead to incidence reduction and will enable introduction of attendance management strategy.*		Initial selection of targeted pilot sites for implementation of absence recording, utilising facility existing within HRBS.	Q1	HR
		Review and full roll-out.	Q3-Q4	
ICT budget control: *New Chart of Accounts will ensure there is visibility of all ICT budgets, both at a corporate and service unit level, to meet the revised accountability requirement from Dept. of Finance (16 / 97).*	ICT Financial Management process in place.	Standardised reporting internally and for CMOD (Dept. of Finance) available.	Q1	ICT
Benchmarking Initiatives				
Admin Review: *The project is designed to assess the appropriateness of the HSE's deployment of clerical, administrative and managerial (CAM) staff.*	Data collected on the current roles of all CAM staff within the statutory sector. PCCC and Office of the CEO data analysed.	Develop a resource allocation model which will, using established techniques and applying variables in the HSE context, assist in providing an evidence base for determining the number and grade of staff required to support each operating unit.	Q1	Office of CEO / HR
		Analysis of all other directorates.	Q4	
Rationalise the utilisation of office accommodation with other bodies (OPW, Local Authorities, etc)	Utilisation survey of HSE office accommodation commenced.	Identify and rationalise the utilisation of HSE accommodation.	Q3	Estates
Single template for assessing and reporting planned and delivered value		Develop a generic template for the assessment and reporting of planned and delivered value as part of the Business Case requirement of the North East Implementation.	Q4	Finance

VFM Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Care Area Resource Reviews		Specific Care Area e.g. Mental Health, examined for specific population groups e.g. Dublin Mid Leinster, in terms of identified need, current level of service, current level of resource (HR and Finance) and recommendations regarding resource allocation.	Q4	PCCC
Internal Audit: *VFM is an intrinsic part of the audit process. Key aspects of the work of internal audit are the identification of areas of the system of internal control requiring improvement, and the formulation of recommendations to assist management improve the system of internal control.*	Approximately 200 internal reports issued which contained recommendations to assist management in their improvement of the system of internal control.	Areas of the system of internal control requiring improvement identified.	Q4	Internal Audit
		Recommendations to assist management improve the system of internal control formulated.		
		Regular exchange of information with VFM group.		
Development of Integrated Workforce Planning Strategy: *With the patient / client at the very core of our service delivery, workforce planning provides the opportunity to strategically plan for the optimum number, mix and distribution of the right skills, competencies and capabilities to deliver appropriate care. Workforce planning must be seamlessly linked to service and financial planning.*	Final Draft Integrated Workforce Planning Strategy Completed 31 December 2007.	Consultation Process and Final Policy Strategy Integrated Workforce Planning completed.	Q2	HR
		Action Plan Integrated Workforce Planning Completed.	Q2	
		Implementation of Integrated Workforce Planning.	Q3 onwards	

SECTION 8

CONSISTENCY AND SOCIAL INCLUSION

SECTION 8 - CONSISTENCY AND SOCIAL INCLUSION

The establishment of a unified health system has provided us with a unique opportunity to promote the harmonisation and equity of all services nationally, while providing best care for patients. Our four year Transformation Programme builds on the momentum for change that has gathered within the HSE and is focussed on building a health and personal social service system that is sustainable and capable of delivering high quality services. This Consistency and Social Inclusion Chapter includes some of the cross directorate initiatives which have been identified as enablers for 2008 in progressing this change agenda, while providing a consistent basis for decision making and a standard, needs based approach to service delivery.

The Social Inclusion section included in Section 4 of this NSP focuses on initiatives specific to the health needs of vulnerable groups such as travellers, drug users and the homeless. There are also many other examples of initiatives aimed at facilitating a more socially inclusive service, responsive to the diverse needs of all service users, which are included within the appropriate care group sections of this Service Plan. Samples of these include: primary and community care and hospitals configuration projects; the chronic illness framework; provision of support for teen mothers and lone parents; support for the RAPID and CLÁR programmes; and commitments arising from the Disability Act.

While Social Inclusion has traditionally been focused on the care and support needs of identified vulnerable groups, this approach is now being broadened within the HSE to encompass measures aimed at enhancing the responsiveness of all services at all levels of care, thereby ensuring inclusiveness and accessibility to all service users on an equitable basis. A Socially Inclusive approach is synonymous with tackling poverty and health inequalities, with health inequalities being addressed through such mechanisms as provision of targeted services, where appropriate, enhancement of mainstream services and optimal intersectoral collaboration. The cross cutting dimension, intrinsic to a Social Inclusion approach, is key to improving access to health services of all service users.

In Ireland, inequalities in health have become an important public health issue, as is the case in many countries across the world. Despite continuing economic growth and increasing health expenditure as a percentage of GDP, there continues to be a widening gap in equalities across the social gradient. It is accepted that these inequities are systematic, cyclical, socially produced and unfair; they are avoidable, not inevitable and can be successfully addressed and changed. The current environment of change in the health sector and the development of a unified service have created opportunities for new structures and mechanisms to incorporate and promote the reduction of health inequalities as an integral part of a comprehensive strategy for health development.

Consistency and Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Management Framework for Services provided by the Non-Statutory Sector: *A review of the current arrangements for the management of health and personal social services provided by the non-statutory sector was commissioned in 2007, in recognition of the need to develop standardised processes that safeguard service users, ensure transparency and fairness in the awarding of funding, link payments to service levels and outcomes, and utilise formal service level agreements.*	Review completed. Proposed Management Framework adopted. National Implementation Steering Group established to oversee the next phase.	3 Project Implementation Teams established (NHO, PCCC and Population Health).	Q1	NHO / PCCC / Pop Health
		Implementation Plans developed.	Q2	

Consistency and Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
***PCCC service configuration framework**: This will involve reconfiguring our resources to provide a significant range of client services as close as possible to people's homes, while maintaining high quality and safety standards. The emphasis will be on local delivery which will be met by local multidisciplinary teams and local diagnostic services.*	PCCC service configuration framework identified as one of the Transformation Programme core driver projects.	Continue realignment from the current model of fragmented service delivery to a population based model organised through Primary Care Teams serving populations of approximately 8,000 people (see Primary Care Section on page 23 for details).	Q1-Q4	PCCC
***Development of hospital services configuration framework** to provide services that are evidence based, efficiently run and quality assured, delivering optimal and cost effective results.*	Reconfiguration of hospital services framework identified as one of the Transformation Programme core driver projects.	Reconfiguration will be reflected in a redeveloped hospital / management construct and in specific service transformation projects in areas such as cancer, paediatrics, maternity services and emergency departments.	Q1-Q4	NHO
***National Cancer Control Programme (NCCP):** Establishment of the NCCP will provide the governance, integration and leadership to ensure that cancer services will be integrated and population based and will be organised primarily around four regional cancer control networks focusing on the needs of patients with cancer.*	Ministerial decision made in 2007 to progress cancer to a Programmatic Structure within the HSE, and a key appointment of Programme Director was announced in September '07.	Establishment of the Cancer Control Programme, with transfer of all budgetary funding, WTE and other resources under the direct control of the Cancer Programme Director.	Q2	Cancer Programme Director
***Services for Persons with Disabilities**: Information from both National Disability Databases will ensure that services will increasingly be allocated based on identified need.*	Resources contained within the multi-annual investment programme for persons with disabilities were allocated on the basis of need, as identified from the Disability Databases.	Continuation of an evidence based approach nationally to development and delivery of services, in response to identified need.	Q1-Q4	PCCC
***Palliative Care Services:** The 2005 Baseline Study provided the basis for developing services to meet identified need.*	Work continued to address inequalities identified in Baseline Study through the development of Area Level action plans, in line with area development committees' reports. Baseline initiated under auspices of Area Development Committees.	Review and examine national needs plan in association with DoHC and other stakeholders. Implementation Plan 2009 -2013 developed, following national needs assessment.	Q3 Q4	PCCC

Consistency and Social Inclusion Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Development of Health Inequalities Framework *to develop and implement a structured population health framework that will tackle health inequalities, reduce the health gradient and work towards achieving equity in health. (TP 4.9)*	National Steering group established.	Literature review on best practice in health inequalities completed.	Q2	Pop Health
		Draft HSE Framework developed.		
The ***National Intercultural Health Strategy*** *has been developed against a backdrop of the increasing ethnic and cultural diversity in Irish society. Census 2006 reports that 10% of the population are non Irish, many of whom have unique and distinctive health and support needs.*	National Intercultural Health Strategy developed and approved.	Public launch of the strategy.	Q1	Office of CEO
		Implementation plan to address recommendations of NIHS finalised.	Q2	Office of CEO / PCCC / NHO / Pop Health / HR

SECTION 9

SUPPORTING SERVICE DELIVERY

HUMAN RESOURCES

An ongoing critical objective of Human Resources (HR) is to ensure that necessary human resource related supports are in place for HSE Service Delivery as and when they are required. The HR programme for 2008 is designed to proactively complement the collective components that form this NSP. The priority areas for Human Resources for the coming year include:

Management of Employment Numbers - Ensure robust mechanisms are in operation to support services in the management of employment levels within the health sector and to enable them, through accurate recording and reporting, to support performance management within the resource levels allocated.

Workforce Planning - Ensure strategies and mechanisms are in place which will deliver appropriate manpower levels and skills to the organisation and assist in the management of people resources within an environment of change. Key programmes in this area will include the Administrative Staffing Assessment Programme (ASAP), the Review and Feasibility analysis of nursing and other related staff resource deployment in the HSE, and the review of future requirements for selected professions.

Absence Management - Introduction of a unitary approach to absence recording, reporting and management.

Embedding the Transformation Change Programme - ensuring that as new structures are put in place, we communicate our Vision and engage our staff in order to ensure full implementation of this Vision.

Leadership - our goal is to develop a leadership development strategy and implementation plan to support and further enhance managers who are moving into, or who are currently in, positions of leadership.

Team Effectiveness - we wish to develop, strengthen and enhance team working amongst newly established and existing teams.

Employee engagement - essential to a modern health service is a high performing and engaged workforce committed to delivering quality public services. An integral part of this engagement will be a process of consultation with staff, measuring their perception of cultural elements of the organisation and our ability to achieve our collective objectives.

Partnership - Using Partnership ensures that the full potential and contribution of all within the organisation is mobilsed through team-working and that new ways of working to improve service delivery are explored.

HR Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Employment Policy: *Support NHO, PCCC and functional Directorates in Managing allocated resource through further improvement in reporting framework*	Revised employment ceilings implemented reflecting 'legacy' service developments and changes in reporting obligations.	Employment ceilings revised to reflect financial sustainability.	Q1	HR
		Timely and accurate performance data available at all levels.	Q1-Q4	
Manpower Planning Administration Staff Assessment Project (ASAP)	Consultancy support procured and project commenced.	Resource allocation model developed.	Q1	HR
Nursing Workforce feasibility study	Consultancy support to conduct feasibility study procured.	Findings of benchmark study on nursing resource deployment progressed.	Q2	HR
		Implementation of 1.5 hrs reduction on cost neutral basis completed, where feasible.	Q2	
Community Welfare Analysis	Completed detailed assessment of resource deployment	Transfer of Community Welfare Staff to the Dept. of Social, Community and Family Affairs (DSCFA).	Q2	HR / PCCC

HR Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Performance Management	Review of performance management initiative undertaken, including alignment with TP performance measurement initiative.	Performance framework, based on 2008 NSP commitments, to support Mangers and Staff in attainment of targets and objectives finalised.	Q1	HR
Development of Integrated Workforce Planning Strategy: *With the patient / client at the very core of our service delivery, workforce planning provides the opportunity to strategically plan for the optimum number, mix and distribution of the right skills, competencies and capabilities to deliver appropriate care. (TP 9)*	Final Draft Integrated Workforce Planning Strategy Completed.	Consultation Process and Final Policy Strategy Integrated Workforce Planning completed.	Q2	HR
		Action Plan Integrated Workforce Planning Completed.	Q2	HR
		Implementation of Integrated Workforce Planning.	Q2-Q4	HR
Health and Social Care: *Support maintenance of standards through continuing professional development for health and social care professionals. This will be particularly important in the context of the challenges for Health and Social Care Professionals in working in new and different ways in PCTs and new integrated care teams. (TP 6,9)*	Data collection and analysis to determine the key themes and strategic directions was completed. Development of actual strategy and policy in 2007 deemed premature.	Development of a HSE strategy and policy statement for the professional education of Health and Social Care Professionals, in consultation with key stakeholders.	Q3	HR
Develop and implement a leadership development strategy for the HSE	Consultation workshop with senior mangers in November 2007.	Development of Leadership Development Strategy and completion of targets for 2008 as outlined in the strategy.	Q1-Q4	HR
Create and implement leadership and management approaches which inspire *Leadership Development Programme. (TP 6.2)*	Procurement process for the selection of a provider to design and deliver phases 1 and 2 completed. The procurement process for an independent evaluation completed.	Delivery of phase 1 programme to Leadership group (over 6 months) commenced.	Q1-Q2	HR
		Phase 1 programme evaluated and adapted.	Q2	
		Phase 2 programme delivery to top 160 managers (over 12 months) commenced.	Q3	HR
Standardisation of management development	Outline policy drafted. Standard objectives for 'newly appointed managers' programme agreed. Report produced on evaluation of 'People Management – the legal framework'.	Standard objectives / formats for management development programmes at all levels agreed.	Q2	HR
		New Performance Management Legal Framework (PMLF) modules designed and existing modules updated, in conjunction with Health Service Employers Agency (HSEA).	Q4	HR

HR Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Implement National Plan for Standard HSE General Learning and Development Programme	Audit of 2007 Planning and Development (P&D) prospectus carried out. Standardised approach agreed to general learning and development programmes across the four Areas for 2008.	Circulation and promotion of standardised prospectus information across all areas commenced.	Q1	HR
		Next phase of integration towards national prospectus.	Q4	HR
Standardisation of National Academic Study Support Scheme	Audit of existing schemes carried out and recommendations prepared. Negotiations with stakeholders still ongoing.	National Academic Study Support Scheme finalised.	Q1	HR
		Implementation of National Scheme.	Q2	HR
		Research in best practice conducted and policy and framework document developed and agreed.	Q4	HR
Implement standards based performance measurement and management throughout the HSE *(TP 9.4)*	National Steering Group on Team Based Performance Management (TBPM) established. Funding allocated to support the roll-out of TBPM. Monitoring the implementation of TBPM agreed. Strategic Performance Management and Development Framework developed.	Implementation Plan for Strategic Performance and Development Framework developed.	Q2	HR
		A roll-out plan for TBPM for the period 2008-2012, developed and agreed, subject to securing the necessary resources to enable the roll-out plan to be implemented.	Q2	HR
E-learning Centre – Further development of www.hseland.ie	HSE Learning Centre redesigned and developed. Promotion through events and road shows.	Broad suite of E-Learning Programmes available on line.	Q1	HR
		On-line resources and bespoke HSE E-Learning Programmes to support Transformation Programme developed.	Q3	
Develop robust model for recording, reporting and tracking expenditure on training, development and education (TDE) across the HSE for performance measurement and benchmarking purposes	Exploratory work undertaken by P&D with Finance on high level expenditure reporting and Area reporting requirements. Research undertaken and requirements for unitary training and development expenditure coding system established.	Uniform TDE expenditure coding, across the HSE, developed in agreement with Finance.	Q2	HR
		Piloted in selected site.	Q3	
		Mainstream / roll out on a national basis.	Q3	
		Full recording of Training and Development expenditure in standard format across the HSE.	Q4	
Develop a set of Human Resources Performance Indicators and Metrics *(TP 9.3)*		Suite of HR Performance Indicators and Metrics developed and tested.	Q4	HR

HR Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Develop and implement an Employee Engagement Strategy *(TP 6.1)*	Consultation carried out with internal key stakeholders. External organisation procured to undertake employee survey. Contract awarded. Survey commenced.	Employee Engagement survey designed, circulated and completed.	Q1	HR
		Survey findings analysed.	Q1	HR
		Action plan to implement survey findings developed and incorporated into an overall Employee Engagement Strategy.	Q2	HR
Support the achievement of organisational effectiveness through team building and other organisational development interventions	Team building programmes, facilitated workshops and forums held. National HR Forum established. First national forum held.	Team building and other organisational development interventions delivered to teams with a particular focus on teams implementing Transformation Projects.	Q1-Q4	HR
		Convening of National HR forum on a quarterly basis.	Q1-Q4	HR
		Development of action plan through National HR Forum and implementation of projects set out in this plan.	Q3-Q4	HR
Development of Employee Wellbeing and Welfare Strategy	Steering Group established and pilot questionnaire completed. Work commenced on documentation of existing structures, practices and policies and preparation for consultation.	Consultation process to be undertaken.	Q1-Q2	HR
		Analysis of data on structures with regard to policies and procedures.	Q1-Q2	
		Development of Strategy and Action Plan.	Q2-Q4	
Equality Agenda	Resources in each of the four administrative areas identified.	Structure for development of the Equality Agenda completed.	Q1	HR
		Implementation of Strategy for Employment of Persons with Disabilities.	Q1-Q4	
		Standardised policies in Occupational Health / Employee Assistance Programme identified and prioritised.	Q1-Q4	
Standardisation of HRBS Process *Review and implement standard process roadmaps for all Employee Schemes. (TP 9.4)*	Process list identified.	Implementation and communication of standard processes progressed, commencing with PPARS Phase 2 sites, and rolled-out nationally.	Q1-Q4	HR
Develop Absence Management Strategy: *Introduce unitary system of absence recording into HSE.*		Pilot sites identified and implement.	Q1	HR
		Pilot reviewed and rolled-out nationally.	Q3-Q4	HR

HR Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Standardisation of Terms and Conditions of employment of new entrants	Discussion with Unions commenced under agreed facilitator.	Standardisation of employment Terms and Conditions progressed across the organisation.	Q1-Q4	HR
Towards 2016 – Implementation of agreement and modernisation and change agenda	All Unions now signed up to 2016 (INO and PNA signed post industrial dispute). Performance Verification rounds completed. Performance Verification Process reviewed and new reporting template implemented.	All Unions engaged in implementation of transformation.	Q1-Q4	HR
		New PVG measurement template applied in accordance with requirements of PVG reporting mechanisms.	Q1-Q4	HR
		Employee Relations (ER) and Industrial Relations (IR) support provided to development of PCTs, with priority on programme 3A in the North East, with Unions' involvement through PCCC National Partnership Working Group.	Q1-Q4	HR
Recruitment: *Consolidation of all management / administration recruitment (TP 9.5)*		All management administration recruitment processing undertaken in National HR Services in Manorhamilton - implemented on a phased basis leading to establishment of national panels.	Q3	HR
Garda Vetting *(TP 9.5)*	New policies and procedures for the vetting of staff now in place nationally. Garda Vetting Unit established in Manorhamilton.	Garda vetting for former ERHA transferred to Manorhamilton.	Q1	HR
Recruitment Information Repository: *Develop a single source and collating content for the storing and recall of all information in respect of all competitions and positions covered under the remit of National HR Services (NHRS) Recruitment Services. This will include job descriptions, competency models, qualification requirements and interview guides.*		Database pertaining to job descriptions / specifications and qualifications for management / administration and therapy / nursing grades established.	Q2	HR
National Internal Transfers: *Establishment of National Inter County transfer protocol and mechanism for Management / Admin grades.*	Pilot system in place and fully operational.	Database rolled-out to other grades, following a review of current system and agreement with Trade Unions.	Q1-Q4	HR

HR Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Recruitment Agencies	Interim review of Agency Recruitment completed.	Full review of Agency Recruitment completed.	Q2	HR
		Research on pricing model completed.	Q2	HR
		Universally applicable set of criteria defined (which may vary for different grades).	Q2	HR
		Protocol for use of recruitment agencies with NHO and Procurement agreed.	Q2	HR
		Protocol for all grades implemented.	Q3	HR
		Staff members who commenced post January 2005 included in HSE Scheme.	Q3	HR
Clinicians in Management (CIM) ***Project:*** *Establish 10 'exemplar' sites and enable clinicians to become more involved in management process*	Exploratory work by multi-disciplinary group involving managers and clinicians completed.	Participating sites identified.	Q1	HR
		Diagnostic / Fact-finding exercise conducted.	Q1-Q2	
		CIM Model developed.	Q1	
		Ownership and go-live promoted on a phased basis.	Q2-Q4	
Professional Development		Skills of Senior Managers in dispute resolution developed.	Q1-Q4	HR

MEASURING PERFORMANCE IN HUMAN RESOURCES

Measurement	Projected Outturn 2007	Target 2008
Total approved WTE Ceiling	112,245	112,245
NHO	51,415	51,415
PCCC	56,694	56,694
Population Health	557	557
Functional directorates e.g. HR, ICT, Finance, Office of CEO, etc.	33,579	33,579

OFFICE OF THE CEO

The role of the Office of the CEO is to represent, advise and support the CEO in carrying out his functions. The office has a number of key corporate functions including Board Affairs, Corporate and Parliamentary Affairs, Quality and Risk Management, Consumer Affairs, Communications and the Regional Health Offices as well as a range of cross directorate, governance and policy development functions including Expert Advisory Groups, Medical Education, Training and Research, Consultant Appointments, Cross-border Relations and Special Reform Projects.

Engagement with Service Users: A Consumer Affairs division was established in 2006. As well as meeting our statutory obligations in relation to Freedom of Information, Data Protection and other legislation based entitlements, we have developed a consumer and community involvement strategy for engaging with members of the public. In December 2006, the Minister for Health and Children signed regulations to fully implement, from 1st January 2007, the statutory complaints process provided for in Part 9 of the Health Act 2004.

Section 43(1) of the Health Act provides for a mechanism for the Executive to consult with local communities, including the establishment of advisory panels.

Expert Advisory Groups (EAGs) provide a central platform for clinicians and health professionals, managers, patients, clients and carers in ensuring that the expertise of those directly involved in providing and receiving services is applied to the development and implementation of operational policy.

The **Parliamentary Affairs Division** manages the formal and informal information requests from members of the Oireachtas. Providing elected representatives with timely, accurate and complete information remains an important priority for the HSE.

The **Regional Health Offices** support the **Regional Health Forums**, the statutory bodies set up by regulation under the Health Act, 2004, which commenced operation in 2006. The members of the Forum are nominated by their respective local authorities. The Forums can make such representations to the HSE as they deem appropriate. Area Briefing meetings for Oireachtas members commenced in 2006.

The **National Communications Unit** (NCU) ensures that the strategic objectives of the HSE and their implementation are communicated effectively to the organisation's employees, stakeholders and the public it serves. It provides direct communications support and advice to the CEO, his advisors, senior management and the staff across the organisation so that they are better prepared to utilise communications as a management tool to achieve their short term and long term objectives.

Office of the CEO Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Consumer Affairs ***Implement statutory complaints framework*** *(TP 12.2)*	Statutory complaints framework fully operational across HSE. Process with voluntary organisation commenced.	Database developed to comply with statutory reporting requirements.	Q4	Office of CEO
		Twice yearly reports on complaints to HSE Board.	Q2 & Q4	
	Projected Outturn 07: 7,000 complaints *Projected Outturn 07: 80% of complaints investigated within 30 working days.*	*Performance Target: 85% of complaints investigated within 30 working days.*	Q1-Q4	
Disability Act 2005 (Complaints Officers)	Not applicable.	Policy and procedures developed in relation to the management of complaints under this legislation.	Q1	Office of CEO
Code of Governance: *Code of Governance is a key element of our accountability framework*	Draft Code of Governance developed, approved by the Management Team and Board and submitted to the Minister for approval.	Action plan to implement Code of Governance developed.	Q1	Office of CEO
		Consultation with staff organisations commenced.	Q1	
		Implementation programme commenced.	Q2	

Office of the CEO Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Expert Advisory Groups: *EAGs advise on the organisation and development of a particular service. They enable health professionals and clinical experts, patients, clients and service user groups to play an active role in health care policy development and monitoring of policy implementation within the HSE. (TP 2.4)*	EAGs on: • Mental Health • Children • Diabetes • Older People continued to influence the strategic and operational development of services in their specific remits, with a number of recommendations submitted in the course of 2007. Each group comprises approximately 20 people, under the Chairmanship of a senior clinician.	Continued development of policy recommendations referred through agreed processes to Management Team for development of Implementation Plans.	Q1-Q4	Office of CEO
		Implementation of approved recommendations monitored by EAGs.	Q1-Q4	
		Establishment of additional EAGs with key priorities and workplans agreed on: ▪ Cardiovascular Health. ▪ Oral Health. ▪ Maternity Services. ▪ Disabilities.	Q1-Q4	
Consultant Appointments Unit *Regulation of the number and type of medical consultant posts.*	71 Consultant posts regulated.	Determine the number and type of new and replacement consultant posts, in line with service needs.	Q1-Q4	Office of CEO
Engagement with the Political System				
Parliamentary Questions received	*Projected Outturn 07: 3,200*	*Performance Target: time to reply reduced to 15 days.*	Q1-Q4	Office of CEO
Ministerial and Public Representations	*Projected Outturn 07: 3,062*	*Performance Target: demand led*	Q1-Q4	Office of CEO
Regional Health Forums (RHF): *Number of questions submitted to RHFs.*	259 questions submitted (and replied to) to RHFs.	Answer all questions and motions for standing orders as advised.	Q1-Q4	Office of CEO
Number of Notices of Motions submitted to Regional Health Forum	115 notices of motion submitted to the Regional Health Forums.	Answer all questions and motions for standing orders as advised.	Q1-Q4	Office of CEO
Internal and External Communications				
National Communications Unit (NCU) (TP 12.1)	Progressed the development of a comprehensive communications strategy for the HSE.	Comprehensive communications strategy for the HSE completed.	Q1	Office of CEO
	4 editions of internal staff magazine Health Matters published.	4 editions of Health Matters national newsletter published, one issue per quarter.	Q1-Q4	
	Processed over 20,000 media queries, issued 160 press releases and managed interview requests and broadcast appearances on behalf of senior management.	Provide a rapid and responsive service to the media, processing over 20,000 media queries.	Q1-Q4	
	Developed communications strategy for Influenza Pandemic.	Communicate National Communications Strategy for Influenza Pandemic.	Q2	

Office of the CEO Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Education, Training and Research (ETR)				
Implementation of Strategic Plan for Medical Education, Training and Research (METR) within HSE	An executive HSE-METR Committee was established by the CEO and charged with developing a HSE-METR Strategy. This Committee, chaired by an external expert in the field, produced a report, whose recommendations were accepted by the HSE Management Team and HSE Board. This report recommended the establishment of a METR Unit in the HSE.	Development of implementation plan.	Q1	Office of CEO
		Implementation of robust METR Unit within the Office of the CEO and associated governance structures.	Q1 – Q2	
Education, Training and Research (ETR) Management Sub-Committee	In addition the report recommended the establishment of an ETR Management Sub-committee to be representative of the spectrum of healthcare professions and HSE executive management and responsible for the co-ordination and alignment of all education and training and research functions throughout the HSE.	Establishment of ETR Management Subcommittee.	Q1	Office of CEO
		Training and education priorities identified and agreed for 2008 with training bodies.	Q1–Q2	
Quality and Risk				
Corporate Safety Statement	Completed and signed off by Management Team and implementation commenced.	Recommendations of Site Specific Statement Project Plan submitted to Risk Management Steering Group.	Q2	Office of CEO / NHO / PCCC / Pop Health
Develop and commence implementation of a Risk Management Framework	Site Specific Safety Statement Project group convened to review the Site Specific Statement Project Plan.	Implementation of Site Specific Statement and Guidelines.	Q4	Office of CEO / NHO / PCCC / Pop Health
Ethnic Minority Services				
National Intercultural Strategy *was developed against a backdrop of the increasing ethnic and cultural diversity in Irish society. New challenges exist in developing appropriate, effective mechanisms of providing health services to a diverse group of service users, many of whom have unique and distinctive health and support needs.*	Completion of National Intercultural Health Strategy	Intercultural Health Strategy Implementation Plan developed.	Q4	Office of the CEO / PCCC

MEASURING PERFORMANCE IN OFFICE OF CEO

Measurement	Projected Outturn 2007	Target 2008
PQs Number of PQ's received and for which a reply is issued within 15 working days.	3,200	Time to reply reduced to 15 days
HSE National Information Line –		
No. of calls received	70,000	Demand led
Ministerial and public representations		
No. received	3,062	Demand led
Complaints *(see additional measures in Section 10)*		
No. of complaints	7,000	Demand led

ESTATES

The role of Estates is to maximise the health physical infrastructure from a combination of existing assets, government funding and private investment. This physical infrastructure is to be aligned with and support the NSP.

Estates Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Development of national structure and facilities / estates strategy *(TP 11:1-6)*	Directorate populated. Estates Strategy documented. Implementation of strategy commenced.	Regional structure realignments completed.	Q3	Estates / HR
		Service Level Agreement (SLA) with directorates established.	Q2	Estates / PCCC / NHO
Primary Care Estate Roll out	Standard specifications agreed and distributed. Procurement methodology finalised.	20 new centres contracted for each quarter.	Q1-Q4	PCCC / Estates
Mater Adult Hospital Development	Site works commenced. Planning permission achieved.	Construction commenced.	Q2	Estates
National Paediatric Hospital	Development Board in place. Site transferred. Framework brief completed.	Design Brief completed.	Q4	Estates
		Costings established.	Q4	
Capital Plan on time	Capital Vote completely spent (tracking >30% above '06 profile throughout year). Quarterly reporting established.	Minor Capital approved and issued in advance.	Q1	Estates
		Leasing costs established in separate revenue stream.		
Uniform Property transactions	Single National Database established. Protocol revised and issued. Clear quarterly reporting established.	Reconcile staff work locations with database.	Q2	Estates
		Medium term property plans established and distributed.	Q1	
		90% adherence to plans.	Q3	
		Land disposal methodology reviewed and approved.	Q2	
		3 large sites released to market.	Q4	
Office Estates	15 largest offices reviewed. Internal meeting / conference room booking established.	Achieve 95% occupancy in all offices.	Q3	All
		80 meeting rooms in National Programme.	Q2	
Elderly long term care	Established Community Nursing Unit (CNU) design. Established good VFM cost and timescale drawdown contracts.	Build 12 CNUs in 2008.	Q4	Estates
		Establish advanced sites for 2009 and 2010 programmes.	Q4	
Quality	Draft standards and guidance developed.	Formalise and document relationship with HIQA.	Q1	Estates
		Complete level 1 standards.	Q3	

FINANCE

The key focus of the Finance Directorate during 2008 is the establishment of an integrated financial management system, the continued focus on standardising procedures throughout the disparate finance functions in preparation for a single financial management system; the completion of the finance structure; recruitment within the regions and at corporate level; the development and implementation of a HSE Value for Money Strategy.

The Finance Directorate provides strategic and operational financial support and advice at all levels across the HSE. This includes the development of policies for financial planning, and control, and supporting and assuring the implementation of theses policies throughout the management system. The Directorate is also responsible for the preparation and interpretation of monthly, bi monthly and annual financial reports.

The introduction of revised accounting arrangements in January 2005 associated with the Chief Executive Officer of the HSE becoming the Accounting Officer for the Executive's Vote has had particular implications for the Directorate in supporting the CEO in his role, and in respect of the working and reporting arrangements on behalf of the Executive with the Department of Health and Children, the Department of Finance, the Comptroller and Auditor General and the Paymaster General.

Finance Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Structure	Recruitment of General Managers commenced.	Appointment of Senior Finance Managers completed.	Q1	Finance
Systems	Pending the recommencement of the project to implement a single financial management system for the HSE, the interim Corporate Reporting Solution (CRS) implemented in early 2006 was expanded in 2007 to include the voluntary acute hospitals and major disability agencies.	Infrastructure to support the implementation of a standardised national financial system in 2008 established.	Q2	Finance
		Implementation of a single financial management system for the HSE commenced.	Q2	
Training	Steering committee continued the work of implementing a Continuous Professional Development (CPD) programme in association with the Association of Chartered Certified Accountants (ACCA). Continued to establish a single Personal Development Plan (PDP) template to be used for CPD purposes.	Formalised programmes of continuing professional development for Finance Staff established, in association with the National Accounting Bodies.	Q2	Finance
National Shared Services *(TP 7.7)*	Processes for Migration agreed and signed off.	People and process migration to Shared Services, on a process or location level, commenced.	Q1	Finance
Vote, Cash and I&E	Enhanced integration of Vote, Cash and I&E issues was achieved in 2007.	Enhancement of reporting, reconciliation and performance monitoring arrangements around Vote, Cash and I&E.	Q1-Q4	Finance
Capital Reporting	CMOD approval for development of the B-plan system received and software developments underway.	B-plan system rolled out nationally to LHO Managers and Network Managers.	Q1	Finance

Finance Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
New Financial Regulations *(TP 7.5)*	Supported the implementation of New National Financial Regulations throughout the HSE through information and training at local level.	Further modules beyond Purchase to Pay developed.	Q4	Finance
		Vote and Cash management implications addressed in national financial regulations.	Q1-Q4	
Devolved Budgeting *(TP 7.2)*	Not applicable	A model for the effective management of the health service budget on a devolved basis developed and implemented.	Q4	Finance
Funding Mechanism	Progress report submitted to September Board meeting. Linkages with Health Research Board project refined. Governance structures agreed. Detailed collation of current expenditure commenced to establish baselines. Integrated and adaptive processes of funding and delivery.	Recommendations of the review in terms of re-engineering the funding and resource distribution process further developed.	Q1-Q4	Finance
		Initiatives piloted in specific locations.	Q1 – Q4	
VFM Programme *(TP 7.3)*	Steering Group agreed to drive strategy for VFM and to agree and monitor work programme. High level approach to defining value was signed off by the VFM Steering group and will form a basis for developing the overall Strategy and Action Plan.	Relationships throughout the HSE to establish VFM priorities further developed.	Q1-Q4	Finance
		Strategic plan for VFM agreed by Management Team and the Board. (See Section 7 on VFM on page 103).	Q1	

ICT

The National ICT Directorate has responsibility for the delivery of value-adding ICT services and supports across the HSE. At corporate level, the Directorate is responsible for the strategic elements, working as appropriate with the DoHC and the Department of Finance.

The Directorate works in partnership with all directorates to ensure that the programme of ICT projects that are undertaken is closely aligned with service needs, and that the projects are effectively managed to deliver speedy, high-quality results within the constraints of funding and capacity to deliver.

ICT Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Continued reliable operation of critical systems and services *A significant amount of the ICT resources are dedicated to the support and maintenance of over 30,000 users, many hundreds of systems, and the largest ICT network in the country.*	No loss of critical systems or services.	Maintain and enhance existing systems and services throughout the year.	Q1-Q4	ICT
Structural Transformation *(TP 10.5) A key ICT objective is to implement the agreed ICT Directorate Structure nationally while ensuring continued focus on service delivery and implementation of national projects.*	Assessment of current position in ICT. Design of ICT Directorate function in partnership with IMPACT Working Group, Consultative Group and DOHC. Integration of the Shared Services ICT Function into the ICT Directorate.	All ICT staff reassigned into the new structure as per the agreed transition plan while ensuring that the existing levels of service are maintained and enhanced through the year.	Q1	ICT
ICT Capital Plan: *Develop and agree an ICT Capital Plan for all ICT enabled Programmes and Projects with all key stakeholders.*	Capital Plan 2007 agreed with ICT steering group and external stakeholders.	Multi annual ICT Capital Plan 2008 approved. • €70m approved for 2008. • Revenue implications specified as per Estates Capital Plan.	Q1	ICT / PCCC / NHO / Finance / Estates
	ICT Capital planning framework agreed with Finance Directorate.	ICT Capital Plan delivered on budget and on time.	Q4	ICT / PCCC / NHO / Finance / Estates
		Framework agreed with the DOHC to ensure the revenue and WTE implications of ICT projects are incorporated in the planning process.	Q1	ICT / Finance
ICT Governance and Organisation *(TP 10.4)*	Established ICT governance group for the HSE and major service areas. Commenced the development of best practice in programme and project management. Worked with DoHC and Department of Finance on implementing ICT financial control procedures and peer review of key projects.	Project approval framework for all projects implemented.	Q1	ICT / Finance
		Agreed project management methodology for key projects implemented.	Q4	ICT / Finance
		National ICT Chart of Accounts implemented.	Q1	Finance
		Financial Regulation for ICT sanction developed and implemented.	Q2	ICT / Finance

ICT Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Staff Development	Proposal for ICT Staff Development multi annual plan agreed with Human Resources.	Staff Development action plan for 2008 implemented.	Q1-Q4	ICT
National Infrastructure: *Improve information transfer and electronic communication across the HSE. (TP 10.1)*	Complete the National Health Network as per action plan from the ICT Infrastructure Review. Single electronic content platform provided. Priority infrastructural deficits addressed by undertaking a minor capital infrastructure programme.	ICT infrastructure policies delivered.	Q1-Q4	ICT
		ICT Capital Infrastructure programme in line with the transformation and capital plans delivered.	Q4	
ICT Strategy: *Establish a vision for ICT within the Health Services and a 3 year strategic framework.*	Formulated and submitted ICT Strategy to Management Team and Board.	Action plan for ICT Strategy developed.	Q1	ICT
		Delivery of the action plan for ICT Strategy commenced.	Q2	

INTERNAL AUDIT

Internal Audit is a key element of HSE's governance framework. It is an independent and objective appraisal function established to provide assurance to the Board and to the CEO, as accounting officer, on the adequacy of and degree of adherence to the system of internal control in areas audited.

The role of Internal Audit is to provide an objective view, which is independent of management, that systems, procedures and controls operated by management are being complied with and are capable of achieving policy objectives. To fulfil this role, the Internal Audit Directorate carries out reviews and evaluations of systems and internal controls and reports its findings and recommendations to the Audit Committee, CEO and the Management Team. The National Director of Internal Audit reports to the Chairperson of the Audit Committee and has a close working relationship with the CEO.

Internal Audit Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Develop Structures for Internal Audit (IA) Function	Interviews held for senior management posts. Successful candidates waiting to take up posts.	Senior management structure (excluding ICT and special investigations) in place.	Q1	Internal Audit
Audit Training Programme	Delivered certificate in Audit Skills training programme.	Follow-on audit training programme for IA staff developed.	Q4	Internal Audit
		Professional training and development programme for internal audit staff agreed and implemented.	Q4	
Audit seminar	IA staff seminar held.	IA staff seminar held.	Q2	Internal Audit
		Audit / Governance seminar held.	Q4	
Audit Plan	Development and approval by audit committee of 2008 audit plan.	Annual audit plan 2008 completed.	Q4	Internal Audit
Internal Audit Reports	Completion of a substantial number of internal audit reports, identifying recommendations to management to improve the system of internal controls.	Delivery of a substantial number of internal audit reports, identifying recommendations to management to improve the system of internal controls.	Q4	Internal Audit
Special Investigations	Special investigations carried out.	Special investigations carried out as required.	Q1-Q4	Internal Audit
Automated Workpapers		Appropriate IT package procured and piloted by Internal Audit.	Q1	Internal Audit
Management Support	Provided advice to Senior Management throughout 2007.	Advice provided to Senior Management throughout the year.	Q1-Q4	Internal Audit
		Briefings provided for regional forums and National Directorates' management teams on the general results of audits.	Q1-Q4	
Policies and Procedures	Assisted in the development of National Financial Regulations, Management Framework for services provided by the non-statutory sector, Risk Management Framework and other policies and procedures.	Assist in the development of National Financial Regulations, as applicable.	Q1-Q4	Internal Audit
		Assist in the development of HSE policies and procedure, as applicable.	Q1-Q4	

PROCUREMENT

Procurement has responsibility for strategic sourcing, tendering and contracting for all of HSE's non pay expenditure and provision of a proactive materials management capability at the point of use in all areas of the HSE.

Procurement Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Implementation of New Procurement Operating Model *(TP 13)*	Assistant National Directors appointed. Business Case to Support New Model developed.	Continued Procurement Transformation to support the needs of overall transformation of HSE.	Q1	Procurement
Implementation of National Portfolio and Category Management Approach *(TP 13)*	New Portfolio and Category Management (P&CM) organisational model agreed and approved posts populated including re-pointing of senior managers. Portfolio and Category Management has managed and supported major procurement projects across all areas and directorates, including Hospital Co-Location, Corporate Pharmacy Unit, Insurances, Ambulances, Capital Equipping projects etc.	Continued development of Portfolio and Category management organisation with responsibility for strategic sourcing, tendering and contracting for all non pay expenditure.	Q1-Q4	Procurement
		Recruitment and appointment of the Assistant Heads of Portfolio and Category Management finalised.	Q1	Procurement
		Strategic review of expenditure undertaken, identifying priority areas for sector wide contracting initiatives.	Q3	Procurement
Implementation of National Approach to Logistics and Inventory Management *(TP 13)*	Assistant National Director as Head of Logistics and Inventory Management recruited and appointed.	Logistics and Inventory Management transformed to provide a proactive materials management capability at the point of use in all areas.	Q1-Q4	Procurement
	Three Assistant Heads of Logistics and Inventory Management recruited.	Recruitment and appointment of the Assistant Heads of Logistics and Inventory Management finalised.	Q1	Procurement
	Existing Logistics and Inventory Management structure repointed (within the control of the former Regional Material Managers) to the New Management Team for Logistics and Inventory Management. Discussions initiated with the other Directorates regarding the repointing of logistics staff in areas outside of Procurement. Review initiated of the 'As Is' Operating Model for Logistics and Inventory Management in the HSE.	Development and implementation approach for the Future Operating Model for Logistics and Inventory Management finalised.	Q2	Procurement
Implementation of communications, training and customer relations (CTCR) programmes *(TP 13)*	Organisational structure to support CTCR defined. Interim Training Strategy completed. Established Linkages with National and Regional Performance and Development Units and Corporate Communications.	Communications, training and customer relations structures developed to support the new procurement operating model.	Q1-Q4	Procurement
		Continued targeted communications to key audiences including Procurement staff, HSE staff and Supplier Base.	Q3	Procurement

Procurement Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
	Communications organised on Transformation Programme. Procurement Newsletter launched. Scope for Procurement Communications Strategy defined. Draft Framework for Customer Relationship Management (CRM) model drafted and completed. Data gathering exercise completed.	CRM model finalised to support Procurement and its customers and requirements regarding CRM technology specified.	Q4	Procurement
Implementation of required business supports *(TP 13)*	Business Support Organisation established. Business Case for Spend Analysis Business Warehouse submitted. E-tenders bid management and tender management development requirements specified.	Knowledge management solutions developed and implemented to support the new operating model, including specific solutions to support the Portfolio and Category Management and Logistics and Inventory Management organisation.	Q1-Q4	Procurement
		Develop and implement high performance procurement processes and procedures to underpin the new operating model.	Q1-Q4	Procurement
Transition and Development of new procurement operating model *(TP 13)*		Collate and report procurement transformation programme status (fortnightly) to the Procurement Leadership Team and the Overall Transformation Programme Office.	Q1-Q4	Procurement
		Maintain and Manage the Procurement Transformation Programme Risk Register.	Q1-Q4	Procurement

CORPORATE PLANNING AND CONTROL PROCESSES

The Corporate Planning and Control Processes Directorate is responsible for driving corporate planning by adopting best practice processes and methodologies across the organisation. The Directorate is responsible for developing, leading and monitoring the HSE's Corporate and Service Plans through the HSE's Business Planning Model and Performance Monitoring and Measurement Framework. It is also responsible for ensuring the HSE complies with its legislative requirements in relation to planning and monitoring the annual NSP.

CPCP Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Corporate Plan (2008-2010) *Our Corporate Plan outlines our Agenda for 2008 – 2010, taking cognisance of our Transformation Programme*	Review of Corporate Plan 2005-2008 undertaken Preparation of new Corporate Plan, 2008 – 2010 underway.	Corporate Plan 2008 – 2010 finalised and presented to the Board.	Q1	CPCP
		Corporate Plan published and circulated.	Q1	
Values *(TP 6.8): Develop a set of organisational values that are reflective of our organisational ethos.*	Process agreed. Consultation undertaken. Values agreed.	Values published.	Q1	CPCP
		Values embedded into organisation through a communication process	Q3	
NSP 2008 and Business Planning Model: *To enable a streamlined, efficient and effective process for the preparation of NSP 2008 supported by our Business Planning Model. A key component in an organisation's success is the strength of its business planning processes. The adoption of a consistent approach to planning through each level of the system offers significant benefits and will enhance comparative analysis, transparency, efficiency and integration.*	Business model for 2007 rolled-out. Monthly and quarterly PMRs prepared. Workshops held with Directorates to review NSP 2007. Desktop evaluation on other models of service and business planning undertaken. Format and content agreed, with DoHC, on NSP 2008. NSP 2008 finalised and endorsed by Board and DoHC. Business Model for 2008 agreed including Performance Monitoring and Measurement Framework.	Training Programme to support business planning developed and rolled-out.	Q1	CPCP
		NSP 2008 implemented through roll-out of Business Planning Model and preparation of Business Plans at each level of the organisation.	Q1	
		Performance Monitoring and Measurement Framework rolled-out.	Q1	
		Monthly and quarterly Performance Monitoring Reports prepared in line with management control and legislative requirements.	Q1-Q4	
		NSP 2009 prepared (including Estimates process), in partnership with Directorates.	Q2 -Q4	
The ***Corporate Control Process*** *enables regular reviews of performance information. It provides an early warning system of key remedial actions which may need to be taken thus ensuring the application of a consistent corporate approach.*	Framework for Corporate Control Process developed. Preparation and co-ordination of monthly meetings and follow-up.	2008 Control Process developed.	Q1	CPCP
		Ongoing support to Corporate Control process.	Q1-Q4	
		Systems and processes developed to support system-wide performance management.	Q1	

CPCP Focus	Output 07	Deliverable 08	Target Timescale	Lead Responsibility
Performance Measures *(TP.5)* *To improve performance measurement while ensuring we are achieving the best possible outcomes for the funding we have been allocated.*	Joint mechanism agreed between HSE and DoHC. Cross Directorate PI Evaluation Group in place. Process agreed for identification of PIs and measures for 2008. Suite of PIs and measures agreed for inclusion in NSP, 2008.	Lead the process to evolve and embed PIs and Measures in the organisation.	Q1-Q4	CPCP
		Support integration of different data sets to ensure single system approach to performance assessment	Q1-Q4	
		PIs and Measures for inclusion in NSP 2009 agreed.	Q3	
Planning Governance Group *To ensure that there is a cohesive and integrated approach towards planning.*	Robust mechanisms in place which promote and facilitate corporate integration.	Cohesive and integrated approach towards planning through working with the Planning Governance Group further developed.	Q1-Q4	CPCP
Transformation Programme	Transformation Programme: Membership of Steering Group for Projects 1, 5 and 6.	Organisational engagement with Health Forum supported.	Q1-Q4	CPCP

SECTION 10

MONITORING AND MEASURING OUR PERFORMANCE

SECTION 10 - MONITORING AND MEASURING OUR PERFORMANCE

The HSE Business Model

As outlined in the introduction to the NSP, our business model is the tool which services use to plan and monitor the delivery of their services and is how we hold our own system to account, at each level of the health delivery system, through our Performance Monitoring and Measurement Framework. This ensures that we are reporting on achievement against our objectives, within allocated resources and approved employment levels and taking the necessary corrective action as appropriate. The business model is supported through a strong performance management approach across the system. Our framework ensures that implementation of the NSP is in accordance with our legal obligations in accounting to the Minister for Health and Children for the provision of services as specified in our Plan.

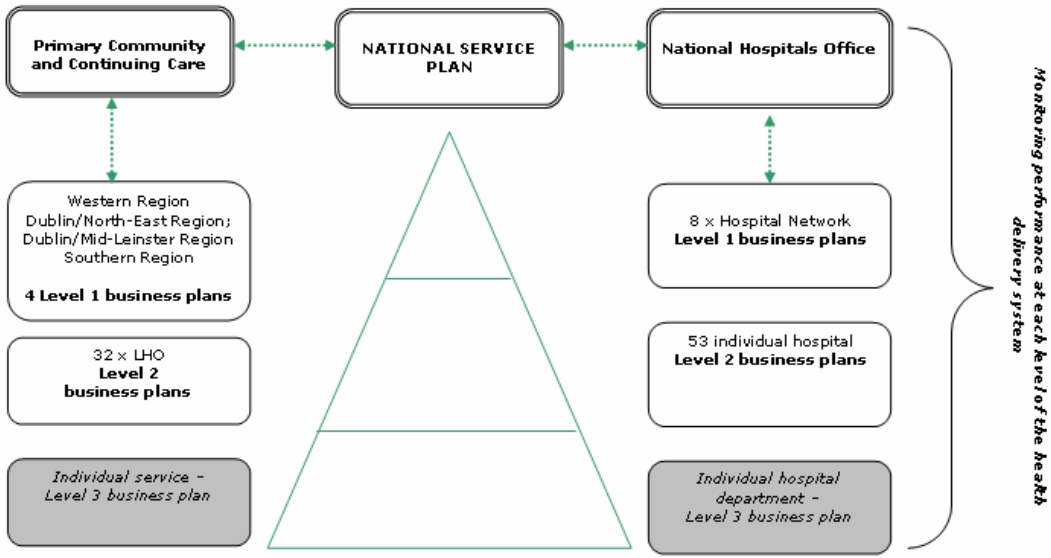
The business planning process shown in Figure 1 illustrates the business model for service delivery in PCCC and NHO.

This model is used by all service delivery and support services in order to facilitate delivery of the NSP by the Executive during the year.

Business Plans (Levels 1, 2 and 3) are used at the relevant levels of the organisation and provide a consistent approach for all Directorates to ensure that the national deliverables are translated into local deliverables at all levels of the system.

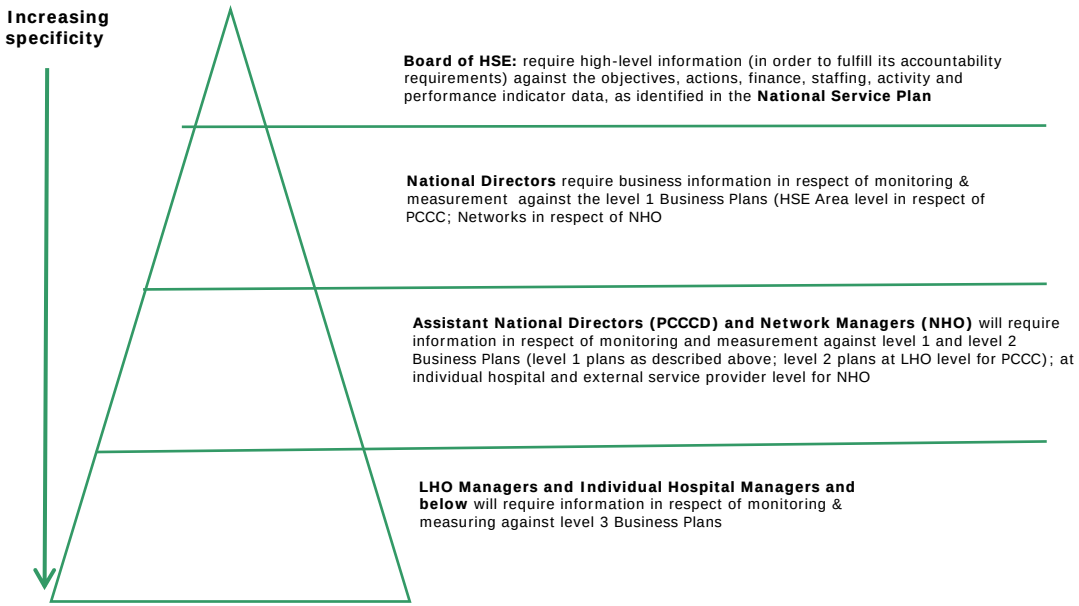
The adoption of a consistent approach in planning through each level of the system offers significant benefits and enhances comparative analysis, transparency, efficiency and integration. This model ensures that each level of the system, down to service unit or department level, has a business plan requiring it to deliver a defined set of deliverables within the resources (human and financial) allocated.

Figure 1: Business Model 2008, illustrating PCCC and NHO



Monitoring our performance, as shown in Figure 2, occurs internally at various levels in the organisation, from service delivery, to corporate and Board level. Externally we are accountable to government through the Minister for Health and Children. We are also continually monitored by the public we are here to serve. A consistent approach to performance monitoring and measurement must occur at each level of the health delivery system. In addition we recognise that different users of performance information have different requirements.

Figure 2
Internal Requirements for Information and its Uses



Measuring and Monitoring Performance

We will continue to invest in our ongoing commitment to improving measurement and reporting across the organisation. If we are to honestly measure how we as an organisation meet our objectives, we must continually strive for information that is consistent, reliable, verifiable and robust. As a complex organisation, this continues to pose many challenges for us at all levels throughout the HSE. Long term investment will be required to ensure that the data we produce can be utilised in such a way as to improve the quality and delivery of our services.

Work has been ongoing to build on and further develop the performance indicators and measures that were used in 2007. Some of last years measures have formed the baseline data on which to develop performance indicators for 2008. It is recognised that this work will continue in 2008 particularly with regard to developing measures and indicators that will support services to monitor performance at all levels.

The majority of indicators and measures have targets; however in some areas, particularly activity, the target identified is more of an indicator of expected activity levels. Some areas identify a baseline for 2008 as apposed to a target, which in time will be developed into targets.

At Corporate level, investment in a Corporate Performance Measurement System was commenced in 2007 to develop a tool for the CEO, Senior Management Team and Board to focus on specific aspects of improvement. Corporate performance measurement is the use of a targeted set of measures to portray how the organisation is doing in meeting its major objectives, the impact of services on users and their experience using them. It is based on the HSE corporate objectives and transformation priorities and describes overall corporate performance across and within the HSE. This tool will be further developed in 2008 with the intention of cascading it throughout the system for line management to use and focus on aspects for specific improvement in hospitals and local health offices; it is also an important means of providing feedback to staff.

A cross directorate group has been working in partnership with the Department of Health and Children to identify indicators and measures that account for and give added value to the services we deliver. In addition as part of the Control Process, a Metrics Group has identified additional drivers for the system which we will collect and measure for the first time in 2008.

All this work is but the beginning of a long process to continually improve quality, measurement and reporting across the organisation.

The Performance Monitoring and Measurement Frame work will be strengthened in 2008, with measures of quality, access, health improvement, value and productivity included for reporting and benchmarking at national and international level. In some cases, particularly for health improvement outcomes, the targets for these measures are identified over a longer three year period as it is recognised that the target cannot be achieved in one year, rather the focus will be a progressive year on year strategic improvement.

Focussing on a number of key performance areas, this suite of information will assist in driving efficiency for improving the patient experience system-wide, including:

- Refocus from inpatient to day case.
- Reduce average length of stay and set discharge targets.
- Increase surgical admission rates on the day of surgery.
- Reduction in the length of wait for inpatient and day care.
- Implement strategies for hospital avoidance (Winter Initiative).
- Improve community based access to diagnostics.
- Reorganisation of cancer services.
- Reduce hospital acquired infection rates.

Reporting

Performance monitoring and measurement of services delivered by HSE is undertaken and reported monthly and quarterly in the HSE Performance Monitoring Reports under the key organisational areas of PCCC, NHO, Population Health, Human Resources and Finance. In addition, specific areas or programmes within the services e.g. Winter Initiative and Transformation Projects provide regular report on progress to a variety of audiences. Some measures are only reported at specific times in the year i.e. annually or bi-annually in a specific quarter. In whatever reporting format, we are committed to measuring and communicating our performance in an open and transparent way.

Control Process

Central to success is the relationship between responsibility, authority and accountability and how this forms the basis of our governance arrangements from CEO to National Director and throughout the system.

By 1st January, 2008, all managers will have received their budgets, their approved employment ceilings and their expected service delivery commitments. Managers will be held accountable for their performance against budget and in respect of service delivery.

In addition to the performance management arrangements, a Corporate Control Group was put in place in 2007 to review and validate organisational performance in the key areas of financial performance, human resource management and the achievement of targets identified in our NSP. These control mechanisms will continue in 2008 and be further strengthened.

Key for Summary Tables

The following pages identify the performance indicators and activity measures that we intend to report on in 2008. Performance Indicators as defined and agreed with DoHC are indicated by **(PI)** next to the indicator.

NA signifies not available

- signifies not applicable

Projected Outturn 07 based on Quarter 3 07 outputs.

HSE Accountability Indicators and Activity Measures Suite

PRIMARY CARE

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality and Access	Efficient and timely information available to General Practice.	**GP Information / Communication Technology (PI)** a) The percentage of GMS GP Practices with Information / Communication Technology links to hospitals.	Annually Q3	46% (based on 23 LHOs)	This will be examined in the context of the ICT requirements of Primary Care Teams.	PCCC ICT Council develop a 3 year action plan to progress business needs of General Practice.
	Out of hours General Practice cover provided for all GMS patients.	**GP Cooperatives(PI)** a) The number of GMS GPs involved in GP co-operatives as a percentage of all GMS GPs.	Annually Q3	77% (based on 26 LHOs)	Provide existing level of service.	Progress the roll out of reconfiguration of PCCC services to deliver optimal and cost effective results (TP 2).
		b) The GMS population covered by GP co-operatives as a percentage of the total GMS population.		58% (based on 24 LHOs)		
	GP vocational training developed in partnership with OCGP.	**GP Training** No. of GPs in training	Annually Q3	379	379	Provide existing levels of service.
	GP Visit cards widen the criteria for accessibility without undue hardship, to access a range of primary care services, including general practice.	**GP Cards** No. of GP Visits Cards Issued	Monthly	73,644 (to Oct 07)	Promote the uptake within the eligibility criteria	Promote uptake of scheme within eligibility criteria.
	Medical Card holders are entitled to GP services, community services, dental services, prescription medicine costs, hospital care and a range of other benefits free of charge.	**Medical Cards** No. of eligible persons on medical cards	Monthly	1,264,434 (to Oct 07)	Promote the uptake within the eligibility criteria	Promote uptake of scheme within eligibility criteria.
	Out of hours services are provided through a number of different cooperative models.	**GP Out of Hours** No. of contacts with GP Out of Hours	Monthly	801,000	801,000	Provide existing levels of service having regard to ongoing development of Primary Care Teams.

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Access	Fully functioning PCTs, all holding clinical meetings.	**Primary Care Teams** No. of Primary Care Teams	Monthly	87	187	Develop additional PCTs in line with agreed target numbers.
		% of PCTs holding a clinical meeting **(PI**		45%	100% (for the original 87 teams)	
		% of PCTs with a meeting methodology agreed for clinical meetings		-	Reporting to begin in 08	
		% of PCTs holding a team development meetings				
		% of PCTs with an agreed meeting methodology for team development meetings				
		% of PCTs with an inter-team referral process agreed				
	Persons who suffer from one or more of a schedule of illnesses are entitled to obtain, without charge, irrespective of income, necessary drugs / medicines and / or appliances under the LTI Scheme.	**Schemes – No / of Claims** Long term illness claims	Monthly	530, 000	543, 000	Demand led schemes.
	Persons who do not have a current medical card can benefit for a monthly cut off point for approved drugs, medicines and appliances.	Drug Payment Scheme claims	Monthly	3, 700, 000	4, 240, 000	
	High Tech medicines are supplied through Community Pharmacies.	High tech claims	Monthly	275, 000	309, 000	
	Enables people with illnesses deemed suitable for the scheme to avoid attending hospital at all or to reduce the length of time of their hospital stay.	**Hospital in the Home**	Q1 only	1,174	400 (contract ends Q1)	Provide service until contract expires and review.

DENTAL

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Health Improvement	Improvement in the dental health of our children, leading to less problems in adulthood.	**Child Dental Health (PI)** a) Percentage of school children in designated classes who received dental screening per LHO (annually).	Annually Q3	Approx. 70%	>70% nationally	Establish EAG on Oral Health.
Access	Impact of revised eligibility guidelines will impact on current waiting lists. Waiting times will be monitored on a quarterly basis to asses this impact.	**Orthodontics (PI)** Average waiting time by 'consultant led clinic' for: 1. Orthodontic assessment (Category A: Category B) 2. Orthodontic treatment (Category A: Category B)	Quarterly	Processing transition from DoHC to HSE. Will monitor on a quarterly basis commencing Q4 2007	Will monitor on a quarterly basis	Implement revised HSE Eligibility Guidelines. Establish EAG on Oral Health.
Quality	Water fluoridation levels will be monitored to ensure they remain within the statutory limits.	**Water Fluoridation (PI)** a) No. of water fluoridation schemes	Quarterly	251 schemes inspected. Based on returns from 29 LHOs	Targets for the no. of schemes monitoring within the 5 statutory limits are not appropriate. The % within limits will be monitored on a quarterly basis in line with NSP reporting timelines.	Environmental health office will monitor public water fluoridation schemes. Continue to provide existing levels of service. Target for % within limits is not appropriate.
		b) % of the total number of monthly readings which are within the statutory limits (per region per quarter) in public water fluoridation schemes		49% based on returns from 20 LHOs.		

CHILDREN AND FAMILIES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Access and Quality	Ensure that pre-school services take all reasonable measures to guarantee the health, safety and welfare of pre-school children attending in accordance with the Child Care Act.	**Pre-School (PI)** a) Total number of notified current operational pre-school centre in the HSE Area during the year. (Not Cumulative).	Quarterly	4,700 (est.)	-	Develop national child care standards for preschools. Maintain inspection standards based on new audit tool**.** Note that targets in relation to notifications and no. of operational centres are not possible to determine. These will be monitored in line with service plan
		b) Number of new pre-school centre notified during the year.		570 (est.)	-	
		c) Number and Percentage of notified current operational pre-school centre in the HSE Area where an Annual Inspection took place during the year.		2258 (49.5%)	2145 (-5%)	

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
		d) Number of pre-school Review Visits / Follow Up Visits that took place during the year.		600 (est.)	-	timeframes. The volume of Review / Follow-Up Visits and Advisory visits cannot be anticipated and so targets are not appropriate.
		e) Number of pre-school Advisory Visits that took place during the year.		1, 500 (est.)	-	
	To ensure best practice in childcare and that children are placed appropriately. Care planning and the provision of a social worker is seen as a vital element of the quality provision of children in our care. Compliance with 1995 Child Care Regulations and National Foster Care Standards 2003.	**Residential and Foster Care (PI)**	Quarterly			Target setting for a number of line items in our current set of activity measures is not appropriate. These will be monitored in line with NSP reporting timelines. Provide existing levels of service. Care planning is a priority for HSE childcare services and a particular focus in 2008 will be to double the number of children coming into care with a written care plan. Its impact will be tracked through quarterly monitoring. An increase in the number of children in Foster Care with a written care plan will also be a priority. Our proposed review of Foster Care Standards will assist in the achievement of this target. The HSE is committed to increasing the number of children in care with an allocated named social worker. Its focus in 2008 will be on increasing the percentage in residential care with an allocated Social Worker from its projected 90% outturn to 95% by end 2008. This will be achieved through its review of High Support and Special Care Units.
		a) The Number and Percentage of children in:				
		i. Residential care (Note: Include Special Arrangements).		426 (7.8%)	426 (7.8%)	
		ii. Foster care (Note: Do not include Day Fostering).		3,327 (60.8%)	3,327 (60.8%)	
		iii. Foster care with relatives.		1,530 (28.0%)	1,530 (28.0%)	
		iv. Other Care Placements / At Home under Care Order.		191 (3.5%)	191 (3.5%)	
		b) How many of the above, currently have a written care plan as defined by Child Care regulations 1995.				
		i. Residential care (Note: Include Special Arrangements).		65%	70%	
		ii. Foster care (Note: Do not include Day Fostering).		64%	70%	
		iii. Foster care with relatives.		62%	70%	
		iv. Other Care Placements / At Home under Care Order.		65%	70%	
		The number and percentage of children who came into care during the reporting period who had a care plan drawn up prior to placement. **(PI)**		20.3%	40%	
		c) Percentage of children in care who has an allocated named social worker. **(PI)**		90%	91%	
		Residential care (Note: Include Special Arrangements).		90%	95%	
		Foster care (Note: Do not include Day Fostering).		88.7%	90%	
		Foster care with relatives.		84.4%	86%	
		Other Care Placements / At Home under Care Order.		88.2%	90%	
		d) The number and percentage of children for whom a review was due during the reporting period and the review took place.		64%	70%	

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
		e) The number and percentage of children for whom a review was due during the reporting period and the review did not take place.		36%	30%	
Access and Quality	Provide services in compliance with S.I. No. 549 / 2004 Children (Family Welfare Conference) Regulations 2004.	**Family Welfare (PI)** a) Total number of referrals to Family Welfare Conferences in the reporting period	Quarterly	423	444	Provide existing levels of service.
		b) Total number of Family Welfare Conferences convened in the reporting period.		216	227	
		c) Number of Family Welfare Conferences convened				Note that targets around the outcome of FWC are not appropriate but will be tracked though quarterly monitoring.
		i) within 28 days of referral		64	-	
		ii) 28 - 35 days following referral		34	-	
		iii) 35 days or more following referral		117	-	
		d) Of the total number of Family Welfare Conferences convened, how many had the following outcomes			-	
		i) recommend to HSE to apply for Supervision Order		3	-	
		ii) recommend to HSE to apply for Special Care Order		48	-	
		iii) recommend to HSE to apply for Care Order		2	-	
		iv) recommend to HSE that Voluntary Care Order is required		4	-	
		v) recommend to HSE to return to Relative Care		5	-	
		vi) recommend to HSE that child remains at home and Community Based Support Plan is implemented with format supports from HSE services.		58	-	
		vii) recommend to HSE that child remains at home and Community Based Support Plan is implemented with informal supports		52	-	
		viii) No plan agreed		2	-	
		ix) Other (Please specify in commentary)		52	-	
		e) Number of prepped / planned Family Welfare Conferences not convened in the reporting period		120	-	
Quality and Health Improvement	Child protection and welfare services are provided by the HSE in accordance with legislative obligations and policy documents	**Child Abuse (PI)** For each HSE region, the a) number of notifications made of child abuse or neglect b) number of assessments conducted following notifications	Quarterly	N / A	Target to be developed in 2008	Reporting against this measure is based on the phased implementation of standardised business process through Childcare Information System project.

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
	based on legislation.	c) number of children on waiting lists for assessments following notification of child abuse or neglect d) average time spent on a waiting list for assessment following notification of child abuse or neglect				Work towards quarterly reporting from Q2 based on implementation
Quality	Springboard projects respond to the most vulnerable children and families in their own home.	**Springboard Projects** a) Total number of families referred to Springboard Projects in the reporting period.	Monthly	786	786	Provide existing levels of service through Springboard projects.
Access	Address the occupancy levels in high support and special care units.	**Special Care-Units**	Monthly			A schedule was put in place in 2007 to maximise the occupancy levels of units. This schedule will impact on the occupancy levels of High-support in 2008.
		a) Bed Nights Used		930	930	
		b) Occupancy levels		84%	84%	
		High Support Units				
		a) Bed Nights Used		2,635	2,899	
		b) Occupancy levels		58%	68%	
	Progress commitments in Towards 2016 to Teen Parent Support Programme.	**Teen Parent Support Programme** No. of clients	Monthly	1,200	1,200	Continue to provide existing levels of service.

CHILD AND ADOLESCENT HEALTH

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Health Improvement / Quality	Advice and support given to families of all new born babies on feeding, immunisations, accident prevention, post natal depression, etc.	**PHN Visits – Newborn (PI)** Number and Percentage of new born babies visited by a Public Health Nurse (PHN) within 48 hours of hospital discharge.	Quarterly	34,137 (71%)	34,137 (71%)	Provide existing levels of service.
	Early detection of childhood illnesses.	**Developmental Screening (PI)** a) The percentage uptake of developmental screening at seven to nine months	Quarterly	-	To begin reporting in 08	Improve screening services for earlier detection.
		b) Number of boys 0 - 4 years (inclusive) with undescended testes undergoing orchidopexy (ICD-10 AM 37803-01, 37803-00) as a percentage of all boys aged 0-15 years (inclusive) with undescended testes undergoing orchidopexy.		0-4 yrs n = 302 0-15 yrs n= 522 58%	70%	

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Health Improvement	Cost effective reduction in childhood morbidity and mortality. Evidence shows that early childhood health and development will have a significant impact on the health outcomes achieved as adults.	**Immunisations (PI)** a) Number and Percentage of children 12 months of age who have received three doses of vaccine against Diphtheria (D3), Pertussis (P3), Tetanus, (T3), Haemophilus influenzae type b (Hib3), Polio (Polio3), Meningococcal group C (MenC3).	Quarterly	87%	90%	Increase immunisations rates in all regions to that pertaining in the best region. **Work towards 95% nationally by 2010.**
		b) Number and Percentage of children 24 months of age who have received three doses of vaccine against Diphtheria (D3), Pertussis (P3), Tetanus (T3), Haemophilus influenzae type b (Hib3), Polio (Polio3), and an age appropriate number of doses of Meningococcal group C (MenC3).		91%	93%	
		c) Number and Percentage of children who have received MMR at 24 months of age.		87%	90%	
Health Improvement	Achieve optimal growth, development and health.	**Breast Feeding (PI)** a) The percentage of babies who are exclusively breastfed at the PHN first visit.	Quarterly	33.2%	33.2%	Support new mothers to continue breastfeeding.
		b) The percentage of babies who are exclusively breastfed at three months.		19.5%	20%	

MENTAL HEALTH

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Access and Quality	Increase in effectiveness of community based services, the appropriateness of intervention with various care groups and the effectiveness of inpatient interventions and integration with community services.	**Acute Units (PI)** a) Number of inpatient places by 100,000 population.	Quarterly	30.7	30.7	A number of additional Child and Adolescent Psychiatry Inpatient beds will be developed over the course of 2008 which will impact on the number of places available, rates of admission, first admission and re-admission. As these developments come on stream their impact will be reflected in our quarterly reporting against this measure.
		b) Admission rates to acute units, per 100,000 population.		96.7	96.7	
		c) First admission rates to acute units (that is, first ever admission), per 100,000 population.		26.4	26.4	
		d) Inpatient re-admission rates to acute units per 100,000 population.		70.3	70.3	
		e) Median length of stay.		12	12	
	In line with Vision for Change we are committed to development and enhancement of CMHTs.	**Community Mental Health Teams** No of CMHT.	Monthly	47	55	Develop Community Mental Health Teams.

OLDER PEOPLE SERVICES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Health Improvement	Prevent respiratory complications and save lives.	**Influenza (PI)** Percentage uptake of influenza vaccine among the GMS population aged over 65 years.	Annually Q3	63%	Promote uptake of vaccine	Continued promotion of flu vaccine uptake. **Achieve target of 75% by 2010.**
Access and Quality	To allow not less than 90% of the total population over 75 years should be able to continue to live at home.	**Residential (PI)** a) Number of people aged 65 – 74 years in residential continuing care settings, i.e. HSE Area and other residential continuing care settings, including private and voluntary, as a percentage of the total population aged between 65 – 74 years. b) Number of people aged 75 years and over in residential continuing care settings, i.e. HSE Area and other residential continuing care settings, including private and voluntary, as a percentage of the total population aged 75 years and over.	Annually Q3	9%	< 10% over 75 in residential care	Provide home and community based services and supports such as home help hours and home care packages, in addition to core community services aimed at maintaining older people in their own homes
Access And Quality	Government policy states that community and home based care should be developed to maintain older people in their own communities for as long as possible.	**Home Help Hours** a) Total No. of Home Help hours b) No of hours monthly c) No of clients in receipt of home help Hours	Monthly	11,780,000 981,000 53,000	11,780,000 981,000 53,000	Provide existing level of service.
	Home care packages including home care cash grants are designed to: • Facilitate timely discharge of older people from acute hospitals • Reduce inappropriate admissions • Reduce pressure on EDs • Support older people to continue to live in their own community.	**Home Care Packages** a) Total no of packages by region / expenditure (equivalents) b) Total no of new packages (equivalents) by region / expenditure. c) Total no of cash grant packages d) Total no. of new clients.	Monthly	4,350 – – –	4,350 Reporting will begin in 2008 Reporting will begin in 2008 Reporting will begin in 2008	Provide existing levels of service. Note measure (b) through (d) will be reported against in 2008.
	Day care is provided to all people who require it.	**Day Care** Total number of day care places by region	Monthly	21, 300	21, 300	Continue to provide existing levels of service.

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
	Provides a hot meal to people of any age for people who are unable to cook for themselves.	**Meals on wheels** Total no. of clients in receipt of meals on wheels.	Monthly	_	Reporting will begin in 2008	Reporting will begin in 2008.
	Post implementation of 'Fair Deal' only persons in receipt of subvention prior to FD will continue on existing subvention scheme, if they choose to do so.	**Nursing Home Subventions (for those in homes prior to 1/1/08 and chose not to avail of 'A Fair Deal').** Total Persons in receipt of:	Monthly			In 08, Subvention will only be available to existing recipients if they wish to retain what they have and not change over to Fair Deal scheme. The introduction of a Fair Deal will require an alternative data suite (see below). Data in respect of Subvention recipients will vary in 2008. Consequently a target is not meaningful for 2008.
		a) Subvention (monthly average)		7,800	-	
		b) Enhanced (monthly average).		4,300	-	
Quality and Equity	As of 1.1.08, nursing home subvention scheme will be replaced by a new nursing home support programme 'A Fair Deal'. The scheme will ensure equity of process, with everyone paying a contribution to the cost of their care.	**Implementation of The Fair Deal** a) The number and proportion of people in long-term residential care availing of the Fair Deal broken down by public, private and voluntary facilities. b) The number and proportion of eligible people who choose to avail of the Deferred Charge.	Quarterly	_	Reporting will begin in 2008	Reporting will begin in 2008 once the legislation has been finalised and NTPF negotiations concluded
Quality	Compliance with best practice.	**Inspections of Residential Units** Total number of statutory Inspections carried out (1st and 2nd Inspections amalgamated)	Monthly	100%	100%	Appointments to dedicated nursing home inspection teams will be progressed in 2008. It is anticipated that responsibility for the inspection of Nursing Homes will transfer to HIQA during 2008. An additional 606 public beds are scheduled to come on stream in 2008. Their impact will be monitored through quarterly service plan reporting.
Access	Access to residential care when needed.	**Residential Care** No of public beds	Monthly	10,156	10,156 (plus impact of public fast track beds)	
Access	These schemes play an important role in supporting older people to remain living in the community, in independence and dignity. Sheltered	**Sheltered Housing** a) No of initiatives nationally / by region b) No of SLAs c) Total no of clients	Quarterly	_	Reporting will begin in 2008 in relation to part (a), (b) and (c).	Reporting will begin in 2008 in relation to part (a), (b) and (c).

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
	housing provides secure accommodation for older people who do not require 24 hour nursing care.					

LONG STAY CHARGES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality and Equity	Equality of service achieved for all patients who require long stay support.	**Inpatient Long Stay Charges** **Relating to Class 1** (broken down by service area) a) Number of people (monthly) i) receiving inpatient care ii) paying charges iii) who should be paying charges but who have not to date or are refusing to do so iv) who are refusing to pay the charges and who are due a refund under the scheme v) paying the maximum charge of €120 per week b) Amount of Money i) being collected (weekly or monthly) ii) not being collected from people who are refusing to pay.	Quarterly	_	Reporting will begin in 2008	Reporting will begin in 2008 on a quarterly basis with a view to reporting monthly in 2009.
		Relating to Class 2 (broken down by service area) a) Number of people (monthly) i) receiving inpatient care ii) paying charges iii) who should be paying charges but who have not to date or are refusing to do so. iv) who are refusing to pay the charges and who are due a refund under the scheme v) paying the maximum charge of €90 per week b) Amount of Money i) being collected (weekly or monthly) ii) not being collected from people who are refusing to pay.		_	Reporting will begin in 2008	

PALLIATIVE CARE

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Access and Quality	Palliative care is the active total care of patients whose disease is no longer responsive to curative treatment. This care is provided in a variety of settings in partnership with non-statutory sector.	a) No. of patients treated in specialist inpatient units / month (monthly average)	Monthly	330	330 (plus impact of new developments)	Additional medical, nursing and paramedical staff to support key service developments in palliative care has been identified for 2008. The impact of these appointments, as they come on stream, on current levels of service provision will be monitored through our service plan reporting. Work to capture utilisation and occupancy levels within Palliative Care services will commence in Quarter 1 2008.
		b) No. of patients accessing Home Care services / Month (monthly average)		2,500	2,500 (plus impact of new developments)	
		c) No. of patients accessing intermediate care in community hospitals / Month (monthly average)		80	80 (plus impact of new developments)	
		d) No. of patients accessing day care / Month (monthly average)		260	260 (plus impact of new developments)	

ADDICTION SERVICES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality and Access	Substance misusers have immediate access to professional assessment, followed by commencement of treatment as deemed appropriate, not later than one month after assessment.	**Substance Misuse (PI)** a) The number of substance misusers for whom treatment, as deemed appropriate, has commenced: 1. within one calendar month 2. Later than one calendar month.	Annually Q3	84% of clients seen within one month	Increase in % of clients seen within one month	Additional staff to support key service developments for Under 18 services with addiction has been identified for 2008. The impact of these appointments on current levels of service provision will be monitored through our service plan reporting.
		b) The number of substance misusers under 18 years for whom treatment as deemed appropriate was commenced: 1. within one calendar month 2. later than one calendar month.				
	Access to treatment if needed.	**Methadone Treatment** a) Average number of clients in methadone treatment per Month (monthly average)	Monthly	7,000	7,000	Provide existing levels of service.
		b) Average number of methadone treatment places utilised in the reporting period		7,000	7,000	

TRAVELLER HEALTH

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality	Increase in sensitivity and awareness of the needs of Travellers when they interact with health services personnel.	**Training (PI)** Number (cumulative) of HSE Area personnel (by category) who have completed cultural awareness and sensitivity training programmes, which have been developed in partnership with Travellers and Traveller organisations.	Bi-annual Q2 & Q4	381	381	The recently published national intercultural strategy makes recommendations around appropriate training for staff in dealing with cultural differences. A pilot training programme was run in 8 sites nationally in 2007 under the auspices of the National Inter-cultural Strategy (NICS). The recommendations from the evaluation of these pilots will be used to agree the design of future training programmes under the remit of the NISC. The HSE has committed to revisiting this performance indicator in early 2008 in the context of this development, with a view to providing a more current measure of performance. Targets for the training programmes beyond ELS have not been set as a consequence.
Equity	Traveller participation on Traveller Health Units is essential for commitment and support to improve services for the Traveller Community.	% of Travellers on THU.	Quarterly	43%	50%	Representation increased on Traveller Health Units.

ASYLUM SEEKERS

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality	Increase in sensitivity and awareness of the needs of Asylum Seekers / Refugees when they interact with health services personnel.	**Training (PI)** Number of HSE Area staff (by category) that have completed Asylum Seekers / Refugees Awareness Training encompassing the following areas: a) General Information on asylum seekers / refugees b) Cultural Diversity c) Anti-racism d) Specific health issues relevant to asylum seekers / refugees.	Annually Q3	476	476	The recently published national intercultural strategy makes recommendations around appropriate training for staff in dealing with cultural differences. A pilot training programme was run in 12 sites nationally in 2007 under the auspices of the National Inter-cultural Strategy (NICS). The recommendations from the evaluation of these pilots will be used to agree the design of future training programmes under the remit of the NISC. The HSE has committed to revisiting this performance indicator in early 2008 in the context of this development, with a view to providing a more current measure of performance. Targets for the training programmes beyond ELS have not been set as a consequence.

HOMELESS SERVICES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality and Access	Improved access to mainstream health and social services for homeless people.	**Policies (PI)** a) The number and percentage of acute, including voluntary, hospitals that operate a formal discharge policy for homeless people, as required under the National Homeless Preventative Strategy.	Quarterly	25 (67%)	100%	Draft protocols for discharge agreed in 2007 will be implemented in 2008.
		b) The number and percentage of acute mental health units / psychiatric hospitals that operate a formal discharge policy for homeless people, as required under the National Homeless Preventative Strategy.		29 (71%)	100%	
		c) The number and percentage of Community Service Areas that operate a formal Leaving and Aftercare Support service for young people leaving care as required under the National Homeless Preventative Strategy.		23 (72%)	100%	

DISABILITY SERVICES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Access and Quality	All disabled clients will have prompt assessment of need and access to the services they require.	**Intellectual Disability** (PI) a) The percentage of clients on the intellectual disability database who have been assessed as requiring day* services.	Annually Q2	97%	97%	Provide existing levels of service * Figures sourced from national Intellectual Disability Database report 2007.
		b) The percentage of clients assessed as requiring day* services, as identified in ID3 (a), and who are receiving the service.		99%	99%	
		c) Percentage of clients identified in ID3 (b) that require a further * day service.		1%	1%	
		d) The percentage of clients assessed as requiring a day service and are receiving an appropriate day service*		99%	99%	
		e) The percentage of clients on the Intellectual Disability database who are assessed as requiring residential* services.		32%	32%	
		f) The percentage of clients on the Intellectual Disability database who are assessed as requiring residential* services, as identified in ID3 (e), and who are receiving the service.		99.7%	99.7%	
		g) Percentage of clients identified in ID3 that require further* residential services		0.3%	0.3%	
		h) The percentage of clients assessed as requiring a residential service and are receiving an appropriate residential service.		99.7%	99.7%	
Access and Quality	Compete the programme to transfer people with an intellectual disability currently in psychiatric hospitals to appropriate accommodation, as per Objective 3 of the National Health Strategy 2001.	**Institutional Transfers (PI)** The percentage and number of clients who have been assessed as needing to be transferred from psychiatric hospitals* and large institutional settings* and who have been transferred.	Annually Q2	0	-	No target for transfers currently been set. Numbers to be transferred will be identified and prioritised in line with need and circumstances.
Access and Quality	Monitor the implementation of Part 2 of the Disability Act, which came into force on 1.6.07 for children	**Under 5's Assessments (PI)** a) The no. of requests for assessments received.	Quarterly	_	Reporting will begin in 2008	Reporting will begin in 2008 In relation to reporting on: j) the number of assessments refused and
		b) The no. of assessments commenced as provided for in the regulations.				
		c) The no. of assessments commenced within the				

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
	under 5 years of age.	timelines as provided for in the regulations. d) The no of assessments not commenced within the stated timelines. e) The no. of assessment completed within the timelines as provided for in the regulations. f) The no of assessments not completed within the stated timelines. g) The no. of service statements completed. h) The no of service statements completed within the timelines as provided for in the regulations. i) The no of service statements not completed within the stated timelines. (j) The number of assessments refused. (k)The aggregate unmet need.				k) the aggregate unmet need This will be reported in the Annual Report required under the Disability legislation.
Access	Monthly allowance paid in respect of eligible children from birth up to 16t, who have a severe disability requiring continual or continuous care and attention which is substantially in excess of that normally required.	**Domiciliary Care Allowance** No. of persons in receipt of Domiciliary Care Allowance / Month (monthly average).	Monthly	19,600	DLED scheme	Provide DCA within eligibility guidelines.
	A review of adult day care services is ongoing and completion is expected early 08. ELS may change as a result of this.	**Sheltered Work** a) No. of persons in sheltered work / Month (monthly average)	Monthly	2,000	2,000	Provide existing levels of service.
		b) No. in Rehabilitation Training (monthly average)		2, 800	2, 800	
Quality	Needs of people with physical and / or sensory disabilities are represented on the National Database. Under the Disability Strategy, 2005 – 2009 investment strategy an additional 250,000 additional hours are provided.	**Physical and Sensory** No. of Residential places	Quarterly	834	834	Provide existing levels of service.
		No of Personal Assistance / Home Support Hours		3, 000, 000	3, 000, 000	

PATIENT SAFETY AND QUALITY

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality	Implementation of appropriate governance structures and enhanced surveillance systems will reduce the incidence of HCAI. Effective control will reduce the potential for infection to pass between people in the health care setting; reduce and improve antibiotic use and reduce antimicrobial resistance.	**Infection Control** % annual progress made towards targets of i) 20% reduction in HCAIs, ii) 30% reduction in MRSA infections iii) 20% reduction in antibiotic consumption	Quarterly	N/A Information not available at time of report –due end November	Targets will be set once baseline established	Gather baseline information to assist in setting of targets Implement key elements of 5 Year Infection Control Action Plan. Continue and expand surveillance of HCAIs through the work of the HCAI Governance Group Provide education and training for all health care workers.
	The prevention and control of healthcare-associated infection (HCAI)	**MRSA** MRSA bacteraemia notification rate per 1,000 admissions by hospital network	Quarterly	N/A Information not available at time of report –due end November	Targets will be set once baseline established	Implementation of the Guidelines for the Prevention and Control of MRSA and GP antibiotic prescribing guidelines in order to control and prevent healthcare associated infections (TP 5) Establish MRSA helpline for public.

ACUTE SERVICES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality and Efficiency	Efficient and effective use of inpatient hospital services	**Average Length of Stay (ALOS) (PI)** For 5 DRGs detailed below in current reporting period and changes on same period in previous year: Average Length of Stay (ALOS) - based on Total Bed Days Used and Inpatient Discharges. Adult Services: • Chest pain (F74Z) • Bronchitis and Asthma Age >49 or W CC (E69B) • Appendicectomy w / o Catastrophic or Severe CC (G07B) Paediatric Services: • Otitis Media and URI w / o CC (D63B) Obstetrics: • Vaginal Delivery w / o Catastrophic or Severe CC (O60B)	Bi-annually Q2 & Q4	 3.09 4.91 3.92 2.13 3.13	5% reduction in mean length of stay	**TP 3** Configure Hospital services to deliver optimal and cost effective results. **TP 3A** North East TP. Implement recommendations of Bed Capacity Review. Progress work on HIPE data. Consultation with hospitals to identify Individual hospital targets. In addition to the identified PI DRGs, work will commence in 2008 to report via Metrics Unit on the following additional DRGs: • MI • COPD • Tonsils • Hip • Diabetes • Cataracts
Quality and Efficiency	Efficient and effective use of day case hospital services.	**Day Cases (PI)** a) Percentage of patients treated as Day Cases for specific list of procedures: • Diagnostic Curettage or Diagnostic Hysteroscopy (N10Z) • Lens Procedures (C16A) • Inguinal and Femoral Hernia Procedures Age>0 (G09Z) • Other Gastroscopy for Non-Major Digestive Disease (G45A) • Vein Ligation and Stripping (F20Z)	Bi-annually Q2 & Q4	 72% 0% 28% 1% 32%	10% increase in overall inpatient / day case activity ratio for specific procedures.	**TP 3** Configure Hospital services to deliver optimal and cost effective results. **TP 3A** North East TP. Implement recommendations of Bed Capacity Review. In addition to the identified PI DRGs, work will commence in 2008 to report via Metrics Unit on the following additional DRGs: • Cataracts • Tonsils
Efficiency	Reduction in hospital costs and community follow up costs due to efficiencies in delivering day case services as apposed inpatient services.	Ratio of day cases to inpatient admissions, Diabetes without catastrophic or severe cc, by hospital network (K60B) **(PI)**	Annually Q4	5%	15%	Progress Chronic Illness framework **TP 3** Configure Hospital services to deliver optimal and cost effective results **TP 3A** North East TP Implement recommendations of Bed Capacity Review

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality and Access	Hospital procedure rates for these DRGs primarily reflect access and in part the burden of disease in the population e.g. CABG.	**Procedure Rate (PI)** a) Number and direct age-standardised hospital procedure rate per 100,000 population of:	Annually Q4		Identify best outcome internationally and monitor progress in trend towards same.	Implement strategies for early identification, prevention and health improvement e.g. Cardiovascular Health initiatives, Development of an integrated national strategy to prevent falls in older people. Control Metrics Group will review hip and cataract procedure rates in 2008. Note: These figures are national and not by hospital network.
		1. Coronary arteriography (ICD-10-AM 38215-00, 38218-00, 38218-01, 38218-02)		223.1		
		2. CABG procedures		35.8		
		3. PTCA (ICD-10-AM 35304-00, 35305-00, 35310-00, 35310-01, 35310-02)		113.8		
		4. Hip		N/A		
		5. Cataract by hospital network of residence.		N/A		
Quality and Access	Comparative hospital activity data on selected procedures can reflect the quality of preventative and treatment services. Hospital discharge rates reflect access to hospital inpatient services.	**Discharge and Procedure Rates (PI)** • Direct age-standardised discharge rate, fracture neck of femur (ICD-10-AM S72.0 - S72.2, S72.43, S72.8), per 100,000 population, by county.	Annually Q4	2.5	Identify best outcome internationally and monitor progress in trend towards same.	Identify international best practice strategies and incorporate into quality improvement programme within NHO. Note: These figures are national and not by county.
		• Direct age-standardised discharge rate, per 100,000 population, Diabetes (ICD-10-AM: E10 - E14), by county.		185.9		
		• Number and direct age-standardised hospital procedure rate per 100,000 population of renal transplant procedures (ICD-10-AM 36503-00, 36503-01) by gender, and by county		3.2		
		• Number and direct age-standardised hospital procedure rate per 100,000 population (age < 15yrs) of Grommet procedures (ICD-10-AM 41626-00, 41626-01, 41632-00, 41632-01) by county		106.3		
		• Number and direct age-standardised hospital procedure rate per 100,000 female (age <40 yrs) population of D&C procedures (ICD-10-AM 35640-00, 35640-03, 35643-00, 35643-01) by county.		281.5		
		• Number and age-standardised hospital discharge rate per 100,000 population of Acute Myocardial Infarctions (ICD-10-AM I21 - I22) by gender.		203.6 Male 159.8 Female		

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Efficiency and Access	Throughput activity and waiting lists for adults and children will aspire to 08 targets.	**Public Inpatient and Day Case (Discharges and Waiting Lists)** Specialty level detail should be submitted: a) Number of Public, Adult, Elective:	Monthly		No adult waiting over 6 months No child waiting over 3 months	Implement elements of **TP 3 / 3A** and Winter Initiative Work with the National Treatment Purchase Fund to reduce waiting lists for inpatient and day case services
		i) Inpatient Discharges		142,981		
		ii) Day Case Discharges.		437,496		
		b) Number of Public, Child, Elective:				
		i) Inpatient Discharges		11,355		
		ii) Day Case Discharges.		24,581		
		c) Number of adults waiting for: i) Inpatient treatment at end of quarter (Public Waiting List Only):				
		• over 3 months		8,012		
		• over 6 months		4,483		
		• over 12 months		1,947		
		ii) Day Case treatment at end of quarter (Public Waiting List Only):				
		• over 3 months		11,070		
		• over 6 months		6,573		
		• over 12 months		3,064		
		d) Number of children waiting for: i) Inpatient treatment at end of quarter (Public Waiting List Only):				
		• over 3 months		1,083		
		• over 6 months		539		
		ii) Day Case treatment at end of quarter (Public Waiting List Only):				
		• over 3 months		-		
		• over 6 months		-		
		e) Adult Patients Waiting:				
		i) over 6 months as % of Public Elective Discharges in Reporting Period.		-		
		ii) over 12 months as % of Public Elective Discharges in Reporting Period.		-		
		f) Child Patients Waiting:				
		i) over 3 months as % of Public Elective Discharges in Reporting Period.		-		

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
		ii) over 6 months as % of Public Elective Discharges in Reporting Period.		-		
		Delayed discharges by type.		-		
Access	Reduction in the number of people waiting in EDs. Reduction in the length of time patients have to wait in ED. Improvement in the overall patient experience.	**Emergency Department Waiting Times** a) average number of patients on trolleys in EDs nationally per month following decision to admit	Monthly	93.5 per day	No one waiting more than 12 hours for admission following decision to admit Accommodation in admission lounge < 24hrs	Implement a performance improvement culture via the eight Local Implementation Teams to address the Emergency Department waiting time issues as part of the Winter Initiative. Monitor hospital performance to ensure outcomes and ED targets are in line with hospital undertakings. Measurement of total patient time from attendance to discharge at an ED will commence in 2008, following stakeholder agreement.
		b) average waiting time for patients in EDs nationally per month following decision to admit broken down as follows: a) < 6 hours b) 6 - 12 hours c) 12 - 24 hours d) > 24 hours		Per day 37.1 21.8 27.9 4.6		
Access	Commitment to ensuring that patients are treated in the healthcare setting most appropriate to their needs while at the same time, maximising use of its resources.	**Elective / Non Elective and Public / Private Discharges (PI)** Number of patients discharged in reporting quarter:	Monthly			Implement Co-Location Private Hospitals strategy to provide additional capacity with the transfer of private activity to those hospitals, thereby freeing up capacity for public patients in public hospitals.
		• Inpatient		609,646	597,135 maintain target ratio	
		o Elective		224,470		
		▪ Public		154,336		
		▪ Private		70,134		
		o Non Elective		385,176		
		▪ Public		303,246		
		▪ Private		81,930		
		• Day Case		574,229	586,740 maintain target ratio	
		▪ Public		462,077		
		▪ Private		112,152		
Access	Predominantly care of public patients – maintain parameters of 80:20 ratio.	**Public / Private** % breakdown of public / private patient	Quarterly	75:25	80:20	
		% breakdown of elective / emergency patients		65:35	65:35	
		% of hospitals adhering to 80:20 ratio (PI)	Quarterly	-	To begin reporting in 08	

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Efficiency and Access	Efficient use of outpatient facilities and a reduction in non attendance	**Outpatients**	Monthly			Implement elements of **TP 3 / 3A** and Winter Initiative.
		a) No. of outpatient attendances (total)		3,076,442	2,770,851	
		b) No. of outpatient attendances (new)		799,875		
		c) No. of new DNAs		163,808	<15% of new attendances	
		d) No. of outpatient attendances (return)		2,276,567	New : return ratio 1:3 or better	
		d) No. of return DNAs		355,687	<15% of return attendances	
Efficiency and Access	Trend for births increasing year on year (22% growth 1997 – 2006)	**Births** No. of births	Monthly	67,742	72,653	Birth activity by its nature is demand led.
Efficiency and Access	Timely and appropriate access to ED.	**ED** a) No. of emergency presentations	Monthly	1,168,412	1,168,412 (expected)	Implement elements of **TP 3 / 3A** and Winter Initiative.
		b) No. of ED attendances		1,131,969	1,131,969 (expected)	
		c) No. of emergency admissions		369,368	369,368 (expected)	
Efficiency	**Winter Initiative** There will be a concerted and targeted programme focusing on improving our hospital lengths of stay in line with best national and international practice. Effective bed utilisation, discharge planning and use of day surgery will be key enablers in this regard supported by robust health intelligence / information.	**Day of Surgery (Winter Initiative)** Overall rate of patients being admitted on their day of surgery.	Monthly	-	To begin reporting in 08	Implementation of Winter Initiative Programme
		Appropriate use of beds (Winter Initiative) % of admissions and inpatients on day of care by hospital	Monthly	-	To begin reporting in 08	Targets will be developed in 2008 as part of the Hospital Control Metrics

AMBULANCE SERVICES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Expected Activity 2008	Strategy to Achieve Target
Quality and Access	The HSE Ambulance Service operates from 93 stations across the country and strives to continually reduce time to response to emergency calls.	**Response Times (PI)** Number and Percentage of emergency ambulance calls responded to within pre-determined time bands. Pre-Hospital Activity:	Monthly			Emergency calls are demand led, based on 07 outturn and population growth predictions an expected activity is indicated for 08 Targets for pre-determined time bands will be discussed in 2008, to work towards meeting international best practice over the coming years. Community Transport is a budgeted service. To date, provision has developed in different ways across the country. To ensure that resources are used appropriately in 2008, policy will be developed that patients will only be provided with transport where there is an identified medical need that prevents or precludes the use of conventional transport.
		• Emergency Calls		206,000	214,000	
		o < 8 Minutes		-	-	
		o < 14 Minutes		-	-	
		o < 19 Minutes		-	-	
		o < 26 Minutes		-	82%	
		• Urgent Calls		62,706	63,000	
		• Non Urgent Calls		211,000	192,000	
		• Community Transport		420,000	188,000	

CANCER SERVICES

Area	Outcome	PI Measure	Report	Projected Outturn 2007	Target 2008	Target 2009	Target 2010	Strategy to Achieve Target
Health Improvement	Increased surveillance and improved outcomes Whilst progress has been achieved in survival rates, Ireland is still lower than average for Europe and USA	**Cancer Registry (PI)** Stage of Presentation of breast and colorectal Common Cancers (defined by T and N Staging)	Annually Q4	Cancer registry Data released in 2006 *5 year survival for patient diagnosed in 1998-2003 (as a % of the expected survival of person with same age and sex profile in the general population)	With the move to high volume surgery and treatments in 8 cancer centres the expected outcomes are expected to improve annually	Expected improvement Monitor cancer registry reports	Expected improvement Monitor cancer registry reports	Move services to high volume surgical services in 8 cancer centres Monitor improved survival via cancer registry reports.
		a) 5 year Relative Survival Rate for Breast Cancer (ICD-10-AM C 50) patients		**1998** 72.9% **2003** 80.5%				
		b) 5 year Relative Survival Rate for Prostate Cancer (ICD-10-AM C 61)		75.9% 75.9%				
		c) 5 year Relative Survival Rate for Colorectal Cancer (ICD-10-AM C18 – C21) patients		51% 54%				
		d) 1 year Relative Survival Rate for Lung Cancer (ICD-10-AM C34)		9%* 10%				
Health Improvement	Reduction in the numbers pf people smoking with determine a general health improvement.	**Smoking (PI)** Cigarette smoking prevalence - % of population smoking, % population non smoking (annual) • By gender • By age	Annually Q4	Interim data from OTC Smoking = 29% of population	No national target established by DoHC. Improve trend year on year.	-	-	Smoking reduction is a multisectoral issue. Identify best outcome internationally and monitor progress in trend towards same.
Health Improvement **Quality** **Access**	Increased screening will result in increased numbers of local excision of early breast lesions. Low volume breast surgery will be ceased and surgery will be transferred to units conforming to the	**Procedures (PI)** a). Number and direct age-standardised procedure rate per 100,000 female population for the following procedures: (with a primary diagnosis of breast cancer)	Annually Q4	*(For a total population 2005)*	*(Numbers based on 2005 HIPE information and extrapolated on the basis of 20 new cases per year and for 2009 and 2010 the expected additional cases with the introduction of BreastCheck in the South and West)*			Introduction of BreastCheck in the South and West Implementation of the Cancer Control Programme and the reorganisation of cancer services
		1.'Local Excision of Lesion of Breast' (ICD-10-AM 31500-00, 31515-00)		901	930	1330	1340	
		2.'Mastectomy' (ICD-10-AM 31524-00, 31524-01, 31518-00, 31518-01)		861	890	930	930	
		b) For surgeons conducting ANY of the above procedures: average total		Dublin N 268 Dublin S 196	Dublin N 276 Dublin S 204	Dublin N 284 Dublin S 212	Dublin N 287 Dublin S 215	

CANCER SERVICES

Area	Outcome	PI Measure	Report	Projected Outturn 2007	Target 2008	Target 2009	Target 2010	Strategy to Achieve Target
	agreed national quality standards. Volume and quality are directly associated with out come. The outcomes for breast therefore are expected to improve.	number of procedures conducted by all surgeons, by Network area.		Midlands 204 S.East 157 South 341 Midwest 102 Western 384 N.East 112	Midlands 212 S.East 265 South 349 Midwest 108 Western 392 N.East 118	Midlands 220 S.East 273 South 472 Midwest 114 Western 471 N.East 124	Midlands 223 S.East 276 South 475 Midwest 115 Western 474 N.East 125	
		c) Percentage of consultant surgical staff conducting > 50 of listed procedures, by hospital network. d) % of total cases (see above list) conducted by surgeons conducting > 50 procedures.		Dublin N 64.5% Dublin S 61.2% Midlands 40.1% S.East 31.8% South 73.9% Midwest 57.8% Western 71.6% N.East 0%	In the 4 cancer control networks Target for 2008 Is 75%	In the 4 cancer control networks Target for 2009 is 90%	In the 4 cancer control networks Target for 2010 is 100%	
		e) Total no. of procedures by hospital type by region (I.e. are > 150 procedures conducted in each hospital?)		Dublin N 173 South 252	In the 4 cancer control networks Target for 2008 is 75%	In the 4 cancer control networks Target for 2009 is 90%	In the 4 cancer control networks Target for 2010 is 100%	
		f) Number of hospitals complying with the National Quality Assurance Standards for Symptomatic Breast Disease Service		Sanctioned as standards in 2007 A number of sites are partially compliant	In the 4 cancer control networks Target for 2008 is 75%	In the 4 cancer control networks Target for 2009 is 90%	In the 4 cancer control networks Target for 2010 is 100%	

HEALTH PROMOTION

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Health Improvement	Every child has the right to study in a school constantly strengthening its capacity as a healthy setting for living, learning and working. SPHE supports teacher training. Policy development is a key element of a health promoting school.	**Schools Training** Provision of Schools Training to: • Primary • Post Primary • SPHE	Annually Q3	1,120 hrs 186 hrs 2,200 hrs	1,400 hrs 200 hrs 2,200 hrs	Progress National programmes In conjunction with the Dept of Education and Science and DOHC, further develop the delivery of SPHE.

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
	Provision of training and skilled development for people is an essential strategy for increasing capacity and potential for promoting health.	**Training** Provision of Training to Health Care Workers, Management / Administration: a) Number of Training Hours i) Health Promotion ii) Accredited HP		 2,768 2,465	 4,350 2,000	Implement training and skills development strategies
		b) Number of persons trained • Medical / Dental • Nursing • Allied Health Professionals • Management / Administration • Support Staff • GPs • Practice Nurses • Pharmacists • Others		 396 1,796 760 327 704 50 111 40 512	 100 2,400 800 400 1,000 10 100 85 300	
		c) Provision of training to other Sectors: • Statutory bodies • Private Sector • Community / Voluntary • Other		 676 89 2,364 431	 900 450 3,500 1,100	
	Health Promotion is a key function of all hospitals	**Health Promoting Hospitals** Participation in Health Promoting Hospital Network a) No. and % of members of the Promoting Hospitals Network.	Annually Q3	 41 (69%)	 41 (69%)	Provide continuing levels of service in the existing network
		b) No and % with a written Health Promotion policy		59 (100%)	59 (100%)	
		c) No and % engaged in Health Promotion Initiatives		41 (69%)	41 (69%)	
	The workplace environment is ideally placed to be Health Promoting, given that the majority of the adult population spends 60% of their waking hours i.e. an average of 2,000 hours a year at work.	**Workplace** Provision of support to Workplaces: a) HSE Worksites b) Non HSE worksites • Small • Medium • Large	Annually Q3	 163 22 21 30	 150 55 10 30	Provide workplace support based on identified need
	The National Health Promotion Strategy (5.3.3) aims to support the development and implementation of	**Community Partnerships** Development of community based Health Promotion Partnerships a) Based on community development approach	Annually Q3	 302	 300	Implement the National Health Strategy as it relates to Community Partnerships

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
	community based approaches.	b) Organised by HP services c) Clinical Dietetics d) Smoking Cessation e) Health Promotion / Public Health campaigns		89 - - 6	150 - - 6	

ENVIRONMENTAL HEALTH

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Health Improvement	In conjunction with Office of Tobacco Control, we will regulate premises for compliance Public Health Tobacco Act	**Tobacco** No. of inspections to ensure compliance with Public Health Tobacco Act	Q4	32,012	32,012	*Projected outturn 2007 based on 2006 outturn.* Roll out National Tobacco Control Database. Implement HSE / OTC business plan 2008
Quality	In conjunction with Food Safety Authority of Ireland we will regulate premises for compliance with food safety	**Food Inspections** No of inspections of food premises	Q4	47,142	45,000	The numbers of inspections in relation to Food Safety / Control will be reduced in 08' as officers will be required to carry out work in relation to new legislation and less will be available for inspections

CORPORATE - OFFICE OF CEO

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality	All parliamentary questions received will be responded to efficiently, in line with set procedures.	**PQs (PI)** Total Number of PQ's received by the HSE, for direct reply to the Deputy, for answer in the Dáil (from first day to last day of 3rd month in relevant quarter) and in respect of the following: a) Which an interim reply issued by the HSE within 15 working days of the date of the Ministers answer to the Dáil and b) For which a final reply has been issued by the HSE within 15 working days of the date of the Ministers answer to the Dáil.	Quarterly	3,200	Time to reply reduced to 15 days	At the request of the DoHC, we will work towards monthly reporting of this information. In 2008, we will reduce our time to reply from 20 days to 15 days.

CORPORATE - OFFICE OF CEO

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Quality	The implementation of the statutory complaints framework will require monitoring and measurement of the number of complaints received and how they are dealt with.	**Complaints** a) Total number of complaints in given period.	Monthly	7,000	-	Introduce monthly reporting on complaints by Complaints Officers Statistical template developed for collecting monthly data on complaints
		b) Number and % of complaints finalised within 30 working days		80%	85%	Training in all aspects of complaints management provided to all Complaints Officers, information sessions rolled out to front line staff, monthly reporting on complaints introduced.
Quality	Development of a national lo-call information line for consumers to contact the HSE. Integrated with existing services in Cork, Donegal and Limerick.	**HSE National Information Line** No. of calls received	Quarterly	70,000	-	Demand led therefore unable to quantify an activity target.
Quality	Provision of timely, accurate and complete information to elected representatives.	**Ministerial and public representations** No. received	Quarterly	3,062	-	Demand led therefore unable to quantify an activity target.

CORPORATE - HUMAN RESOURCES

Area	Outcome / Context	PI Measure	Report	Projected Outturn 2007	Target 2008	Strategy to Achieve Target
Efficiency		Total approved WTE Ceiling	Monthly	112,245	112,245	Stringent control through our Performance Monitoring and Measurement Framework
		NHO		51,415	51,415	
		PCCC		56,694	56,694	
		Population Health		557	557	
		Functional Directorates (e.g. HR, ICT, Finance, Office CEO etc)		33,579	33,579	

APPENDIX 1

NSP 2008 Deliverables – Linkage with Transformation Programme

Transformation Programme
Our four year Transformation Programme (TP), which was launched in 2006 in respect of the period 2007 to 2010, builds on the momentum for change that has gathered within the HSE and is focussed on building a health and personal social service system that is sustainable and capable of delivering high quality services. This programme was developed following consultations with service users, staff and our Board.

Our Vision is that everybody will have access to high quality care that they have confidence in and staff are proud to provide. In order to achieve our Vision, the TP focuses on six transformation priorities.

These priorities are:

- Developing integrated services across all stages of the care journey.
- Configuring Primary, Community and Continuing Care (PCCC) services so that they deliver optimal and cost effective results.
- Configuring hospital services to deliver optimal and cost effective results.
- Improving the health of the population and implementing a model for the prevention and management of chronic illness.
- Implementing standards based performance measurement and management throughout the HSE
- Engaging all staff in transforming health and personal social services in Ireland

As already mentioned, while not the only driver for change, the TP constitutes the primary mechanism and framework for developments across the HSE in the period 2007 to 2010.

The arrangements which have been put in place by us to deliver on transformation are highly structured and provide a rigorous implementation process. Thirteen major programmes have been established to deliver on the 6 transformation priorities. Seven programmes will directly address the above priorities and a further 6 programmes will provide the enabling infrastructure for transformation to be achieved.

Progress continues across a broad range of projects within the TP and much of the project definition work has identified the need to manage inter-dependencies and drive the required level of integration across the service delivery programmes. There is also a need for an initial focus on areas that will demonstrate real service change on the ground. This has led to the identification of what has been termed 'Core Driver Projects' across the service areas of PCCC, NHO and Population Health. These projects are:

1.1 Develop end-to-end integrated patient / client journey processes

Patients and clients will be able to move easily through the entire care system because we will have services that are well organised and connected seamlessly across the organisation. Integrated care will be at the heart of the way we work.

2.1 Develop and implement PCCC service configuration framework

This will involve reconfiguring our resources to provide a significant range of client services within local communities. These will be provided as close as possible to people's homes, while maintaining high quality and safety standards. The emphasis will be on local delivery which will be met by local multidisciplinary teams and local diagnostic services.

Realignment from the current model of fragmented service delivery to a population based model organised through Primary Care Teams serving populations of approximately 8,000 people.

3.1 Development of hospital services configuration framework

The National Hospitals Office (NHO) will have substantially reconfigured and developed its resources and services to provide the full range of secondary, tertiary, and quaternary acute services that fit appropriately into the integrated care model and are evidence based, efficiently run and quality assured, delivering optimal and cost-effective results.

3.5 Transformation of National Paediatric Services

This project will develop and implement a framework for all paediatric services nationally through a new model of care defined by international best practice for the National Paediatric Hospital. In addition it will define how paediatric services should be configured and delivered outside of Dublin as part of one national paediatric network integrated with the National Paediatric Hospital within the framework developed.

3.6 Transformation of National Maternity Services

Develop a framework for all maternity services nationally in line with international best practice, and review current and future demands and the capacity within the system. Specifically, this project will develop a national plan to address infrastructure and workforce constraints and develop a model of care, together with a fully reconfigured maternity service for the Greater Dublin area. In addition, this project will develop a reconstructed relational arrangement between Dublin maternity services and a restructured maternity service at national level.

4.1 Develop a framework for the prevention and management of chronic illness

We will have evidence based prevention programmes and treatments for people with chronic illnesses such as diabetes, chronic obstructive pulmonary disease and cardiovascular problems. This will provide better outcomes and survival rates for people with chronic illness.

4.8 Development of National Population Health Strategy

Which will provide an international evidence base for a population health approach applied to the Irish context.

These pieces of work are referenced in the relevant service delivery (Section 4) of the NSP.

The design and implementation of an Integrated Care Model requires a unified approach across projects in the Core Programmes 1 – 4 and is one of the Core Driver Projects for the Transformation Programme. This project will provide the overarching vision and high level framework for integrated health services across the continuum of care, the aim of which is to enable the effective planning and development of services (this is further detailed on page 94).

In addition, in order to support the delivery of these projects, it has been recognised that other 'Enabling' projects will need to be progressed apace. Thirty five of these key 'Enabling' projects have been identified and will be the subject of intensive work in order to facilitate the achievement of objectives for the Core Driver projects. A specific focus for 2008 will be to implement Transformation in the North East. This is primarily an implementation programme which will allow us to focus both resources and change capacity on demonstrating achievement of accelerated service improvement for a substantial population base within a significant geographical area (this is further detailed on page 94).

The primary focus of the Transformation Programme and its supporting team structure will maintain the principle of integrating the work of the Core Driver Projects.

In addition, the work of the Expert Advisory Groups will continue to support the implementation of our TP through the development of specific health and personal social services.

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Programme 1: Develop integrated services across all stages of the care journey		
Integrated Model of Care *Development of an Integrated Model of Care is one of the Core Driver Projects for the HSE Transformation Programme. This project will provide the overarching vision and high level framework for integrated health services across the continuum of care, the aim of which is to enable the effective planning and development of services.*	Programme Lead	1

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Winter Initiative *There will be a concerted and targeted programme focusing on improving our hospital lengths of stay in line with best national and international practice. Effective bed utilisation, discharge planning and use of day surgery will be key enablers in this regard supported by robust health intelligence/information.*	Programme Lead	1
Management of Emergency Patients *A key priority for the HSE is to reduce the numbers waiting in ED Departments. Hospitals assessed against 3 goals in relation to ED performance:* • *reduce the numbers waiting in EDs* • *reduce the length of time that patients wait* • *improve the overall patient experience*	NHO	1.1 & 3.4
Implementation of the national framework for diabetes.	Office of the CEO / Pop Health / PCCC / NHO	1.2 & 4.2.2
Develop a National Database to monitor prevalence trends of growth, overweight and obesity.	Pop Health	4.7
HSE Information Governance Framework	Pop Health	1.9
CEMACH - (Confidential Enquiry into Maternal and Child Health)	Pop Health	4.7
Implement National Client Index	Pop Health	1.10
Laboratory Review *Determine the most appropriate structure and arrangements for the delivery of laboratory medicine services required by the HSE across the full continuum of care including primary, community, secondary, and tertiary care.*	NHO	1.11
Programme 2: Configure PCCC Services to deliver optimal and cost effective results		
Primary Care Reform and Integration	PCCC	2.1-2.6
Contractual framework for GMS and other publicly funded services involving GP's: *This is a key enabler to the transformation of primary care services The objective is to achieve improved outcomes in the management of chronic disease, greater responsiveness to vulnerable patients (i.e. elderly, homeless, addiction) and increased productivity in a 24/7 provided service.*		
Dental Treatment Services Scheme: *A new contractual arrangement with dental contractors to provide emergency and routine dental treatment to eligible adults.*		
Pharmacy Contract: *A new contractual arrangement with community pharmacy contractors as a key element in the reform of the community drug schemes.*		
Demand Led Schemes: *The demand led schemes include the GMS, community drug schemes and the discretionary 'Hardship Scheme'. A range of allowances such as the Domiciliary Care Allowance is also included under the Demand Led Schemes.*		

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Develop and implement Primary, Community and Continuing Care Configuration Framework ***Development of additional Primary Care Teams (PCTs).*** *Primary Care Teams are the unit of service delivery for non-acute care and will be assigned to populations of approximately 8,000. They will be made up of a number of health professionals working alongside GPs. Their development involves both the recruitment of additional staff and the re-organisation of existing PCCC staff. Fully-functioning teams are those who are holding clinical meetings concerning patients and the achievement of this stage of development is key.*	PCCC	2.1-2.4
Use of Information Technology *ICT is a key enabler of integrated care*		2.1-2.4
Out of Hours GP services / GP Co-operatives *Out of hours GP services are provided through a number of different co-operative models.*	PCCC	2.5
GP Vocational training *(in partnership with the ICGP*	OCEO / PCCC	2.5
Development of the Hospital in the Home Service (HITH). *HITH is a consultant led community service, treating conditions such as Chronic Obstructive Airways Disease available to patients of DATHs and Connolly Hospitals and the patients of General Practitioners in the greater Dublin area.*	PCCC	2.5
National Schemes Modernisation Project	PCCC	2.8
Implement recommendations of Community Ophthalmic Services Medical Pilot Scheme. *This will enable the cost effective delivery of a range of medical and surgical interventions in the primary care setting, which would otherwise have to be delivered in the acute hospital setting.*		
The Application/ Assessment process for Medical/ GP Visit Cards *To be streamlined and made more 'customer friendly'.*	PCCC Contracts	
Development and enhancement of competency and knowledge base within HSE (PCCC) on E.U Health regulations		
Review of the Indicative Drug Target Saving Scheme: *A review of the Indicative Drug Target Savings scheme was carried out by the National Pharmo-economic Unit to establish if the scheme was meeting its original objectives of promoting cost effective prescribing.*		
Complete review of Dental Treatment Services Scheme	PCCC	
National Review Group on Orthodontic Service	PCCC	
Development of Orthodontic Services	PCCC	
Development of action plan to address oral health needs of patients with special needs	PCCC / OCEO	
Hepatitis C Services: *Health Amendment Act Cardholders (i.e. those infected with Hepatitis C through administration of contaminated blood and blood products)*	PCCC	
Children and Families Transformation Plan	PCCC	2.1

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Family Support Strategy *National policy commitment to family support services development.*	PCCC	2.5 & 2.6
Ferns Report *Implement the findings of the Ferns Report*	PCCC	2.6
Implementation of Vision for Change*, which has been adopted by the HSE as policy for mental health services.*	PCCC	2.6
General Adult Psychiatry *The establishment of multidisciplinary mental health teams to deliver core mental health service for sector populations of 50,000, with two consultant led teams per sector.*	PCCC	
Develop additional Child and Adolescent Community Mental Health Teams (CAMHTs) *In line with Vision for Change and the Forum on Child & Adolescent Psychiatry, the HSE is committed to the development and enhancement of child and adolescent mental health teams and the development of additional inpatient facilities.*	PCCC	
Home Help *Government policy states that community and home based care should be developed to maintain older people in their own communities for as long as possible and to support the important role of the family and informal carer. The Home Help service and the provision of Home Care Packages (HCPs) are at the core of these community and home based services.*	PCCC	2.5 & 2.6
Home Care Packages (HCP)s *Additional support over and above existing mainstream community services and are used to support and maintain the older person at home via additional home supports and therapy services. They are designed to be flexible and are particularly targeted at those at risk of admission to long term care, inappropriate admission to acute hospital or requiring discharge to home from acute hospital.*	PCCC	2.5 & 2.6
Public Fast Track Beds *Beds developed to support the provision of extended care, rehabilitation and respite to patients. This initiative is key to the timely discharge of patients who have completed the acute phase of their care (delayed discharge).*	PCCC	2.5 & 2.6
Day / Respite Care Older People *Sheltered Housing schemes play an important role in supporting older people to remain living in the community, in independence and dignity. Sheltered housing provides secure accommodation for older people who do not require 24 hour nursing care.*	PCCC	2.5 & 2.6
A Fair Deal and Associated Work *From January 1, 2008, the current nursing home subvention will be replaced by a new nursing home care support scheme, to be known as "A Fair Deal". The new scheme is designed to ensure that everyone that enters a nursing home in either the public or private sector has their needs assessed through a common process and needs pays a fair portion of their income as a contribution towards the cost of their care.*	PCCC	2.5
Common Assessment Process & Clinical Pathways for Long term Care *In the overall context of the significant investment in, and development of, community based, acute and residential care services for older people, there is a growing requirement to ensure effective clinical co-ordination of services across these domains.*	PCCC, NHO	2.5
Develop Geriatrician Led Teams in Community *Develop the capacity of community services in order to meet the more complex needs of older people and to support implementation of "A Fair Deal".*	PCCC	2.5

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Drug and Alcohol services. Quality initiatives / standards *Quality in alcohol and drug services or QUADS and Drug and Alcohol Occupational Standards (DANOS) are benchmarking standards for the drug and alcohol service.*	PCCC	2.6
Services for Persons with Intellectual Disability and Autism	PCCC	2.6
Physical and Sensory Disability *Review models of service provision to reflect the revised Primary Care structures* *Review congregated settings*	PCCC	2.6
Implementation of the Disability Act*: Part II of the Disability Act 2005, establishes a system for the assessment of individual health service needs and, where appropriate, educational needs. The Act provides a statutory entitlement to:* • *An independent assessment of health and educational needs* • *A statement of the services (Service Statement) which it is proposed to provide, within available resources* • *To pursue a complaint through an independent redress mechanism if there is a failure to provide these entitlement* *Part II of the Disability Act was implemented from 01/06/2007 for children under 5 years of age.*	PCCC	2.6
Work with the DoHC, Dept of Education and Science and the National Council for Special Education to plan the implementation of the EPSEN Act 2004	PCCC	2.6
Programme 3: Configure hospital services to deliver optimal and cost effective results		
National Cancer Control Programme(NCCP)	HSE / DOHC Cancer Programme Director	3.9
Key appointments into the NCCP *(e.g. National head of systemic therapy, radiation oncology, oncology surgery)*	HSE / Cancer Programme Director	
Establishment of 4 cancer control networks, with 2 cancer centres per network *Based on the recommendations of the 2006 Cancer Control Strategy, the NCCP Advisory group established the evidence to support 8 cancer centres, 2 per network, with some cancer surgeries being delivered in less than the 8 centres.*		
Symptomatic Breast Disease services *This is an essential element of the quality agenda set out in the National Cancer Control Strategy. The aim is to provide equal opportunities for women, to be managed in a centre capable of delivering the best possible outcome. Volume and outcome is the most important determinate of survival for people who develop breast cancer. Centres will be developed within the QA standards aimed at a managed population, minimum case load of 150 per year, and have at least two each nominated breast surgeons, radiologists and histopathologists..*		
National Plan For Radiation Oncology (NPRO) To 2010 *Well established plan from 2005 for 4 main radiation oncology developments within a national structure, with 2 smaller linked centres to be delivered by a combination of capital development and PPP.*	HSE / Cancer Programme Director / NPRO	
NPRO To 2014		

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Phase 2 developments in St James's and Beaumont hospitals, and transfer of services from St Luke's hospital, expansion of services at Cork University Hospital with a networked new department in Waterford, expansion of services at University College Hospital Galway and Limerick Regional Hospital.		
NPRO Education and Training Strategy	HSE / Cancer Programme Director / NPRO / Universities	
Communications	HSE communications / Cancer Programme Director / NCCP advisory group	
A National Acute Bed Capacity Review (ABCR) *was commissioned, to identify the acute bed capacity needs to the year 2020 and to identify, at HSE Administrative Area level, the required type and location of acute beds.*	NHO	3.1
Acute Hospital Configuration *Joint HSE/Department of Health and Children Group* *Reconfiguration of Mid-West and Southern Hospitals Groups* *Reviews of acute hospitals services in greater Dublin Area and Midlands*		
Critical Care Planning		
Management of Emergency Patient *A key priority for the HSE is to reduce the numbers waiting in ED Departments. Hospitals are assessed against 3 goals in relation to ED performance:* • *reduce the numbers waiting in EDs* • *reduce the length of time that patients wait* • *improve the overall patient experience.*	NHO	1.1 & 3.4
Implementation of 100+ consultant post scheme *to reward hospitals that are maintaining high performing Emergency Departments*	NHO	3.4
Transformation of National Paediatric Services *Development of the new National Paediatric Hospital Establish a single network approach to all services currently provided in the three children's hospitals* *Appropriate arrangements for delivery of specialist paediatric services in non paediatric hospitals* *Secondary Paediatric outside Dublin* *National Paediatric Transport programme*	NHO	3.5
Transformation of Maternity Services.	NHO	3.6

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Development of Governance Arrangements in the Acute Sector	NHO	3.3
Hospital Performance Management	NHO	3.8
Madden Reports on Post Mortems	NHO	3.7
Tissue & Cells development funding	NHO	3.7
Programme 3A: North East Transformation Plan		
*The **North East Transformation Programme** has been identified as the number one priority for the HSE within its overall Transformation Programme. It is primarily an implementation programme which will allow HSE to focus its resources and change capacity in order to demonstrate achievement of accelerated service improvement for a substantial population base within a significant geographical area.*	Programme Manager	3A
The key drivers for service transformation in the North East are: • *Improving the safety and quality of patient care by centralising acute and complex care so that clinical skills levels can be safeguarded through ensuring sufficient throughput of cases.* • *Recognising that the majority of care can and should be provided locally including in the community or at home wherever practical. In 2008, 2009 and thereafter the NE Transformation Programme will require significant additional investment to be prioritised within overall HSE national funding.*		
Programme 4: Improving the health of the population (including a model for the prevention and management of chronic illness)		
Promote a strategic approach to child health research	Pop Health / Office of the CEO	4.7
Cardiovascular Strategy	Pop Health / PCCC	4.2.4
Management of population health related data and information resources *Health Intelligence will focus on key outputs in particular through the Health Atlas Ireland in support of national, regional and local health development matters.*	Pop Health	4.7
The use and development of the evidence base of health *The Horizon Scanning Unit will lead the HSE on activities to distil new and novel ideas, derived from sources both nationally and internationally, to inform direction and decision making.*		
Framework for Prevention and Management of Chronic Illness *The purpose of the framework is to identify the way forward so as to prevent chronic illness where possible and to detect, minimise and manage the impact of chronic illness on individuals and the population.*	Pop Health	4.1
Chronic Disease Patient Support Programme *Implement a pilot project for chronic disease patient support.*	Pop Health	4.2.1

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Implementation of the national framework for diabetes	Office of the CEO / Pop Health / PCCC / NHO	1.2 & 4.2.2
Develop the management of Chronic Obstructive Airways Disease (COPD) *Preparation and Completion of a COPD Strategy* *The COPD strategy will ensure that best evidence care is provided in a structured manner to patients and that their care is provided as close to home as possible.*	PCCC / Pop Health	4.2.3
Lead the development of a national sexual health strategy and action plan	Pop Health	4.8
New Population Health Strategy developed	Pop Health	4.8
Development of Health Inequalities Framework Develop and implement a structured population health framework that will tackle health inequalities, reduce the health gradient and work towards achieving equity in health	Pop Health	4.9
Undertake surveillance on infectious diseases in accordance with the infectious disease legislation	Pop Health	4.10
Targeted campaigns at specific Health Care Associated Infection (HCAI)		4.10
Health Impact Assessment	Pop Health / other relevant agencies	4.6
Develop an integrated national strategy to prevent falls in older people *Falls account for 90% of hip fracture hospitalisations among older persons. The average inpatient cost for a hip fracture in a person aged 65 years or older is estimated at €12,610.*	Pop Health / Local Authorities	4.2.6
Programme 6: Engage all staff in delivering transformation of health and social care in Ireland		
Health and Social Care *Support maintenance of standards through continuing professional development for health and social care professionals. This will be particularly important in the context of the challenges for health and social care professionals in working in new and different ways in primary care teams and new integrated care teams.*	HR	6 & 9
Develop and implement a leadership development strategy for the HSE *Create and implement leadership and management approaches which inspire Leadership Development Programme for top 180 Managers*	HR	6.2
Develop and implement an Employee Engagement Strategy	HR	6.1
HSE Values *published and embedded into the organisation through a communication process*	CPCP	6.8

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Programme 7: Finance: Budget allocation model and Finance Systems Project		
Single Financial Management System *Commence the procurement of a standardised national financial system in 2008. This system will be SAP based and will enable the organisation to establish a Finance and Procurement foundation and will assist in the integration of internal financial management and control processes and information.*	Finance	7.4
National Shared Services	Finance	7.7
New Financial Regulations	Finance	7.5
Devolved Budgeting	Finance	7.2
VFM Programme	Finance	7.3
Implementation of Strategic Plan *A cross Directorate VFM Group was established in 2007 and will continue during 2008 to oversee the work on the development of a strategy for driving and delivering value in the HSE along with the associated Action Plan for meeting the €500m. 4 year savings target set in 2007, while also promoting the development of a culture of delivering value in all that we do.*		
Develop role and function of VFM Unit Secure additional dedicated financial and evaluation skills and expertise to facilitate and support driving and delivering value in the HSE		
Programme 9: Human Resource Strategy and Delivery		
Development of Integrated Workforce Planning Strategy *With the patient / client at the very core of our service delivery, workforce planning provides the opportunity to strategically plan for the optimum number, mix and distribution of the right skills, competencies and capabilities to deliver appropriate care.*	HR	9
Health and Social Care *Support maintenance of standards through continuing professional development for health and social care professionals. This will be particularly important in the context of the challenges for health and social care professionals in working in new and different ways in primary care teams and new integrated care teams.*	HR	9 & 6
Implement standards based performance measurement and management throughout the HSE	HR	9.4
Develop a set of Human Resources Performance Indicators and Metrics	HR	9.2.3
Standardisation of HRBS Process *Review and implement standard process roadmaps for all Employee Schemes*	HR	9.4
Garda Vetting	HR	9.5
Recruitment	HR	9.5

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
A consolidation of all management / administration recruitment processing on one site to exploit effaces and streamline processing activity.		
Programme 10: ICT strategy and Implementation Projects		
ICT Governance and Organisation	ICT	10.5
Structural Transformation *A key ICT objective is to implement the agreed ICT Directorate structure nationally while ensuring continued focus on service delivery and implementation of national projects*		
National Infrastructure *Improve information transfer and electronic communication across the HSE*	ICT	10.1
Programme 11: Facilities/Estates Strategy and Implementation		
Development of national structure and facilities / estates strategy	Estates / HR	11.1 - 11.6
Primary Care Estate Roll out	PCCC / Estates	
National Paediatric Hospital	Estates	
Uniform Property transactions	Estates	
Office Estates	All	
Elderly long term care	Estates	
Programme 12: Corporate Stakeholder and Relationship Management		
Expert Advisory Groups *EAGs advise on the organisation and development of a particular service. They enable health professionals and clinical experts, patients, clients and service user groups to play an active role in health care policy development and monitoring of policy implementation within the HSE.*	Office of CEO	12.4
National Communications Unit (NCU)	Office of CEO	12.1
Implement statutory complaints framework	Office of CEO	12.2
Implementation of the 'Quality & Risk Management Framework' *including the 'Quality and Risk Management Standard' throughout all directorates.*	NHO / PCCC / Pop. Health / Office of CEO (OQR)	12.7

National Service Plan 2008 Deliverables	Lead Responsibility	TP Reference
Programme 13: Procurement Strategy and Implementation		
Implementation of New Procurement Operating Model	Procurement	13.1
Implementation of National Portfolio an Category Management Approach	Procurement	13.2
Implementation of National Approach to Logistics & Inventory Management	Procurement	13.7
Implementation of communications, training and customer relations (CTCR) programmes	Procurement	13
Implementation of required business supports	Procurement	13
Transition & Development of new procurement operating model	Procurement	13

Abbreviations

ABCR	Acute Bed Capacity Review
ACCA	Association of Chartered Certified Accountants
AED	Automated External Defibrillators
AMI	Acute Myocardial Infarction
AND	Assistant National Director
ASAP	Administrative Staffing Assessment Programme
CAAB	Children's Act Advisory Board
CAM	Clerical, Administrative and Managerial
CAMHT	Child and Adolescent Mental Health Team
CDB	City / County Development Board
CEMACH	Confidential Enquiry into Maternal and Child Health
CEO	Chief Executive Officer
CF	Cystic Fibrosis
CHAIN	Contact, Help, Advise and Information Networks
CHD	coronary heart disease
CHISP	Child Health Information Support for Parents
CIDR	Computerised Infectious Disease Reporting
CIM	Clinicians in Management
CLAR	Ceantair Laga Árd-Riachtanais
CMH	Central Mental Hospital
CMHT	Community Mental Health Team
CMOD	Change Management and Organisational Development
CNU	Community Nursing Unit
COPD	Chronic Obstructive Airways Disease
CPD	Continuous Professional Development
CPOD	Chronic Obstructive Pulmonary Disease
CPR	Cardiopulmonary Resuscitation
CRM	Customer Relationship Management
CSO	Central Statistics Office
CSSD	Central Sterile Supplies Department
CT	Computed Axial Tomography
CTCR	Communications, Training and Customer Relations
CUH	Cork University Hospital
CVD	Cardiovascular Disease
CWO	Community Welfare Officer
D&C	Dilation and Curettage
DANOS	Drug and Alcohol Occupational Standards
DATHs	Dublin Academic Teaching Hospitals
DCRAGA	The Department for Community, Rural and Gaelteacht Affairs
DML	Dublin Mid Leinster
DNA	Did Not Attend
DoF	Department of Finance
DoHC	Department of Health and Children
DPS	Drug Payment Scheme
DRG	Diagnosis Related Group
DSFA	Department of Social and Family Affairs
DSH	Deliberate Self Harm
DTA	Decision to admit
DTSS	Dental Treatment Services Scheme
EAG	Expert Advisory Group
ED	Emergency Department
ELS	Existing Level of Service
EM	Emergency Management
EMTA	Emergency Medical Technician – Advanced
ENT	Ear, Nose and Throat
EPA	Environmental Protection Agency
EPSEN	Education for People with Special Educational Needs
ER	Employee Relations
ERHA	Eastern Regional Health Authority
ESPAD	The European School Survey Project on Alcohol and Drugs
ETR	Education, Training and Research
EU	European Union
FSAI	Food Safety Authority of Ireland
GIS	Geographical Information System
GMS	General Medical Services
GP	General Practitioner
HAA	Health Amendment Act
HAI	Hospital Acquired Infection
HAS	Health and Safety Authority
HBSC	The Health Behaviour in School-Aged Children
HCAI	Healthcare-Associated Infection
HCP	Home Care Package
HFSA	Hydrofluosilicic Acid
HI	Health Intelligence
HIQA	Health Information and Quality Authority
HitH	Hospital in the Home
HPH	Health Promoting Hospitals
HPSC	Health Protection Surveillance Centre
HR	Human Resources
HRB	Health Research Board
HRBS	Human Resources Business Solution
HSCN	Health and Social Care Network
HSE	Health Service Executive
HSEA	Health Service Employers Agency
HTA	Health Technology Assessment
HTA	Health Technology Assessment
I&E	Income and Expenditure
IA	Internal Audit
ICGP	Irish College of General Practitioners

ICT	Information Communication Technology
ID	Intellectual Disability
IFCA	Irish Foster Care Association
IHCA	Irish Hospital Consultants Association
IHI	Institute of Health Improvement
IMB	Irish Medicines Board
IMO	Irish Medical Organisation
INO	Irish Nurses Organisation
IPHA	Irish Pharmaceutical Healthcare Association
IR	Industrial Relations
ISSHR	Irish Study of Sexual Health and Relationships
IT	Information Technology
LEHAP	Local Environment and Health Action Plan
LHO	Local Health Office
LIT	Local Implementation Teams
MC / GPVC	Medical Card / GP Visit Card
MDT	Multidisciplinary Team
MERC	Medical Exposure Radiation Committee
METR	Medical Education, Training and Research
MIMMS	Major Incident Medical Management System
MMR	Mumps Measles and Rubella
MRI	Magnetic resonance imaging
MRSA	Methicillin-Resistant Staphylococcus aureus
MUH	Mercy University Hospital
NAS	National Ambulance Service
NCCP	National Cancer Control Programme
NCR	National Cancer Registry
NCU	National Communications Unit
NE	North East
NEMO	National Employment Monitoring Office
NGO	Non Governmental Organisations
NHO	National Hospitals Office
NHRS	National Human Resource Services
NIMIS	National Integrated Medical Imaging System
NOSP	National Office for Suicide Prevention
NPMO	National Plan for Medical Oncology
NPRO	National Plan For Radiation Oncology
NSEU	National Service User Council
NSP	National Service Plan
OECD	Organisation for Economic Cooperation and Development
OLOL	Our Lady of Lourdes Hospital (Drogheda)
OP	Outpatient
OPD	Outpatient Department
OPW	Office of Public Works
OQR	Office of Quality and Risk
OT	Occupational Therapy
OTC	Office of Tobacco Control
P&CM	Portfolio and Category Management
P&D	Performance and Development or Planning and Development
PBO	Pre-Budget Outlook
PC	Personal Computer
PCCC	Primary, Community and Continuing Care
PCIP	Primary Childhood Immunisation Programme
PCT	Primary Care Team
PDP	Personal Development Plan
PET	Positron Emission Tomography
PHN	Public Health Nurse
PHSCN	Primary and Health and Social Care Network
PI	Performance Indicator
PMLF	Performance Management Legal Framework
PMR	Performance Monitoring Report
PNA	Psychiatric Nurses Association
PPARS	Personnel, Payroll and Related Systems
PPP	Public Private Partnership
PPSN	Personal Public Service Number
PQ	Parliamentary Question
PS	Physical and Sensory
PVG	Performance Verification Group
Q&R	Quality and Risk
QUADS	Quality in alcohol and drug services
RAPID	Revitalising Areas by Planning Investment and Development
RCSI	Royal College of Surgeons Ireland
RFP	Request for Proposal
RPII	Radiological Protection Institute of Ireland
SATU	Sexual Assault Treatment Unit
SCD	Sudden Cardiac Death
SIVUH	South Infirmary – Victoria University Hospital
SLA	Service Level Agreement
SLAN	Survey of Lifestyles Attitudes and Nutrition
SPHE	Social Personal and Health Education
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBPM	Team Based Performance Management
TDE	Training, Development and Education
THU	Traveller Health Unit
TP	Transformation Programme
TSSD	Theatre Sterile Supplies Department
UCD	University College Dublin
VFM	Value for Money
UKT	United Kingdom Transplant
WHO	World Health Organisation
WTE	Whole Time Equivalent