Health Service Executive

National Service Plan

2007

11th January, 2007

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FOREWORD

National Service Plan

For 2007 our focus is on improving patient care, better health care management and driving increased value for taxpayer's money.

This National Service Plan (NSP) outlines how we plan to achieve our priorities during 2007. It reflects our purpose, our ambition, our priorities and our opportunities.

We welcome the support of Government in the package of investment in key health and social care services as part of the Budget 2007 and the continued increases in expenditure on health and social care in recent years. In 2007, the planned HSE expenditure is €13.08bn, up from €12.4 bn in 2006.

Our purpose

Our fundamental purpose, the reason we come to work everyday, is ***to enable people live healthier and more fulfilled lives.***

To achieve this we must rapidly build a national health and social care system that is sustainable and capable of delivering consistently high quality services, within the resources available.

All who work for the Health Service Executive (HSE) and the agencies we fund must share the responsibility for achieving this.

Our Ambition

Since the publication of the Government Decision on the Health Reform Programme in 2003 and the establishment of the HSE in 2005, much of the focus has been on structural reform.

While this has been essential, it is now time to turn our focus to transforming and adapting how we work, the way we work, the way we relate to each other, our culture and our ambitions.

We look forward to strengthening the HSE during 2007 as a unified organisation. We have identified key deliverables within the areas of assessing need, standardising performance, embedding management accountability and arrangements through a number of measures including a more enhanced performance measurement system.

If we embrace change and transformation and see the opportunities as well as the challenges we will move closer to our ambition for the future which is where ***everyone will have easy access to high quality health and social services that they have confidence in and staff are proud to provide.***

To achieve this, during the next four years, we will focus on six Transformation Priorities.

Transformation

Our Transformation Priorities 2007-2010 are:-

1. Develop integrated services across all stages of the care journey so that people can easily get into, through and out of the health and social care system.

2. Configure Primary, Community and Continuing Care services to deliver optimal and cost effective results, and in so doing make it easy for people to access a broad spectrum of services through their local primary care teams.

3. Configure hospital services to deliver optimal and cost effective results so people will be able to easily and rapidly access high quality acute care through designated centres of excellence.

4. Implement a model to prevent and manage chronic illness so that people can expect high quality care and results from comprehensive and integrated care in their communities and designated care centres.

5. Implement standards based performance measurement and management throughout the HSE so that people can be confident that they will receive high quality care measured against transparent standards.

6. Ensure all staff engage in transforming health and social care in Ireland and ensure their work has a direct impact on, and contributes to, the overall transformation of health and social services.

Individual projects have been identified to deliver on these six transformation priorities and they have been integrated into this National Service Plan.

Opportunity

In setting these priorities we have taken into account that people are living longer, populations are increasing and getting older and at the same time expectations and demands for services are increasing and costs continue to rise.

During the past four years our population has increased by more than 8% and is becoming increasingly diverse. There are now 4.2 million people living in Ireland, the highest since 1861. Some forecast that this will increase beyond 5 million in 10 years.

The pressures facing Ireland's health and social care system mirror those facing some of the world's most advanced nations.

While the varying needs of those we serve are changing, it brings with it a great opportunity to simplify our services and to improve the community's experience of our health and social care services.

Together we can achieve our ambition if we are all determined, persistent and faithful to our accountabilities and responsibilities. This will require us to support each other and work as part of multidisciplinary teams which are responsive to the needs of people at all stages of their care cycle.

We have a tremendous potential to provide a world class service. We have many talented staff who are passionate and committed to excellence. There are also many individuals and organisations, voluntary and private, which share and support our goals.

I would like to acknowledge the contribution of all the staff, agencies and individuals to the health service. It is only with their commitment and dedication that we will achieve all that we aspire to achieve.

This is a very exciting and challenging time to be working in health and social care and it is up to us together to turn our ambition into reality.

Professor Brendan Drumm
Chief Executive Officer

Guide to National Service Plan 2007

The HSE delivers front line health and personal social services through 3 service delivery Directorates: Primary, Community and Continuing Care; National Hospitals Office; and Population Health. These services are enabled by a number of functional supports, including the Office of the CEO, Finance, HR, ICT, Procurement and Estates. In the context of this Service Plan, while deliverables for 2007 are presented by lead Directorate, in many instances their implementation will require conjoint working. In order to avoid replication, these are not repeated in each section of this Service Plan, but will be detailed as appropriate in the relevant Business Plans.

The format of this Service Plan is different to that used for both the 2005 and 2006 National Service Plans.
The new format is designed to present a Service Plan that is firmly based on quantifiable outputs, outcomes and targets and presents a more integrated approach to service delivery.

We have linked, where applicable, the different actions to the Transformation Programme and project (s) that they are supporting. This is to ensure that what we are doing is aligned to achieving our overall Transformation Priorities and that we deliver on the agenda.

The Service Plan is set out in the following sections:

Section 1 – Introduction

The Introduction briefly outlines the legal and policy framework and identifies the key underlying planning assumptions governing the preparation of the National Service Plan, and describes the proposed accountability and governance arrangements to ensure its delivery in 2007. It also outlines the Population Health priorities that have been used to guide the preparation of this Service Plan.

Section 2 - Outstanding Issues

This section reviews, at a high level, the items we committed to in the 2006 NSP but have not been in a position to progress or complete in 2006.

Section 3 - HR data

This section sets out in tabular form the HR resources to be employed for 2007.

Section 4- Outputs

Here we describe the focus of the relevant service area, outline what was achieved in 2006 and the deliverables we will be assessing our performance against in 2007.

Section 5 - Service Initiatives for which investment funding has been allocated

This section is where we detail the services for which we have received investment funding.

Section 6 - Quality

While quality is inherent and embedded in all our actions and daily practices, this section of the service plan outlines some of the initiatives that are planned in each directorate as part of the HSE's commitment to improving quality.

Section 7- Value for Money

Value for Money initiatives are those which ensure that resources are used economically and efficiently and that where economies of scale or sharing of best practice can achieve these principles, initiatives are implemented accordingly to ensure the most effective outcome. Specific initiatives planned for 2007 are included here.

Section 8 - Consistency and Social Inclusion

Consistency of service provision relates to those initiatives being pursued which ensure geographical equity and equity of access to treatment and care. Specific initiatives planned for 2007 are included here.

Section 9 - Outcomes

This section outlines some of the key health impact areas which will influence health outcomes, and are by definition long-term.

SECTION 1– INTRODUCTION

National Service Plan (NSP) – the legal framework
Under the terms of the Health Act 2004 the Health Service Executive (HSE) is required to prepare a Service Plan for the financial year in question. Once adopted by the Board of the Executive, the National Service Plan must then be submitted to the Minister for Health and Children for approval. While the Act stipulates that this should be done no later than 21 days after the publication of the Estimates (i.e. by December 8th 2006), the Minister has extended the time for submission of the National Service Plan 2007 to 17th January 2007 in order to allow the Board time to incorporate the additional funding and measures which the Government announced in the Budget.

This service plan outlines the agreed level of health and personal social services to be provided by the Executive for 2007 within the voted allocation of the Oireachtas, to be published in the Revised Book of Estimates 2007, and in accordance with government policy on employment control within the health service. The CEO, as the Accounting Officer, will give priority to managing the vote in compliance with his legal remit.

The Service Plan 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 Act).

National Policy Context and Strategic Focus
Health and personal social services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System For You* (2001).

In October 2005, the Minister for Health and Children formally accepted the HSE Corporate Plan in respect of the period 2005-2008. This Corporate Plan fulfils a number of roles. It outlines the HSE agenda for the period, identifies our response to the National Health Strategy (Quality and Fairness), reflects the policy 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 National Service Plan and associated business planning process.

The Corporate Plan was framed in a time of transition and we envisaged at the time of publication that we would need to revisit the plan as the organisation matured and new information emerged. During 2006, we have been working on the preparation of a transformation programme for the HSE. Since the publication of the Government Decision on the Health Reform Programme in 2003 and the establishment of the HSE in 2005, much of the focus has been on structural reform. While this has been essential, it is now timely that we turn our focus to transformation.

We have identified six transformation priorities (2007-2010). To achieve our six Transformation Priorities within the next four years, we will be focusing on 13 different Transformation Programmes.

These programmes fall into two separate groups;

A. Those that will impact directly on services that patients, clients and carers receive; and
B. Those that will improve our infrastructure and capability to provide and support these services.

Within these programmes will be a series of individual projects and sub projects which will have specific objectives, measures, milestones and accountabilities.

The deliverables in relation to implementation of these programmes and projects for 2007 are included as appropriate in this service plan.

Planning Assumptions
In drafting our service plan for 2007 the following planning assumptions apply:

- The priority focus is improving patient care, better value for taxpayers' money and improved health care management.
- The overall policy framework is that set out in the *National Health Strategy Quality and Fairness: A Health System For You* (2001) and the approved HSE Corporate Plan (2005-2008)
- Commitment to achievement of our 6 Transformation Priorities
- Service delivery is framed within a Population Health model.
- Delivering on our commitments as set out in Towards 2016 – *Ten Year Framework Social Partnership Agreement 2006-2015.*
- Service developments will be financed in two ways, either through new development funds which have been specifically allocated to the Executive in the Vote or through the realignment of existing resources.
- Approved employment ceilings apply and a tight focus on employment control will continue.
- Delivering better Value for Money (VFM) is a key objective.
- Supplementary Estimates cannot be anticipated, ongoing contingency arrangements continue to apply.

Accountability and Governance
The NSP is supported by a business planning process which will facilitate its delivery by the Executive during the year. Each element of the NSP is supported by a range of Business Plans at area, local and unit level that translate the national deliverables into local deliverables at all levels of the system.

We are committed to the further development and promotion of a performance management culture as an integral part of the way we work. This ensures that we account for our performance in a transparent manner. To ensure that implementation of, and accountability for, the NSP and associated business plans are in place, a standardised Performance Monitoring Framework is in place. This Framework ensures that at all levels of the Executive we are monitoring the achievement of our objectives within allocated resources and approved employment levels and taking the necessary corrective action as appropriate.

The Framework details timeframes for the completion of defined monthly and quarterly performance monitoring reports. It also outlines the format of these reports, which include both a qualitative and quantitative assessment of our performance by reporting against the objectives and actions outlined in the NSP, activity and performance measures (including the National Performance Indicator Suite) together with financial and human resource performance.

A standardised approach to performance monitoring will enable the Board to oversee the implementation of the NSP in accordance with its legal obligations, and account to the Minister for Health and Children for the provision of the services as specified within the Plan.

The Minister for Health & Children has specifically requested that special attention be given in 2007 to the management of investment funding. The new format of the Service Plan will facilitate the provision of reports which include a dedicated section on the application of targeted investment funding for 2007.

The Minister has also emphasised the need to secure greater value for money and cost effectiveness from our core funding. The HSE is developing an active VFM and cost reduction plan for 2007-2010. During this period savings of €500m are being targeted. These savings will be ring fenced and redeployed to frontline services. Section 7 of this Service Plan sets out the HSE strategy and listed initiatives to progress the development and delivery of VFM in 2007; again, the format of the Service Plan will enable us to provide clear reports on progress in this critical area.

Population Health Model of Health & Social Care
The traditional health and social care model is primarily episode-based and demand led. A Population Health model, on the other hand, takes a more proactive approach by focusing on maximising the health and social well being of the population and providing opportunities to plan for better health.

Its primary focus is the promotion and protection of the health of the whole population and/or its subgroups, with particular emphasis on reducing health inequalities. It takes account of all the factors that can influence the health and well being of the population such as demographics, socio economic factors, chronic disease, health technology and legislation. It also recognises that everyone has a responsibility to promote and protect their own health and the health of others.

With the Population Health approach the opportunities to sustain a healthy population can be increased when funding is rebalanced towards reducing health and social inequalities and disease prevention. Experience elsewhere suggests that this approach is likely to be the least expensive model in the long run (Wanless 2004). This 'full engaged scenario' as described by Wanless also helps to prepare a health service that can meet the demographic and other changes that will take place during the next 10 – 20 years.

The Population Health model is a single interconnected, integrated health and social care system with the primary and social care network at the heart of system for a person accessing the required services.

With this approach the primary point of contact between a person and the Health and Social Care System is through their local Primary Care Team (PCT). PCTs provide an expanded level of services and empower people to self care and promote their own healthy lifestyles. This reorientation enables more care to be provided in more appropriate settings.

Each PCT will provide services to a population of approximately 4,000 to 10,000. Where necessary the PCT will utilise services in the wider Primary Care and Social Network where a broader range of services will be available (e.g. Speech and Language Therapy). The wider Primary and Social Care networks will provide services to populations of approximately 30,000 to 50,000. Where required, the PCT will refer to specialist services provided within the primary, community and continuing care setting (e.g. child and adolescent mental health services) or acute hospital services. The establishment of primary care services will allow hospitals to concentrate on those who need more complex interventions. In the hospital sector, there will be an emphasis on developing clinical networks and defined roles for each hospital.

Health Status 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 HSE's Service Plan 2007.

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 *and*
5. Changing legislation

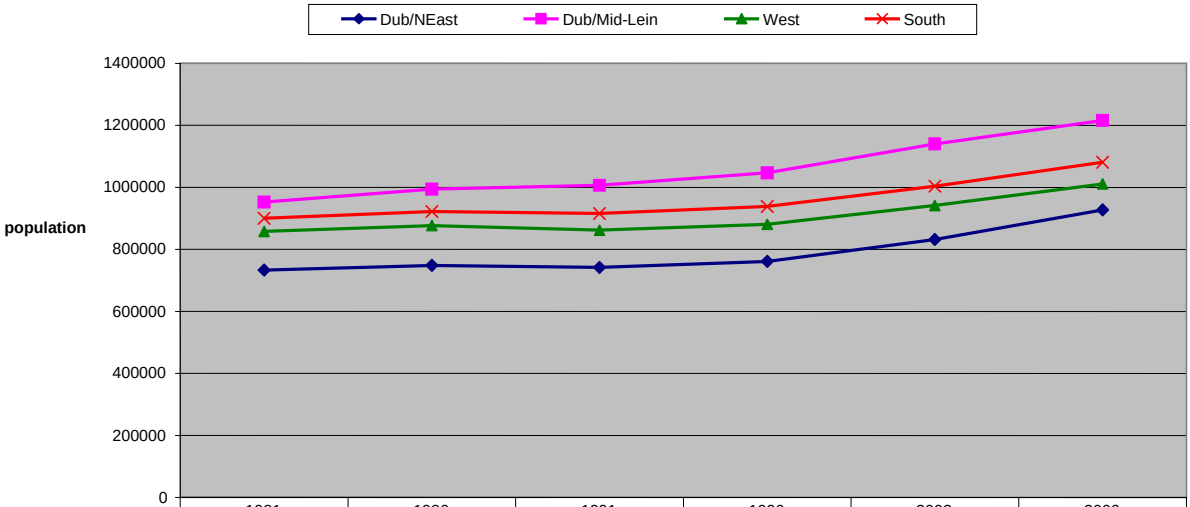
1. Demography
A key factor in the demand for health and social care services will be the structure of the population and how that is expected to change.

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 the highest number recorded since 1861. Figure 1 below 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 2 below, Ireland's population increased at an annual average rate of 1.6 per cent between 1996 and 2006 – the largest population growth rate in the EU.

In addition to providing census data at regular intervals, usually every five years, the Central Statistics Office (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 2 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 2 Population Projections 2005-2019

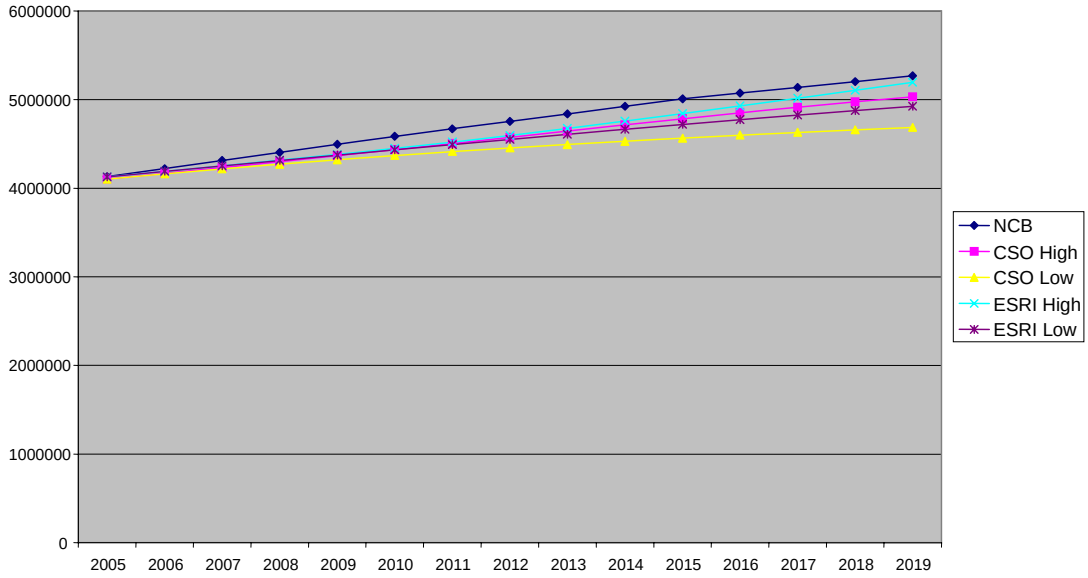
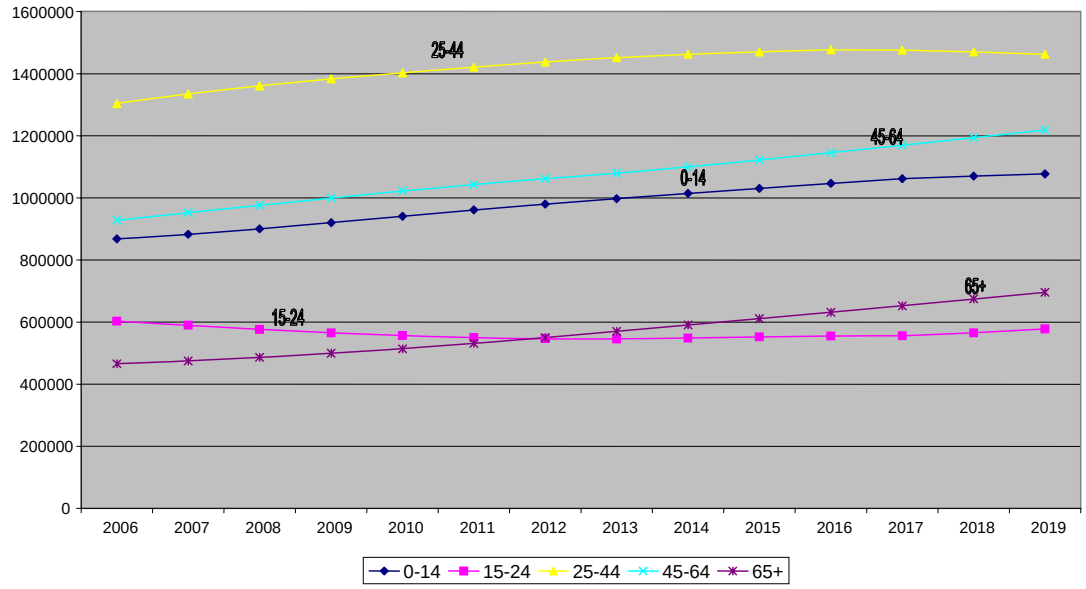


Figure 3 below outlines how the age-groups will change in that period

Figure 3 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 an increased comprehensive health and social care 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 diseases 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 disease management will be crucial.

Conclusions on these demographic trends:

- The population is at an all time high. Population growth will require an increase in services for all age groups.
- The ageing of the population will have implications for the provision of most services.

- The increasing incidence and prevalence of chronic disease among the middle aged and older groups will require, in particular, the development of new models of chronic disease management.
- The HSE will need to engage with other relevant bodies, for example, local authorities in relation to social housing for older people.
- 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 etc.
  - Tackle significant lifestyle risk factors which currently represent a major threat to the health of Irish people e.g. alcohol, tobacco, and obesity.
  - Ensure that everyone has access to evidence based interventions such as statin drugs, treatment for high blood pressure, better treatment of chronic disease 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.

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 social care services will need to provide for a multi-ethnic mix of cultures in the delivery of health and social care. 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 effect the sense of well being of adults and children and the pressures on the health and social care services.

3. The level and Management of Chronic Illness

Worldwide there is an increasing incidence and prevalence of chronic diseases and conditions. Chronic diseases 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 disease. Approximately 25% of the population has a chronic disease and 60% of deaths are as a result of a chronic disease.

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 diseases. 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 diseases. The care of people with chronic diseases consumes a large proportion of health and social care resources:

- Chronic diseases account for 78% of all health costs (US data).
- 80% of G.P. consultations relate to chronic disease and patients with chronic disease or complications use over 60% of hospital bed days (UK data)**.**
- 2 out of 3 patients admitted as medical emergencies have exacerbations of chronic disease.
- People with multiple chronic diseases are extremely high users of acute services; 5% of in patients account for over 40% of all inpatient bed days.

Formal generic chronic disease management programmes have been operational in the U.S. for over a decade, they 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 the older persons of 41% ,
- 35% reduction in urgent care visits, and
- Significant increases in patient and family satisfaction together with improvements in service integration, more appropriate referrals and faster response times.

Our current provision of primary care services is out of line with the epidemiology of chronic disease. Acute exacerbations of chronic disease are the cause of most emergency medical admissions to hospital in Ireland and contribute significantly to the difficulties facing Emergency Departments. Chronic disease management is therefore one of the biggest challenges facing the HSE 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 the HSE 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. The HSE will support the new Health Information and Quality Authority in conducting Health Technology Assessment, which is a methodology to consider the effectiveness, appropriateness and cost of technologies, and will ensure that such assessments inform the use of technology.

5. Changing legislation

Another significant driver of services and costs is new legislation. European Union Directives and new and changing legislation has 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 2007

Increasing the emphasis on primary care and health promotion

By increasing its emphasis on primary care, the HSE can provide high quality care, through community-based primary care teams, to people with stable chronic disease, such as diabetes, heart disease, 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 shifting 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

By seeking to improve the health and well being of the whole population, and in particular the health of population sub groups, the HSE is seeking, for example, to improve survival rates from heart disease, five year survival from cancer, the social well being of older people and disadvantaged groups.

Improving quality & safety

By strengthening quality and risk management governance structures and processes, the HSE can support the goal of improving the ability of all health and social care providers to offer a safe and seamless service to the highest international standards.

bDuring 2006 a dedicated **Quality & Risk** division was established and commenced work on the development of a national strategy. A Quality & Risk committee of the HSE Board was also established, which will oversee the work of the division. During 2007 national standards for Quality & Risk will be introduced, and effectiveness will be monitored.

Promoting equity as a strong value in the health system

There is a strong social class gradient in health status where those in the lowest socio-economic group have the highest death rates for all causes of death. The HSE is working to narrow this gap by influencing all the major factors which determine the health and well being of the population and by targeting resources to those most in need.

Developing services based on 'identified need' and evidence

By adopting a 'formal needs assessment' approach to identifying service shortfalls, the HSE can establish the most appropriate investment options based on anticipated outcomes and cost. This approach, which makes its planning process more explicit, also ensures that evidence based interventions are put into practice.

Measuring investment returns

By ensuring that specific and measurable health outcome targets are measured against achievements, the HSE can identify the health and social return accruing from its health investments. For example, in the implementation of the newly published Cancer Control Strategy, five year survival rates for different cancers will be monitored and compared to the level of investment provided for cancer services.

Improving user participation and empowerment

This involves constructively engaging the public in the development and delivery of health and social care services. It requires, amongst other things, measuring user satisfaction, a statutory system of complaints handling, involvement of individuals and families in their own care and the participation of the community in decisions regarding health and social care services. Responding to the increasing trend for people to access health information from different sources such as pharmacies, the internet etc., the HSE will support local people to access high quality evidence based information on health promotion and self management of chronic and minor illnesses.

SECTION 2 – OUTSTANDING ISSUES / COMMITMENTS

This section reviews, at a high level, the items we committed to in the 2006 NSP but have not been in a position to progress or complete in 2006.

Primary, Community and Continuing Care (PCCC)

A number of commitments made in the context of the 2006 Service Plan require a continued focus in 2007. These are outlined in the sections below.

Primary Care
The reform of primary care services is a key priority for the HSE and this service plan outlines a series of measures which support the realisation of the reform agenda.

Considerable work was undertaken in 2006 to transform and re-orientate Primary and Community Services, principally through preparation to roll out 100 Primary Care Teams in Development.

A major national recruitment campaign was undertaken to source 300 frontline clinical staff to support these new teams and to facilitate the introduction of a national system of integrated, patient centred care. In addition, significant interest was expressed by existing HSE staff in participating in the re-orientation of Primary Care services

A panel has been created following the campaign and the filling of posts has commenced.

Plans to bring on stream the targeted number of GP training places in 2006 required an adjustment early in the year. In all, 13 additional places were delivered and plans are progressing at national level through the GP Vocational Training Steering Group to identify the additional capacity targeted for 2007 / 8.

Children and Families
Significant progress has been recorded across Children and Families services over the course of the year.

During the year resources were applied to successfully complete the Hib Catch-Up campaign, a core element of the Child Health vaccination programme.

Implementing the remaining health related components of the Children's Act will continue to be a priority for the HSE, as is our commitment to the strengthening of Social Work, community based services for children and Family Welfare Conferencing. This will be progressed in 2007.

While preparatory work on the introduction of universal neonatal hearing screening for children was undertaken during 2006, there are still significant issues to be addressed.

Mental Health
2006 was a year of significant progress across Mental Health services in Ireland. The Report of the Expert Group on Mental Health Policy – A Vision for Change was adopted as HSE policy in May 2006 and an Implementation Group to drive and co-ordinate the implementation of the Vision was established in July 2006.

Work has commenced in preparing an Action Plan for the implementation of the Vision for Change and the HSE has met with the Monitoring Group on its implementation. New resources provided in 2006 were used to begin the process of implementing the Vision as all allocations were considered against the recommendations of the Expert Group. This will continue in 2007.

Part 2 of the Mental Health Act, 2001 was commenced on 1st November 2006. This was the culmination of considerable work during 2006 to prepare the system for full implementation.

In 2006, the HSE provided for the development nationally of 18 consultant led mental health teams in General Adult Psychiatry. A further 14 team enhancements were also approved.

The focus in 2006 has been on recruiting Consultants within these developments. By the end of the 3rd quarter 2006, 10.6 WTE had been filled on a locum basis, with the balance to be recruited by year end.

During the year a forum on Child and Adolescent Psychiatry was established to make recommendations on capacity in this key service. Each Administrative Area identified 3-4 beds on an interim basis in 2006 to address the capacity issue in the short term. The recommendations of the forum will be addressed in 2007, having regard to resources.

Additional capacity was also provided for persons with a significant intellectual disability and mental illness, for services for the homeless and mentally ill and for older persons. These are at varying stages of progress and will continue into 2007.

The timeline for new services at Our Lady's Hospital Cashel to come on stream was revised during 2006. The service is expected to be operational by early 2007. The new unit at Cardonagh is expected to be operational in early 2007.

2007 will continue the trend set in 2006 with the bedding in of developments and further capacity building in the areas referred to above.

Older Persons
Considerable resources were applied across Services for Older People in 2006.

A number of commitments made in the context of the 2006 National Service Plan require a continued focus in 2007.

Significant progress was achieved on the development of a standardised care needs assessment tool across Local Health Offices. The initial phase of this work is

now complete and a Steering Group has been established to oversee its phased implementation in 2007, having regard to resources.

Resources allocated for the development of meals on wheels services were targeted at strengthening and supporting the management, technical capacity and overall delivery of services by the voluntary sector to enable them meet higher regulatory standards. This will continue in 2007.

The piloted Assistive Technology project targeted at maintaining older people in their own homes will continue to be progressed in 2007.

Palliative Care
The recruitment of new Community Outreach nursing staff for Paediatric Palliative Care services commenced in 2006 and is expected to conclude by the end of the first quarter 2007.

Enhancement of community services was undertaken in all Areas with varying approaches taken to the augmentation of teams. Work is ongoing on this and will continue in 2007.

Social Inclusion
The mid-term review of the National Drugs Strategy recommended the development of a pillar of the strategy specifically focussing on rehabilitation. The implementation of this phase will continue to be a priority in 2007 and will be incremental year on year, with a project plan underpinned by a population health approach.

The National Intercultural Strategy will be completed, with a launch scheduled for the first quarter of 2007. The implementation plan will identify short, medium and long term goals and mechanisms for monitoring progress. Work will continue on the training, learning and support needs of staff to deliver intercultural health services.

Work will commence to integrate the piloted (2006) ethnic identifier question into appropriate systems of generic data collection.

Undertaking the first national traveller health study will continue to be a significant task for the HSE in 2007.

Work will begin in partnership with respective government departments and NGO's to implement the review of the integrated strategy on homelessness.

Work will commence to scope the transition of the management of alcohol services from mental health to social inclusion services.

A review of how drug and alcohol services can have a better fit with the unitary structure of the HSE will be completed.

Embedding National Anti Poverty Strategy (NAPS) including the RAPID and CLAR programmes in an integrated manner within the development and delivery of services will continue to be a priority in 2007.

Mapping work undertaken by Social Inclusion services will continue in 2007.

Disability Services
The implementation of part 2 of the Disability Act with effect from the 1st June 2007: While work has begun now on the recruitment of Liaison and Assessment Officers, the ongoing reconfiguration of Early Intervention Services will have to be completed prior to the implementation of the Act and work in this area is being progressed.

The Multi-Annual Investment Programme provided additional capacity in home support, personal assistants, residential, day and respite places in 2006. However, the provision of enhanced multi disciplinary support to adults and children with a disability was contingent on the successful recruitment of additional therapy staff. A number of staff have been recruited or are in the process of being recruited to support this initiative and this will continue in 2007.

The recruitment of Resource Officers for persons with Physical and Sensory Disability will conclude in early 2007.

Work which began in 2006 on reviewing the Partnership Framework will continue and will reflect the revised organisational structure of the HSE.

A delay in planning permission for the new unit at COPE Foundation, Cork required an adjustment of the timetable for completion of the build. It is expected to commence in March 2007.

National Hospitals' Office (NHO)

2006 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 is reflected in increased activity levels, with hospitals reporting an overall trend of increasing levels of emergency admissions impacting on scheduled elective workload.

There are some significant gaps in acute service provision to be addressed, in particular in relation to the move to regional self sufficiency e.g. Neurology, resulting in an additional burden on existing service providers and on patients who may have to wait for access to services or travel outside of their region.

There are also many key service areas that need further investment e.g. critical care and neurosurgery. Similarly, gaps in other non acute service areas result in an over dependence on the acute sector for services that should be provided in the community setting. This contributes to the high level of attendances at EDs and to delays in discharging patients once the acute episode of care has been completed. These issues are being addressed by the HSE both strategically and operationally and this will continue in 2007.

Infection Control was identified as a key priority to be addressed by the HSE in 2006. There has been increasing surveillance of hospital-acquired infection (HAI) nationally due to a greater awareness of the consequences of antibiotic resistance and the impact on the quality of health care. The HSE will continue to work with agencies during 2007 to reduce the numbers of HAIs, particularly the spread of MRSA.

Implementation of the 10 Point Plan: The NHO continued to progress the initiatives funded under the 10 point plan to reduce the numbers of patients awaiting admission to hospital.

The need for proactive management of acute bed utilisation has been a key priority for the hospital sector and this will continue into 2007.

The NHO has played a key role in 2006 in developing the HSE approach to ensuring that the services required to address the particular demands of the winter season are in place and operating optimally. In particular, the work initiated in reducing the ED waiting times for patients for admission will continue to be prioritised in 2007 at NHO national, network and hospital levels.

In March, the HSE established a dedicated A&E Task Force, led by NHO, to facilitate the implementation of the HSE's Framework for addressing ED Services and to work closely with hospitals experiencing problems in the delivery of ED services. The Task Force focused on those hospitals that have persistent challenges in ED Departments and emphasised three goals to these hospitals: reducing the numbers waiting in ED Departments; reducing the length of time that patients wait; and improving the overall patient experience. The NHO will continue to work in 2007 to address the issues highlighted in the Task Force report.

Planning and Development
During 2006 the NHO established a Planning and Development function and have been centrally involved in a number of service reviews and strategic planning areas that will be ongoing into 2007. These include:

- The National Acute Bed Capacity Review
- Southern Hospitals Review
- Mid West Hospitals Review
- Paediatric Services Transition to new National Paediatric Hospital
- Implementation of the Report on the North East
- Acute Hospital Inpatient Bed Utilisation Review

Acute Hospital Service Developments:
During 2006 additional funding was allocated for service developments in cystic fibrosis, neurology, obesity, renal and cancer services. There was some progress in enhancing services in all of these areas during the year, as reported in the Service Plan Performance Monitoring Quarterly reports 2006. However there was a lag in full implementation of service developments as the implementation of any new developments are timed in the context of hospitals achieving financial breakeven for the year.
The NHO will continue to track the implementation of these developments in 2007.

New Units:
During 2006 additional funding was allocated to facilitate the opening of new units as reported in the Service Plan Performance Monitoring Quarterly reports 2006. The NHO will continue to track the implementation of these new units in 2007.

Contracts and Utilisation
The NHO Contracts and utilisation function has also been centrally involved in a number of strategic reviews and contracting work that will be ongoing into 2007. These include:

- The National Laboratory review:
- Co-Location procurement process introducing private hospitals on up to 10 public hospital sites
- Tender for Renal Services
- Promoting Performance Related Funding
- Allocation and Utilisation of funding in Acute Hospitals – VFM Review – Southern Hospitals Group
- Establishment of a national Performance Monitoring Unit.

Quality and Risk
During 2006 the NHO Quality and Risk function progressed a number of key areas of work that will continue into 2007. These include:

- Development of standards relating to hygiene services, medical records and decontamination
- Membership on the EU Blood Directive National Steering Group established by the Department of Health and Children (DoHC) relating to (2002/98/EC). Analysis of EU Blood Directive related needs including minor capital and human resources.
- The report entitled 'The Prevention of Transmission of Blood-Borne diseases in the Health Care setting' was published in quarter two 2006. Implementation group has been established across directorates and will continue to review recommendations/implementations.
- Membership on National Steering Group established by DoHC relating to EU Tissues and Cells Directive (2004/23/EC). Working group established in fourth quarter 2006 to carry out analysis of needs. This work will continue in 2007.
- Selection of five pilot sites to implement Institute of Healthcare Improvement methodology to improve the management of patients presenting with chest pain. This will be extended in 2007 (100,000 lives campaign) which is an initiative to ensure that evidence based care is delivered to patients for a range of specific conditions e.g. chest pain, wound infection
- Collaborated with the Irish Health Services Accreditation Board to develop hygiene services standards. While these are consistent with infection control protocols, work will continue in 2007 to develop separate infection control standards.

Pre Hospital Emergency Care
During 2006 the NHO Pre Hospital Emergency Care function progressed a number of key areas of work that will continue into 2007. These include:

- Appointment of a cross functional committee to examine and commence a patient needs assessment process and make recommendations in relation to development of policy and systems for provision of patient transport services nationally.
- Prioritisation of the roll out of the Emergency Medical Technician – Advanced (EMTA).
- Ongoing training for EMTs
- Roll out of the Community First Responder Programmes in the HSE Areas in which it operates, to supplement and improve emergency response times.
- Development of programmes to replace current on call arrangements which will enhance employees' working environment and improve service delivery and response times.
- Consideration of the implications of the Technical Review of the Ambulance Command and Control Systems.

Population Health (Pop Health)

The Population Health Directorate has developed in a manner that promotes strong inter-directorate working. particularly with NHO and PCCC. Key areas of collaboration include cancer services, chronic disease management, hospital configuration, emergency planning, healthcare – associated infection, alcohol awareness, breastfeeding, diabetes, and the transition of staff in the Transformation process. In 2006 the directorate contributed strongly to the work of SPRI, for example with the estimates process and the development of high-level national performance indicators. This work is underpinned by the 'Population Health Model of Care'. In 2007 the directorate will work across the HSE in progressing the priorities of the Transformation Programme.

A number of actions that commenced in 2006 will continue to be progressed and implemented in 2007.

Health Intelligence
A major goal is to enhance the health intelligence and learning capability for all personnel in the HSE. Health service delivery cannot be carried out to an acceptable standard without a strong and well established Health Intelligence function. Providing robust evidence and detail about healthcare trends and best practices will progress through the EUROCAT Registry and the Health Atlas. Enhancing capacity in health technology assessment and health impact assessment in consultation with HIQA has developed in 2006 and will be further progressed in 2007.
In addition, specific links with academic partners and government agencies will be maintained.

Health Protection
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. The third prevalence survey of healthcare associated infection in acute hospitals took place in 2006. It has provided important details on the prevalence on HCAI and there is a need for on-going surveillance in 2007.

Health Protection plays a critical role in protecting people from infectious disease. Computerised Infectious Disease Reporting (CIDR) an information system developed to manage the surveillance and control, has expanded to over 85% of the country in 2006.

Negotiations progressed in 2006 in relation to the merger of the Irish Cervical Screening Programme (ICSP) with BreastCheck. Preparations for the national roll out of the ICSP programme will be progressed in 2007.

Emergency Planning
The national and local structures for emergency planning have been agreed by the HSE management team. The development of a robust emergency plan for an influenza pandemic across the HSE is a priority for 2007.

Strategic Health Planning
An evidence based approach for delivering generic chronic disease management programmes is urgently required due to the rising prevalence of diseases such as diabetes, chronic obstructive pulmonary disease and heart failure. Acute exacerbations of these diseases are the cause of many emergency medical admissions and contribute significantly to the difficulties facing emergency departments and to long lengths of hospital stay. Chronic disease management is therefore a top priority and a major challenge for the HSE. In 2006 a scoping/ feasibility study was undertaken which puts the HSE in a position to commence preparation in 2007.

The implementation of the Cancer Control Strategy is a priority in 2007. The initial step will be to undertake a needs assessment which will inform priorities, ensure an evidence based approach to developments and upon which decisions can be made on the many aspects of the service, from prevention to acute care to palliative care. The Cancer Control Programme will be population based.

Maintenance of Cardiovascular services and preparation of a Stroke Strategy will continue in 2007. This is in keeping with the population burden of vascular disease in Ireland in terms of deaths and morbidity. An inter-directorate team has been established to build on the success of 'Building Healthier Hearts' and to conduct an audit of the strategy to date.

The HSE has established a neurosciences multi-sectoral working group to undertake a strategic review and a needs assessment of neurology services nationally. This work is due to report in early 2007 and it will provide an action plan for the further development of the service, taking account of the need for integrated care, technology developments, national and regional priorities and multidisciplinary approaches to meet patient needs.

The development of osteoporosis services and an evidence-based approach to prevent falls in older

people is being planned by a multi-sectoral team. The implementation of the recommendations of this report has the potential to enhance quality of life for people at risk of osteoporosis and older people who are at risk of falling. It will also reduce unnecessary admissions to hospital among older people with serious fractures.

Health Promotion
It is acknowledged that there will continue to be significant growth in demand for adult and child obesity services nationally. The Health Promotion function has provided robust proposals highlighting the various programmes that will be undertaken in order to tackle the obesity crises. In addition, inter directorate work in relation to alcohol awareness, breastfeeding and diabetes has progressed in 2006.

The development of a national tobacco framework incorporating guidelines and quality standards for smoking cessation services continued in 2006. Further advancement with key stakeholders will progress in 2007.

We will lead the development of a National Health Promotion Strategy in collaboration with the DoHC.

Functional Directorates

Finance

Value for Money Program
The Value for Money programme is a key priority for the Finance Directorate in 2007. In 2006 approval was obtained to appoint a head of VFM. This appointment will be in place during 2007. The head of VFM will lead the development of the VFM programme of the HSE for 2007 and will be responsible for developing the VFM strategy and implementing the programme in conjunction with the appropriate Directorates. A key objective of the strategy will be to build a national focus on VFM.

A high level cross directorate VFM group, under the leadership of the head of VFM, will oversee implementation of the Plan and drive the strategy.

Appropriation Account
The Vote accounting team is committed to developing and standardising Vote reporting across the HSE. Work on this project commenced in 2006 and will continue through to completion in 2007.

Financial Reporting
A project to extend the HSE's corporate reporting system to integrate the financial data from the voluntary hospitals and the major disability organisations is underway. Work on this project commenced in 2006 and will continue through to completion in early 2007.

In 2007 the Finance Team will continue to work toward establishing consistency and standardisation in financial management reporting in respect of the Vote and Expenditure Analysis Reports.

The implementation of a single financial management system is critical for the efficient and effective management of the finances of the HSE. Work to recommence this project started in 2006 with a view to the project being fully operational in early 2007.

Transformation
A key finance objective is the transformation of the Finance function from the former eleven Board/ERHA structure to an integrated function in line with the HSE business objectives. During 2006 work commenced on putting in place a senior financial management structure at the level below Assistant National Director to achieve a more integrated finance function in terms of supporting the service areas. This structure will be in place in 2007.

The effective development of relationships with the service areas to support the business of the HSE is very important in the provision of a finance service to advance the aims of the HSE. This work commenced in 2006 will be further facilitated as the structure is implemented in 2007.

As part of the transformation of finance we need to build excellence in finance management. In 2006 this work commenced with the provision of national training on Expenditure Analysis Reporting, Vote accounting, Consolidation of Annual Financial Statement (AFS) and the recently published Financial Regulations. Work commenced on the establishment of a continuing professional development programme by establishing links with Professional Accountancy Bodies. This work will be continued in 2007.

Structure
The finance structures need to reflect the organisational structure if finance is to provide efficient and effective financial management. The structure has been agreed during 2006. In 2007 the next steps will be to complete recruitment into the new structure and undertake appropriate team working initiatives to support the new modes of working.

Capital
A 2006 objective was to implement the B-Plan capital projects cash management system. This was done and in 2007 the work will be completed by rolling out the B-plan system nationally to LHO Managers and Network Managers

Human Resources

There is a significant volume of work, which will continue to challenge the capacity of HR operations within HSE Administrative Areas for 2007. The development of standardised ways of working to prepare for the transfer of high level processing aspects of services such as Recruitment, Personnel Administration and Superannuation to a shared services delivery system has commenced. A joint approach is being taken by the Area Assistant National Directors and Assistant National Director HR - Shared Services to agree and deliver clear objectives.

An ongoing challenge is to provide an integrated approach across the HSE in the area of employment monitoring and reporting. HR will ensure consistent definitions, calculations, treatment, understanding and reporting of WTE utilisation in relation to ceilings.

Strong working relationships across the HR structure have already been established with the National Employment Monitoring Unit (NEMU).

Implementation of the pre-registration midwifery and integrated general / sick children's nursing programmes, including the full roll out of preceptorship training programmes and development of clinical placement sites, will continue in 2007.

Structure for the Nursing Midwifery Planning and Development Units (NMDPU) in the HSE structure will be negotiated and agreed. This will provide for a coherent and integrated approach to nurse education and eliminate any duplication current in the system.

The planned implementation of 100 Primary Care Teams during 2007 will require significant HR service support, occupying significant HR resources throughout the coming year.

ICT

Governance
New governance structures will help speed up the identification and implementation of core clinical systems (laboratory, PACS, pharmacy/prescribing, etc.) and address governance issues raised as part of the PPARS review. Work on this will continue in 2007.

Integrated Patient Management System
Phase 1 of this national initiative has delivered live systems in a number of hospitals in the South, West and Dublin North East regions in 2006. Roll out to further hospitals in the West and Dublin mid-Leinster will continue into the first half of 2007.

Relationship with Department of Finance
Improved working arrangements that better recognise the role (and related procedures and impact) of the department of Finance on HSE ICT operations and spending, will be agreed in 2007. These will then be assimilated into HSE procedures as part of the processes to manage and ensure value for money on ICT investments.

eGovernment
The Government IS Action Plan, EU, i2010 has resulted in a number of recommendations and requirements specifically in respect of ICT in Heath and Personal Social Services delivery being identified by both Government and European Commission. The National ICT Directorate will continue to endeavour to meet these throughout 2007.

Internal Audit

Finalisation and agreement of remaining HSE Internal Audit Structure.

Completion of any outstanding 2006 audits - these were deferred due to resourcing issues and additional special contingency work undertaken by internal audit within 2006. These deferred audits will be reviewed in the context of developing the 2007 internal audit plan. A decision regarding these will be taken in conjunction with the Audit Committee and management team.

National Shared Services (NSS)

The development of Shared Services for the HSE is a key element in the overall Health Service Transformation Programme. The implementation of Shared Services has the potential to deliver significant benefits to the HSE.

The National Shared Services implementation programme commenced in February 2006. Having completed Phase 1 Conceptual Design which defined the scope of services and processes to be delivered by NSS, the programme progressed to Phase 2 (Detailed Design). Phase 2 examined in greater detail and validated the conclusions arrived at in Phase 1. Phase 2 also evaluated implementation approaches for NSS. Following the analysis undertaken in Phase 2, it was concluded that in the absence of single National Information Technology systems and in the interest of minimising risks and maximising benefits the most appropriate approach to implementing Shared Services in the HSE is through the functional directorates.

The NSS programme evaluated possible alternative implementation strategies that are not dependent on national systems, and in December 2006 a decision was taken by the HSE management team and ratified by the Board of the HSE to deploy Shared Services through the functional directorates.

Procurement

During 2006, Procurement formed part of the National Finance Directorate until the latter part of the year when a new Procurement Directorate was established. This will require a strong focus in 2007.

A key objective is the transformation of the Procurement function from the former Board/ERHA structure to an integrated function aligned with overall HSE business needs. The population of the senior posts within the new structure will be completed within the 1st quarter of 2007.

During 2006 significant progress was achieved in developing a senior management structure, at the level below Assistant National Directors, aimed at achieving an integrated procurement organisation. This structure will be in put in place in 2007.

The development of effective relationships with the service areas and supporting directorates is essential in the provision of an integrated procurement service to support the aims of the HSE. Work in this regard commenced in 2006 and will be further facilitated as the structure is implemented is 2007.

A high level cross directorate Steering Committee will oversee implementation of the new directorate and the Head of Procurement (Operations) will drive this implementation in 2007.

SECTION 3 – HUMAN RESOURCE INPUTS

Human Resources HSE by Structure

	2006 Outturn	2007 (Estimate)
	These are actuals at 30th Sept 06	
i) National Hospitals Office	51,351	54,547.50
ii) Primary, Community and Continuing Care	51,065	52,153.00
iii) Population Health	506	568.50
iv) Functional Directorate (e.g. HR, ICT, Finance, NSS, Office of CEO, etc.)	2,997	3,087.25
Total	**105,917***	**110,354.25**

*Variance between overall total and the sum of the totals in the constituent tables is due to rounding.

Note: 2007 Estimate is based on 2006 Outturn (actuals at September 06), plus an estimate of the WTE requirements associated with the targeted investment funding on Pages 95-111. The final figures and distribution by staff category will be the subject of ongoing discussion with the DoHC and HSE.

Human Resources HSE by Staff Category

	2006 Outturn	
i) Management/Administration	12,364	
ii) Medical & Dental	4,884	
iii) Nursing	24,498	
iv) Health & Social Care Professionals	9,117	
v) General Support Services	10,666	
vi) Other Patient and Client Care	8,763	
Total	**70,291**	

Human Resources Voluntary Hospitals by Staff Category

	2006 Outturn	
i) Management/Administration	3,709	
ii) Medical & Dental	2,858	
iii) Nursing	8,280	
iv) Health & Social Care Professionals	2,877	
v) General Support Services	2,924	
vi) Other Patient and Client Care	1,167	
Total	**21,816**	

Human Resources Intellectual Disability Sector Agencies by Staff Category

	2006 Outturn	
i) Management/Administration	1,268	
ii) Medical & Dental	178	
iii) Nursing	3,447	
iv) Health & Social Care Professionals	2,330	
v) General Support Services	1,619	
vi) Other Patient and Client Care	4,970	
Total	**13,812**	

Outputs

Describing, at a high level, the focus of each of our service areas, outlining what was achieved in 2006 and the deliverables (which can be metrics or milestones) we will be assessing our performance against in 2007.)

SECTION 4 - OUTPUTS

Primary Care

Primary Care services aim to support and promote the health and well-being of the population by providing locally based accessible services. The development of primary care services is a key priority for the HSE and a corner stone of its reform programme.

***Primary Care Teams** will be the unit of service delivery for non-acute care and will be assigned to populations of between 7,000 and 15,000. They will be made up of a number of health professionals working alongside General Practitioners.*

Their development involves both the recruitment of additional staff and the re-organisation of existing PCCC staff.

Focus	Output 06	Deliverable 07	Lead Responsibility
Primary Care Reform and Integration *(Transformation Programme 2.1-3)*			
Agree new Contractual framework for GMS and other publicly funded services involving GP's	Negotiations commenced and ongoing	Contractual Framework agreed	PCCC
Agree new D.T.S.S Contract	Negotiations commenced and ongoing	Contract agreed	PCCC
Develop and implement Primary, Community and Continuing Care Configuration Framework *(Transformation Programme 2.2 & 2.3)* *Development of additional Primary Care Teams (PCTs)*	PCCC Reform Implementation Steering Group established. Local Steering Groups established, the majority with senior staff and GP representation. Geo-mapping work identifying location of facilities and resources for new PCTs continued. Needs assessment workbook completed and distributed to all LHOs to inform planning. 100 PCTs in development in place Recruitment process undertaken for 300 support staff for PCTs. Review of 10 Primary Care Implementation Projects completed.	Configuration framework will be developed and will inform the introduction of 100 Primary Care Teams which will be in place by Q4 2007. Quarterly report to describe progress on the re-orientation of existing posts to PCTs. Recommendations of the Review of the 10 pilot Primary Care Teams will be prioritised and disseminated to new Teams	PCCC
Expand access to diagnostic facilities for GPs – X-Ray, bloods, ultrasound *(Transformation Programme 2.5)*	National Governing group for GP/Community Diagnostics Initiative established with agreed governance structure in place.	Output from sub-groups considered and recommendations prioritised. Increased access by GPs to diagnostic radiography facilities via the recruitment of additional HSE radiography staff and/or the purchase of diagnostic capacity from the private sector. Ongoing X-Rays 60,628 Ultrasounds 54,222	PCCC

Primary Care

Focus	Output 06	Deliverable 07	Lead Responsibility
Use of Information Technology	*Computer literacy and computerisation is a development tool for primary care services and is a further reflection of efficiency potential. ICT links with Acute Hospitals offer substantial scope for further efficiency through inter service co-operation.* *Indicator (PC3):* • 28% of GMS GP Practices with Information / Communication Technology links to hospitals • 24% of GMS GP Practices that transmit and receive information via email 70% of GMS GP Practices using certified software packages as recommended by the National General Practice Information Technology Group.	Work with ICGP to promote and support GPs in computerisation of their practices through the GP Tutor Network. (PC3)	PCCC
Expand out of hours GP services	D-DOC Out of Hours Service operational with coverage extending to a further 10% of the national population. 750,000 contacts (estimated year-end)	860,000 contacts (projected)	PCCC
Development of GP Co-operatives *(Transformation Programme 2.5)*	*Indicator (PC10):* • 73% GPs involved in GP co-operatives as a % of all GMS GPs; • 80% of the total GMS population is covered by GP co-operatives.	83% by Q4 90% by Q4	
HSE National Information Line	55,000 (est.) calls received	60,000 (est.) calls dealt with	PCCC
Expand the number of GP Vocational training places in partnership with the ICGP	National Executive Sub-group established in Q1 2006. 13 additional places provided in 2006 Total of 349 GPs in training (July 1st 2006)	Plan to develop additional places over 2007 / 2008 completed.	PCCC
Development of the Hospital in the Home Service (HITH)	HITH proposal developed. Tender process concluded. Service Level Agreement prepared. Preparation for implementation. Oversight committee established.	Subject to awarding the contract. Service initiated in Dublin City and County. 1,500 patients in programme. Q4 Evaluation of programme.	PCCC

Primary Care

*The **National Schemes Modernisation Project** aims to radically reform the Medical Card scheme and related schemes. This involves the development of a modern customer focus approach, with an emphasis on standardisation and simplification making them more customer friendly, administratively streamlined, fair, accountable and I.T. enabled.*

Focus	Output 06	Deliverable 07	Lead Responsibility
National Schemes Modernisation Project *(Transformation Programme 2.7)*			
Implement recommendations of Community Ophthalmic Services Medical Pilot Scheme	Review completed and schedule for implementation agreed.	Recommendations prioritised for implementation, within available resources. End Q4	PCCC
Complete standardisation of medical card business processes.	Work undertaken on the development of a National Business Process document. Standardised data set developed in relation to medical card processes. Work plan developed for Schemes Modernisation Programme.	Audit of implementation of National Business Processes undertaken. Work plan prioritised and its elements implemented on a phased basis, with the following outputs:	PCCC
1. *Integrating Local Schemes registration systems with National Schemes Index*	Functional and technical specifications for real time integration signed off and process commenced.	Local systems integrated with National Schemes Index on real time basis, replacing "batch update" processes. All local systems synchronised with National Index. End Q4	PCCC
2. *Populate Medical Card and GP Visit Card registration database with verified PPSNs and implement National Standard Processes to capture PPSNs on all new applications.*	Population of database with verified PPSN's – 95% of database assigned verified PPSN. Projected 100% of database at 31st of December 2006 assigned verified PPSN.	National Process for PPSN capture in respect of new applications signed off and implemented. Compliance monitoring system in place. End Q4	PCCC
3. *Implement National Data Management and Control Framework in respect of Medical Card/ GP Visit control database to optimise quality, accuracy and currency of data.*	Data synchronisation exercise completed. Review of database in accordance with National Data Management and Control Framework including, review of potential duplicates, review of death notifications, national roll call for persons on database aged 65 years and over. Feasibility study on the establishment of a National Data Quality function initiated.	Data Management and Control Framework implemented in a uniform manner. Feasibility study on National data quality function completed and report to PCCC Management Team for consideration. Project plan in place to facilitate establishment of National data quality function. End Q4	PCCC

Primary Care

Focus	Output 06	Deliverable 07	Lead Responsibility
4. *Review of Community Drugs Schemes, including the establishment of cost effective mechanisms for the supply of drugs/medicines and non drug items under local arrangements such as "Hardship Scheme".*	Report Completed	Commence Implementation of plan on phased basis, following sign-off.	PCCC
5. *Review of National Guidelines for staff involved in decision making for eligibility for Health Services.*	Review completed of National Guidelines.	Revised guidelines document issued to staff. Continued roll out of complementary National Training programme for staff. Ongoing in 2007	PCCC
6. *Development of national information booklet for public on various primary care schemes.*	Booklet signed off and printed.	Booklet distributed to the public, public representatives and advocacy groups etc. End Q1 Booklet reviewed end of 2007 and update process commenced. Ongoing	PCCC
7. *The Application/ Assessment process for Medical/ GP Visit Cards to be streamlined and made more 'customer friendly'.*	Pilot self assessment system commenced in one LHO Area. On line application process for persons aged 70 years and over.	Pilot self assessment system evaluated and report finalised for consideration by PCCC Management Team. End 2007	PCCC
8. *Development and enhancement of competency and knowledge base within HSE (PCCC) on E.U Health regulations.*	Integration of E.U Health Regulations into Schemes Modernisation programme. Transitional arrangements in respect of the European Health Insurance Card Registration process successfully completed.	Carry out review of structures, procedures and overall capacity to manage in an effective way this very complex emerging issue in a proactive manner. Review report finalised and recommendations on restructuring around this complex area of business brought to PCCC Management Team for Consideration.	PCCC
Review of the Indicative Drug Target Saving Scheme.	Review completed.	Recommendations of review will be prioritised and an action plan developed.	PCCC

Primary Care

***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 on contract to the HSE.*

Focus	Output 06	Deliverable 07	Lead Responsibility
Oral Health *(Transformation Programme 2.7)*			
Complete review of Dental Treatment Services Scheme	Review commenced Q2 2006 (including such areas as probity, new contract, treatment items etc).	Completion of Review. End Q2 Development of plan for implementation through agreed governance structure.	PCCC
Access to dental screening services for children and adults	*Indicator (PC7) is an indicator of equity of access to dental screening services:* • 71% of school children in designated classes within national schools have received dental screening.	Promote uptake of DTSS within guidelines. Ongoing Output from Oral Health Services Research Centre will be reviewed in context of standardisation of approach to dental screening in schools. Improve data collection on dental screening uptake in schools. (PC7)	PCCC
National Review Group on Orthodontic Service	Review Report completed	Group established to review and prioritise recommendations. Work plan for implementation developed. Further roll out to HSE Areas, within available resources. Ongoing	PCCC
Development of Integrated Oral Health Services within PCCC		Establishment of National Planning Forum / other appropriate mechanism to develop, integrate and co-ordinate Dental and Orthodontic Services. Structure, terms of Reference and work plan will be agreed. Commence Q1 2007 Development of action plan to address oral health needs of patients with special needs. End Q4 2007 Development of action plan to address oral health needs of patients in long-term residence. End Q4 2007	PCCC
Improve management information on orthodontic services		*A new measure has been identified for collation for 2007:* • Average waiting times by Local Health Office area for orthodontic assessment and orthodontic treatment. Progress the collection of data on waiting times. New data set agreed and rolled out. End Q2	PCCC

Primary Care

Audiology Services *are delivered by PCCC to both Children and Adults. A unitary system provides a number of opportunities to optimise the manner in which services are organised and delivered.*

Podiatry Services *are provided in an ad hoc fashion to older people. Their role will change with the development of Primary Cares Teams/Networks and the greater focus on diabetic care.*

Focus	Output 06	Deliverable 07	Lead Responsibility
Review of Audiology Services	Not applicable	Needs Assessment undertaken. National Plan developed. End Q4	PCCC
National Framework for Podiatry Services	Negotiations with private practitioners providing services on behalf of the HSE completed. Progress made towards agreement on structure for podiatry within the HSE.	Undertake needs assessment/develop Work Force plan. End Q2 Roll out of service-level agreement. Commencing Q1 Participate in planning for School of Podiatry. Ongoing	PCCC PCCC / HR

Children and Families

Services for Children and Families aim to promote and protect the health and well-being of children and families.

Responsive services based on best practice, delivered in partnership with children and their families, carers, local communities and non-statutory, voluntary and community groups enable them to realise their potential.

The emphasis is on provision of universal preventive services, with positive discrimination in favour of the most vulnerable and those experiencing greatest adversity.

A key component of the plan for 2007 is the standardisation of standards, policies and services in the new unitary system.

The 2006 Preliminary Census Statistics indicated that there were 1,041,180

Focus	Output 06	Deliverable 07	Lead Responsibility
Expert Advisory Group on Children *(Transformation Programme 12.4)*	Group established and membership agreed.	Work plan developed. End Q1 2007	Office of the CEO
Towards 2016 *Local Interagency Children's Committee*	Commitment (included in Towards 2016) to establishment of pilot county committees drawing together key agencies, (e.g. local authorities, education, justice).	Participate in and contribute leadership to new county committees to be established on a pilot basis under the auspices of Towards 2016 Children's Implementation Committee.	PCCC
Family Support ***Family Support Strategy*** *(Transformation Programme 2.5 and 2.6)*	Family Support Strategy agreed with DoHC.	Assist the OMC in incorporating the family support strategy within a national policy for children's services. Align policy with PCCC Transformation and rollout of primary care teams and networks. Promote policy across children's services and the wider HSE in association with the OMC. Develop implementation plan for rollout of recommendations on a prioritised basis.	PCCC
Family Welfare Conferences	*Family Welfare Conferences are held in accordance with the provisions of the Children's Act, 2001* *Indicator (CC9):* • 155 Family Welfare Conferences held (projected year-end).	155 Family Welfare Conferences held (estimated)	PCCC
Springboard projects	*Springboard projects respond to the most vulnerable children and families in their own areas.* *Indicator (CC8):* • 1,000 families referred to Springboard Projects (projected year-end).	1,000 families referred to Springboard Projects (estimated).	PCCC
Alternative Care *(Transformation Programme 2.6)* ***Standardising Residential and Foster care***	*Care planning is an important component for the provision of services to children in care. It is important that plans are reviewed regularly to take account of changing circumstances and the needs of the child. The measure below ensures compliance with the 1995 Child Care Regulations.*		PCCC

Children and Families

young people (i.e. people aged 0-17 years) in the country, representing 25% of the overall population.

Overall, the children and adolescent population has increased by 28,149 (2.8%) in the period since 2002. This increase has been in the age groups from 0-9 years as a consequence of year-to-year increases in births from 1997 to 2003.

Since 2003, births have remained at more than 60,000 per year, much higher than in the 1990's.

The numbers of 10 – 17 year olds dropped by about 5% from 2002 to 2005 and remained relatively constant from 2005 to 2006.

Focus	Output 06	Deliverable 07	Lead Responsibility
	Indicator (CC7): • Alternative (Fostering & Residential) Care Working Group established. • Children In Care (October 2006): o Residential - 423 o Foster Care – 3, 083 o Foster Care With Relatives – 1,410 o Other – 189	• Roll-out of new Foster Care Standards to all Local Health Offices by end 2007. • Projected no. of Children in Care: o Residential - 423 o Foster Care – 3,083 o Foster Care With Relatives – 1,410 o Other - 189	
	• 92.4% of Children in Residential care had an allocated Social Worker.	Work towards improved performance in this area.	
	• 31% of children coming into care had a written care plan in place.	Prioritise written care plans for all children in the care of the HSE. Work with professionals to achieve implementation of a consistent format and approach across the HSE.	
Child Welfare and Protection			
Implementation of the Children's Act 2001	Core elements of Children's Act addressed.	Improve our response to core requirements of the Act.	PCCC
Implement a standardised pre-school monitoring framework	Sub-group established to address the production of a standardised report. *These Inspections 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.* *Indicator (CC4):* • 1,984 Pre-school Inspections provided up to Q3	Implement results of Standardised Framework Project. Begin making standardised reports available to the public by end Q2 2007. All reports available to public by Q4 2007.	PCCC
Out of Hours Social Work Service for Homeless Children	Group established to examine recommendations of recent reports in relation to the development of an Out of Hours Social Work Service for Homeless Children.	Policy direction in place subject to agreement with relevant stakeholders.	PCCC

Children and Families

Focus	Output 06	Deliverable 07	Lead Responsibility
Develop responses to the needs of Unaccompanied Minors	Agreement reached with DoHC and the Irish Social Services Inspectorate (ISSI) on application of national residential and foster care standards in centres providing support to unaccompanied children up to the age of 16. Guidelines agreed with ISSI and DoHC regarding care of children aged 17 and 18.	Guidelines rolled out on phased basis within available resources. Recommendations of Bruton Report to be advanced in association with the Office of the Minister for Children and other relevant parties so as to clarify respective roles and improve arrangements for the care of unaccompanied minors.	PCCC
Strengthen the management of High-Support and Special Care Units	National Manager and initial support staff appointed Criteria for appropriate use of Special Care Units developed. 80% of high-support units were consistently reported occupied on monthly basis. Special care averaged 73%.	Single structure framework for High support / Special Care Units in place Resource and staffing reconfigured. Occupancy levels of units addressed. Capacity managed in a flexible and effective way to meet the needs of children. Criteria for use of Special Care applied across Local Health Offices St. Joseph's Clonmel transferred from Dept. of Education and Science and incorporated within HSE Management structures, systems and policies.	PCCC
Review existing Child Protection and Welfare Structures and Services *in relation to the requirements of the Children Act.*		Work with Office for the Minister for Children on implications of Children First review of HSE Child Protection systems.	PCCC / Office of the CEO
Sexual Assault Treatment Unit report	Report Completed.	See Page 111 for details.	PCCC NHO
Youth Homelessness *(Transformation Programme 2.6)*			
Implement the recommendations of the Youth Homeless Strategy	Establish group to examine recommendations of the Youth Homeless Strategy.	Regular reports provided on progress.	PCCC

Children and Families	Focus	Output 06	Deliverable 07	Lead Responsibility
	Management Information			
	Review existing datasets across Children and Family Services *including the National Childcare Minimum Dataset*	Significant improvement in data availability and quality achieved in monthly and quarterly indicators and measures.	Agree prioritised, in-depth approach to collection, use and dissemination of key management information which underpins a strategic representation of children's services and informs their development. *New Indicators have been identified for collation during 2007:* • Number of notifications made of child abuse or neglect; • Number of assessments conducted following notification; • Number of children on waiting lists for assessments following notification of child abuse or neglect • Average time spent on a waiting list for assessment following notification of child abuse or neglect. Note: *Specifics will need to be refined in the context of the development of the Indicators*	PCCC / Office of the CEO

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 Primary Care Teams.*

All of these have significant implications for the manner in which Mental Health Services are planned for and delivered.

Focus	Output 06	Deliverable 07	Lead Responsibility
***Implementation of Vision for Change,** which has been adopted as policy by the HSE for mental health services.* *(Transformation Programme 2.6)*	Awareness raising within the services and among staff. Implementation Team established. Report to Monitoring Group on progress 2006.	Preparation of Action Plan and timeline. Establishment of Project Groups/Sub-Groups to progress priorities identified. Timely reports on progress to Monitoring Group.	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.*	18 additional consultant led multidisciplinary teams in development. 14 team enhancements in development. 10.6 Consultant posts in General Adult Psychiatry filled in a locum capacity (31st October 2006).	Complete the initial development of 18 MDTs. Complete the 14 team enhancements.	PCCC
Expert Advisory Group on Mental Health *(Transformation Programme 12.4)*	Group established and membership agreed.	Work plan developed. End Q1 2007	Office of the CEO
Old Age Psychiatry *Develop Mental Health Services for Older Persons' MDTs of 1 per 100,000, providing domiciliary and community based care.*	Resources targeted at areas where there was no access to old age psychiatry services.	Complete recruitment of old age psychiatry posts and prioritise service development in this area on the basis of need. End Q4 2007	PCCC
Develop additional Child and Adolescent Community Mental Health Teams (CAMHTs).	Working Group established to consider needs of young people with mental illness. Commenced implementing the recommendations of the Working Group. Eight locations nationally identified to provide 3-4 inpatient beds for 16/17 age group, 2 in each administrative area Interim proposals developed to increase by 12 beds the existing child psychiatric units at St Anne's and Warrenstown. 8 additional child and adolescent mental health teams in development. Completion of plans for provision of additional capacity, both beds and staffing, capital and revenue.	Complete the initial development of 8 CAMHT from 2006. Progress the capital plans for the provision of additional capacity in line with recommendations. Ongoing	PCCC

Mental Health

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.

Focus	Output 06	Deliverable 07	Lead Responsibility
Services for people with Intellectual Disability and Mental Health Problems			
Provision of 5 acute mental health intellectual disability inpatient beds *per 300,000 population, or 70 approx nationally.*	A service planning forum to consider and identify the most appropriate model of service delivery required for persons with mental health and intellectual disability needs was established. Report of the Forum was issued in late 2006. Model of service delivery identified.	Local Health Offices to work with existing Mental Health and IDS resources in their areas towards reconfiguration to Mental Health Intellectual Disability (MHID) teams, as described in the Vision for Change. End Q2 2007 Gaps in service identified following re-configuration. Ongoing	PCCC
National Forensic Service (Central Mental Hospital)	Deferral of proposals to expand outreach service due to impact of Criminal Law Insanity Act. Opening of 8 new beds to increase capacity. Establishment of Project Group for relocation of CMH to Thornton.	Continue with the expansion of outreach services (Ongoing). Progress the Relocation Project in conjunction with the Department of Justice Equality and Law Reform and the Department of Health and Children	PCCC
Homelessness and Mental Health	Enhancement of the provision of services in larger urban areas undertaken.	Development of supported accommodation/mental health service for Dublin area to mirror Homeless Access Team.	PCCC
Implementation of Mental Health Act			
Development of role of Authorised Officers	Draft Regulations circulated by DoHC. Interim arrangements for role prepared.	Development and roll out of training for Authorised Officers in conjunction with Mental Health Commission. Ongoing	PCCC
Arrangements for Second Medical Opinion	Working Group established to recommend proposals to meet this requirement.	Implement recommendations of Working Group. 2nd opinions provided in line with demand for same.	PCCC
Meet legal obligations in providing for Assisted Admissions	Working Group established to consider how best to meet this requirement and to make recommendations. Engage staff associations in dialogue on the issue.	Keep the arrangements for the provision of service under review in line with demand.	PCCC

Mental Health

Focus	Output 06	Deliverable 07	Lead Responsibility
Primary Care and Mental Health *(Transformation Programme 2)*	In conjunction with the ICGP: • Produced protocols for the recognition and treatment of depression and anxiety. • Developed a standardised referral form to improve communication between Primary Care and Specialised Mental Health Services. • Developed and piloted a 10 module online training for GP's in collaboration with ICGP. • Developed a specification for counselling in primary care settings.	Build on work from 2006 to support the primary care professionals by: • Implementing the protocols. • Introducing the standardised referral form. • Extending pilot training programme. • Work with the Primary Care Teams in Development to support and enhance the care pathways through primary care to mental health services.	PCCC
Management Information	Began the process of geo-mapping the mental health services by population, in conjunction with Population Health.	Developing the analysis of need on a population basis and using the analysis to target resources. By end Q2 2007 Complete the geo-mapping of the mental health services. By end Q2 2007	PCCC
	Improved the quality of reporting on minimum dataset and on service plan. *As part of reporting against the minimum dataset, Indicator MH5 facilitates monitoring of :* *1st admission rates as a proxy measure of the effectiveness of community based services. Indicates the appropriateness of intervention with various care groups. Trends over time are an indicator of improvement. Re-admission rates to inpatient acute units can be an indicator of the effectiveness of inpatient interventions and integration with community services*	Build on the minimum dataset in conjunction with the HRB and the Local Health Managers.	
	Specific measures include: • Admissions to General Hospital psychiatric units / Psychiatric Hospitals* : 17,194	17,194	
	• First Admission rates to General Hospital psychiatric units / Psychiatric Hospitals* : 4,472	4,472	

Mental Health

Focus	Output 06	Deliverable 07	Lead Responsibility
	• Inpatient re-admissions to General Hospital psychiatric units / Psychiatric Hospitals* : 12,722	12,722	
	• Discharges from General Hospital psychiatric units / Psychiatric Hospitals* : 16,851	16,851	
	• No. of Inpatient days utilised in General Hospital psychiatric units / Psychiatric Hospitals* : 427,084 *Note 2005 validated data – excludes activity in private hospitals.	427,084	

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-centredness and empowerment of service users underpin service delivery. Services for Older Persons are also an integral part of the HSE response to the requirements of the ***Winter Initiative Programme*** *which strives to implement a range of actions to ensure the delivery of patient care in the most appropriate setting and includes the introduction of*

Focus	Output 06	Deliverable 07	Lead Responsibility
Expert Advisory Group on Older People *(Transformation Programme 12.4)*	Group established and membership agreed.	Work plan developed. End Q1 2007	Office of the CEO
Home / Community Supports *(Transformation Programme 2.5 and 2.6)*			
Development of home and community based services and supports – *Home Help*	<u>Home Help Hours</u> 11,000,000 916,000 Monthly average hours provided 45,500 clients in receipt of home help service (monthly average)	<u>Home Help Hours</u> 11,000,000 hours and additional 780,000 (see page 100). 916,000 Monthly average of hours provided (by end Q4). Average of 45,500 clients in receipt of home help service (allocation of investment funding will affect this average as resources are applied).	PCCC
Development of home and community based services and supports – Home Care Packages (HCPs) *Home Care Packages 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 from community, inappropriate admission to acute hospital or requiring discharge to home from acute hospital.*	<u>Home Care Packages</u> National Guidelines on Home Care Packages finalised 2,350 (equivalent) Home Care Packages in place.	Evaluation of the effectiveness of Home Care Packages 2,350 equivalent HCPs and additional 2,000 (see page 100).	PCCC
Development of day-care services.	1,325 additional places provided, bringing total places to 21,000.	21,000 places and additional 1,100 (see page 101).	PCCC

Older People

hospital avoidance mechanisms, the development of local plans to ensure maximum operational capacity and capability within both hospital and community settings.

The 2006 Preliminary Census Statistics indicated that there were 470,600 older people (i.e. people aged > 65 years) in the country, representing 11% of the overall population.

While the share that older people represent of the overall population has remained steady at 11.1% since 2002, there has been very substantial growth in the number of those over the age of 85 in the past four years.

Focus	Output 06	Deliverable 07	Lead Responsibility
Community Intervention Teams (CIT) *(Transformation Programme 2.5)*	4 Community Intervention Teams developed in 2006.	4 teams fully operating.	PCCC
Sheltered Housing	Report of HSE national committee on sheltered housing finalised. Standardised application process for sheltered housing funding and template for Service Level Agreement developed and distributed to all LHOs. Development funding allocated to voluntary sheltered housing providers.	Continue to resource sheltered housing providers to develop social support services for residents and community, including home support and personal care services, day care, meals, etc. Ongoing	PCCC
Uptake of Flu Vaccine *(Transformation Programme 1.2)*	Promotion of the vaccine undertaken as part of the Winter Initiative Campaign. *Immunisation with the influenza campaign can prevent respiratory complications and save lives.* *Indicator (OP3):* • 56%* uptake of influenza vaccine among the GMS population aged over 65 years. *(based on PCRS data)	Continued promotion of uptake of vaccine (OP3).	PCCC
Implementation of national standardised care needs assessment process, including a common assessment tool for the HSE	Report of working group finalised. Implementation Group established to oversee the implementation of a National standardised care-needs assessment process.	Phased implementation of National Standardised Care Needs Assessment process across Local Health Offices. Ongoing Regular reports provided on implementation.	PCCC / NHO
Long-Stay Care Provision			
Long stay charges Reimbursement Scheme	Contract awarded to external company to make payments under this scheme. Payments initiated in November, 06.	Continue with payment schedule as laid out in Contract. Ongoing	PCCC
National Needs Analysis of Long Stay Residential Care Requirements for Older People *(Including Respite Care).* *(Transformation Programme 2.7)*	Needs Analysis completed and submitted to the DoHC.	Report will inform priorities for the National Development Plan and HSE Capital Plan. Implementation plan developed on a prioritised basis.	PCCC

Older People

Focus	Output 06	Deliverable 07	Lead Responsibility
Nursing Home Subventions *(Transformation Programme 2.7)*	Persons in receipt of subvention (Oct '06): Medium – 276 High – 1,025 Maximum – 6,262 Of these 4,735 were in receipt of Enhanced Subvention	Continued provision of subvention in line with eligibility guidelines.	PCCC
	Current health policy states that not less than 90% of the total population over 75 years should be able to continue to live at home. *Indicator (OP4):* • 1% of the total population aged between 65-74 years are in residential continuing care settings; • 9% of the total population aged 75 years and over are in residential continuing care settings.	Work towards the achievement of not more than 10% of the population aged 75 and over in residential continuing care. (OP4)	PCCC
Delayed Discharges	1,050 beds contracted from the private sector. Project plan drawn up for the development of 860 public extended care beds throughout the country. Approved by HSE Board. Discussions with DoHC on funding.	Phased implementation of project plan (see page 102 for details).	
Development of Complex Discharge Unit	Project Group formed. Business case developed.	Subject to Board approval: Service Level Agreement signed. Q1 Service commenced. Q3	PCCC
Rapid Access Clinic (Public / Private Integrated Service)	Service commenced November 2006.	2,000 older people to receive service by year end.	PCCC
Integrated and collaborative working.	Winter Initiative Steering Group established. Integration / Implementation Teams established at LHO / Network Level.	Regular report on local initiatives to support Winter Initiative.	PCCC

Older People

Focus	Output 06	Deliverable 07	Lead Responsibility
Implementation of a standardised nursing home inspection process.	Standardised approach to inspection and reporting of private nursing homes developed, including the development of standardised documentation in all HSE areas. Results of a number of inspection reports of private nursing homes made available on HSE website 798 Nursing Homes Inspections completed (Oct 2006 position).	All inspection reports to be available to the public on HSE website (End Q1 2007) 100% of nursing homes to receive 1st and 2nd inspection.	PCCC
Enhancement of structures to prevent Elder Abuse	National Implementation group on Elder Abuse established to oversee the implementation of the recommendations contained in the Report on Elder Abuse.	1 Senior Case Worker in place in each LHO (32). End Q1 1 Designated Officer in place in each Administrative Area (4). End Q1	PCCC
Clinical Co-ordination of Patient Care pathways In the overall context of the significant investment in and development of community based acute and residential care services there is a growing requirement to ensure effective clinical co-ordination of services across these domains. Service and Standards Improvement.		PCCC will, from within the overall investment package provided target the development of effective arrangements to appropriately manage the risks involved and to ensure high quality and safe service provision to the highest standards Enhance current service improvement through a standardised approach to service delivery and standards	PCCC
Management Information			
Further develop Older Persons Minimum Data set	Minimum data set developed and rolled out across all Local Health Offices.	Expansion of minimum data set. End Q1	PCCC

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 region and Hospital Network both directly provided by the HSE or in partnership with the non-statutory sector.*

Focus	Output 06	Deliverable 07	Lead Responsibility
Development of plans for paediatric palliative care.	National Steering Group on Paediatric Palliative Care established. Work on a 5 year strategy for Paediatric Palliative care initiated.	Prioritisation of plans for paediatric palliative care. End Q1 2007 5 Year Strategy developed. End Q4 2007	PCCC
Development of standards in Palliative Care.	Work undertaken on standards development in partnership with the National Palliative Care Advisory Council, DoHC and voluntary partners.	Framework for National Standards for Palliative Care agreed with relevant stakeholders. End Q2 2007 Work towards the phased implementation of the framework across services. Ongoing	PCCC / Office of the CEO
National Palliative Care Report 2001	Continued implementation of recommendations of the 2001 report.	Area-level action plans developed in line with 2001 National Palliative Care Report. End Q2 2007	PCCC
Baseline Palliative Care Study (published End 2005).		Continue to address inequalities identified in the Baseline Palliative Care Study. Ongoing	
Provision of Palliative Care services for non-malignant conditions.	Initial discussions undertaken.	Process agreed for the Review of Palliative Care Services for non-malignant conditions. End Q4 2007	PCCC / Office of the CEO
Access to bereavement services		Mechanisms identified to improve access to palliative care services for ethnic minorities. Ongoing	PCCC / Office of the CEO
Provision of care pathways for specialist services		Continued development of integrated care pathways for specialist services. Ongoing	PCCC / Office of the CEO
Provision of day care services		Action plan for day-care provision developed in partnership with relevant stakeholders. Q4 2007	PCCC
Minimum data-set for Palliative Care	A new minimum data-set for Palliative Care services was developed and piloted in 2006.	Minimum data set rolled out to all services. Commencing Q1 2007	PCCC / Office of the CEO
Specialist Inpatient Units	Average of 300 patients treated per month in 2006.	300 (average per month)*	PCCC
Home Care Services	Average of 2,200 patients per month in receipt of home care services in 2006.	2,200 (average per month)*	PCCC

Palliative Care

Focus	Output 06	Deliverable 07	Lead Responsibility
Intermediate Care	Average of 100 patients per month accessing intermediate care.	100 (average per month)*	PCCC
Day Care	Average of 200 patients per month accessing day care services.	200 (average per month)* *new minimum data set may necessitate some adjustment to the measures outlined above due to changes in recording methodology.	PCCC

*The allocation of investment funding may impact on the deliverables in 2007 – adjusted targets will be provided should resources be allocated to increasing capacity in these areas.

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, the National Health Strategy and Equality legislation.

The Government's geographically targeted social inclusion programmes, RAPID and CLAR, are targeted initiatives aimed at delivering existing resources to areas of maximum need and extend to

Focus	Output 06	Deliverable 07	Lead Responsibility
Implementation of Traveller Health Strategy *(Transformation Programme 2.6)*			
Expansion of the Primary Healthcare for Travellers' Projects.	The roll-out of the Primary Healthcare for Travellers Projects continued.	Projects reviewed to ensure integrated approach to implementation of the Primary Care Strategy / Travellers Health Strategy.	PCCC/Office of the CEO
Complete All-Ireland Traveller Health Study in partnership with DoHC.	Companies were selected to undertake the Study.	Facilitate roll-out of study in conjunction with selected company, having regard to Interagency Plans. Training provided to staff involved in data collection. Initial phase of the study completed. End Q4	PCCC/Office of the CEO
Traveller Health Units representation / cultural awareness training	Percentage of representatives on Traveller Health Units who are Travellers – 49% *Agencies in partnership with Traveller Organisations should have in-service training courses for all health professionals on the circumstances, culture of, and discrimination practised against Travellers.* *Indicator (TH1):* • 424 HSE personnel completed cultural awareness and sensitivity training programmes, developed in partnership with Travellers and Traveller Organisations.	Target 50% representation for 2007. 550 (TH1)	PCCC/Office of the CEO
Ethnic Identifier			
Review outcomes of the pilot of the ethnic identifier tool *with a view to its further implementation. Include an ethnic identifier question across appropriate data collection systems within the HSE.*	Pilot reviewed and significant preparation and planning undertaken on its future implementation	Develop implementation plan in line with the findings of the pilot. Implementation commenced on a phased basis by Q3 2007, within available resources.	PCCC/Office of the CEO
Ethnic Minority Services	Consultation sessions took place for the National Intercultural Strategy. Pilot sites were identified for the Learning, Training and Support Framework for staff.	National Inter-Cultural Strategy completed. Learning, Training and Support Framework for staff rolled out across Local Health Offices to facilitate the delivery of	PCCC/Office of the CEO

Social Inclusion

a number of areas throughout the country.

Focus	Output 06	Deliverable 07	Lead Responsibility
	The review of translations services within PCCC has been initiated, towards the provision of a consistent service. Work has commenced to allow for the National Framework for interpreting services to be finalised in 2007. *Enhancing cultural competency amongst staff is crucial in helping them not only access health services but also improve the quality of service they receive.* *Indicator (AR3):* 330 HSE staff completed Asylum Seekers / Refugees Awareness Training.	appropriate health service responses to minority ethnic communities. Complete review of approaches to translation services within PCCC with a view to having a unitary approach to the provision of this service. Develop a National Framework for Interpreting Services. Work towards an increase in numbers completing training programmes by year end. (AR3)	
Homeless Services *(Transformation Programme 2.6)* ***Improve access to mainstream health and social services for homeless people*** *and enhance targeted adult homeless services in partnership with Local Authorities.*	Protocols improved on access to mainstream services. Funding was provided to Non- Government Organisations (NGOs) Partnership working between the HSE and the Local Authorities were strengthened. *Research indicates that a high proportion of homeless people have a history of institutional care. Persons leaving mental health care and young people leaving care are at particular risk of becoming homeless. Clear policies and protocols should ensure that all discharges from mental health and child care are planned with the aim of preventing homelessness amongst these groups.* *Indicator (HO5):* • % of Local Health Offices with formal leaving and aftercare policy in place for young people leaving care – 78%. • % of Community Service Areas that have a system in place for fast-tracking access to the GMS system for homeless – 66%.	Develop a new National Action Plan on Adult Homelessness through established consultative forum. Review the findings of the Simon Brookes Report. Work with Local Authorities to provide appropriate housing supports to homeless people so they can move out of emergency homeless accommodation into stable housing. Ensure that Homeless Persons needs are being met through improved access to Primary Care. Work with the NHO and PCCC to ensure that staff respond appropriately and effectively to the needs of homeless people. Works towards improved performance in these areas.	PCCC/Office of the CEO

Social Inclusion

Focus	Output 06	Deliverable 07	Lead Responsibility
Drugs & HIV Services *(Transformation Programme 2.6)*			
Expand the Tier 3 teams.	Additional funding was provided for Specialist Adolescent Addiction Teams.	Continued provision of existing levels of service.	PCCC
Enhance Treatment Services with a particular focus on under 18's.	New protocols and a policy on treatment of under 18's was disseminated and promoted nationally. National Training Workshops were provided for frontline staff on the treatment of under 18's with serious drug problems. *Substance misusers should have immediate access to professional assessment, followed by commencement of treatment as deemed appropriate, not later than one month after assessment. Additionally, the extent of substance misuse in the under 18 year group has grown and this needs specific attention in terms of monitoring:* *Indicator (AD3, AD4):* • Percentage of Adults (new clients) commencing treatment within one month – 60% (Heroin) 95% (all other substances). • Percentage of Under 18s (new clients) commencing treatment within one month – 65% approx.	Increase the Provision of training to staff on appropriate interventions for under 18's. Implement the protocols and the new policy nationally in line with available resources. Work towards improved performance in these areas.	PCCC/Office of the CEO
Enhance Treatment Services to cocaine and polydrug users.	Awareness on the trends and prevalence of Cocaine use disseminated. A Workshop was provided on appropriate treatment interventions to address cocaine use.	Develop a Model for the management of cocaine abuse and deliver appropriate training to HSE staff.	PCCC/Office of the CEO
Combat substance misuse *through a concerted focus on supply reduction, prevention, treatment and research.*		Develop a comprehensive action plan for the delivery of rehabilitation services in line with the National Drug Strategy review and the outcome of the Rehabilitation Working Group Monitor the prescribing of Benzodiazepines.	PCCC

Social Inclusion

Focus	Output 06	Deliverable 07	Lead Responsibility
Focus on reducing alcohol related harm *including implementation of the recommendations of the Working Group on Alcohol and taking account of the recommendations of the Strategic Task Force on Alcohol.*	Work on the Alcohol Aware pilot with the ICGP commenced in 2006.	Implement relevant recommendations on the Strategic Task Force on Alcohol, within available resources. Work with ED and Primary Care Services on the early detection and screening of people with problematic and dependant alcohol use. Complete review of current mental health based alcohol services with a view to improved integration.	PCCC
No. of clients in methadone treatment.	Average of 6,800 per month.	6,800 (average per month).	PCCC
No. of methadone treatment places utilised during the period	Average of 6, 800 per month.	6,800 (average per month).	PCCC

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

Focus	Output 06	Deliverable 07	Lead Responsibility
Services for Persons with Intellectual Disability and Autism *(Transformation Programme 2)*			
Residential Care			
Residential care provision for persons with an intellectual disability.	8,181 persons in residential care	8,181 and additional 255 (see page 105).	PCCC
Day Care			
Day care provision for persons with an intellectual disability (ID3)	*Day service provision is an important element in the spectrum of services for people with Intellectual Disability.* *Indicator (ID3):* • 24,386 persons in receipt of day care services.	24,386 and additional 535 (see page 105).	PCCC
Undertake a 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.*	Scoping work commenced.	Completion of a full census of all HSE funded day services. Agreed National definitions for HSE funded day services in place. Progress discussions with Department of Enterprise, Trade and Employment on a framework for supporting persons while in work / employment settings.	PCCC/Office of the CEO
Respite Care			
Respite care provision for persons with an intellectual disability	4,242 persons in receipt of respite services	4,242 and additional 85 (see page 105).	PCCC
Additional Disability Support Services Intellectual, Physical and Sensory Disability/Autism			
Enhance the level and range of multidisciplinary support services available to adults and children with intellectual, physical and sensory disabilities and those with	778 WTE recruited (as at end September 2006). Recruitment campaign overseas initiated.	Balance of 2006 developments to be recruited by year-end 2007	PCCC

Disability Services

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 2006 Annual Report of the National Intellectual Disability Database Committee shows a total register of 25,518 – an increase of 2.4% from the 24,917 persons identified in 2005.

Of the 25,518 persons registered on the National Intellectual Disability Database, needs have been identified for the period 2007-2011.

Focus	Output 06	Deliverable 07	Lead Responsibility
autism, *with a priority in 2007 on enhancing the assessment and support services for children with disabilities.*			
Implement part 2 of the Disability Act		Develop regulations to facilitate implementation of the Disability Act (with DoHC). Standards for assessment developed (with HIQA). Complaints procedure implemented. Assessment and liaison officers recruited and trained to commence implementation of the reconfigured early intervention services.	Office of the CEO
Transfer of clients inappropriately placed	*A key priority in disability services is ensuring that people with an intellectual disability, currently in psychiatric hospitals, are transferred to appropriate accommodation. This is dependent on suitable alternatives being available in the community.* *Indicator (ID5)* 38 clients transferred	Numbers to be transferred in 2007 will be identified and prioritised in line with need and circumstances.	PCCC
Review models of service provision to reflect the revised Primary Care structures *(Transformation Programme 2.6)*	Scoping Work Commenced.	Commence reconfiguration of Early Intervention Services (0-5yrs). Completion of plans for the reconfiguring of children's services (6-18yrs) Completion of review of current models of adult provision.	PCCC/Office of the CEO
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	Work Commenced.	Agreement in place on the approach and structures for the delivery of health related supports in a school setting, consistent with the requirements of the Act.	PCCC/Office of the CEO

Disability Services

Focus	Output 06	Deliverable 07	Lead Responsibility
Governance and accountability	Consideration of the C&AG Report	Review the recommendations of the C&AG Report on VFM and implement same where appropriate.	PCCC
Develop a Minimum Data set		Completion of review of current information systems including the three National Databases and a multiplicity of local databases. Completion of review of current arrangements for data collection to ensure that data gathering processes are compliant with the legal requirements of the Disability Legislation. Minimum Data set developed in partnership with contracted agencies.	PCCC
No. of persons in receipt of Domiciliary Care Allowance.	19,000 recipients of DCA (monthly average)	Promote uptake within eligibility guidelines	PCCC
No. of persons in sheltered work	6,900 persons in sheltered work (monthly average).	6,900 monthly average (projected).	PCCC
No. of persons in rehabilitative training	2,800 persons in rehabilitative training (monthly average).	2,800 monthly average (projected).	PCCC

Environmental Health

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.

Focus	Output 06	Deliverable 07	Lead Responsibility
Food Control	Implementation of contract with FSAI New EU regulations introduced. 51,995* Inspections of food premises carried out. (* 2005 figures)	Implement contract within available resources. Ongoing Business plan agreed with FSAI. Q2 Establish National Food Business Register (EU regulation 882). 51,995 inspections	PCCC
Enforce Tobacco Control Legislation (PH1)	Preliminary work on establishment of database. Inspections carried out to investigate compliance with Section46/47 of the Public Health Tobacco Act. 35,042* inspections carried out. (*2005 figures)	Establish database for HSE. Q4 35,042 inspections	PCCC
Monitoring of Water Fluoridation	Public water fluoridation schemes inspected.	Continue to monitor schemes to ensure compliance with the regulations. Ongoing	PCCC
Develop minimum data set for Environmental Health Service		Data group established. Q1 Data set developed and rolled out across the service. Q4	PCCC
Develop research capacity in area of Road Safety		Provide evidence based research to assist policy formation by Road Safety Authority. Q4	Pop Health
Cosmetic Products regulations	New EU regulations introduced in 2005. Implementation of regulations assessed.	Develop a standardised approach to the implementation of the regulations. Q4 Develop and implement a training programme for staff. End Q4	PCCC

Child Health

Ireland has the highest percentage in the EU of children and young people in the 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

Focus	Output 06	Deliverable 07	Lead Responsibility
Expert Advisory Group on Children *(Transformation Programme 12.4)*	Group established and membership agreed.	Work plan developed. End Q1 2007	Office of the CEO
Immunisations			
Achievement of immunisation targets: *identify areas of low vaccine uptake and put in place strategies to increase uptake by 5%*	Indicator (CH5): • 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): D3 -87% P3 -87% T3 -87% Hib3 -87% Polio3 -87% MenC3 -86% • 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): D3 -91% P3 -91% T3 -91% Hib3 – 91% Polio3 -91% MenC3 – 91%	Work towards achievement of 95% National uptake rate by end of year.	Pop Health / PCCC
Child and Adolescent Health			
Implement 'European Strategy for Child and Adolescent Health and Development'.	Preparatory work undertaken	Project group established by Q1. Self audit using WHO tools completed by Q3 Action Plan by Q4.	Pop Health

Child Health

Focus	Output 06	Deliverable 07	Lead Responsibility
Develop new strategic health promotion policy in partnership with DoHC *which will address factors undermining the health of young people*	"Towards 2016" commitment	Scoping for strategy completed End Q4	Pop Health
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.* *Indicator (CH1):* • Number and percentage of newborn babies visited by a PHN within 48 hours of discharge: 81%	Work towards improvement in data collection in this area (CH1). 81%	PCCC
	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". *Indicator (CH7):* • The percentage of babies who are breastfed at PHN first visit: 28% • The percentage of babies who are breastfed at 3 months: 13%	Support new mothers to continue breastfeeding.	
Adolescent Friendly Services	Quality tool developed	Roll out training in use of tool in locations delivering services to young people	Pop Health

Child Health

Focus	Output 06	Deliverable 07	Lead Responsibility
Monitor prevalence trends of smoking and substance use *through the National Health and lifestyle Surveys and European School Survey Project on alcohol and other drugs.*	"Towards 2016" commitment	SLAN / ESSP surveys completed.	Pop Health
Child Health Surveillance	Development work progressed, including Public Health Nurse (PHN) training.	Evaluation of developmental surveillance tool for children in Ireland.	Pop Health
Promote a strategic approach to child health research *(Transformation Programme 1.3)*	Child health research agenda progressed.	Guidelines for carrying out research with children completed Specific research studies contracted	Pop Health
Emotional well being of children	Review of evidence completed.	Training model for Public Health Nurses (PHN) delivered. Action plan developed. Q4	PCCC PCCC
Obesity Prevention			
Develop a national database to monitor prevalence trends of growth, overweight and obesity *(Transformation Programme 1.3)*	New Irish growth charts developed. Guidelines on management of childhood obesity produced. Tendering for growth monitoring equipment.	Project team established to review impact of New WHO charts. Dissemination of evidence. Training on management. Equipment disseminated and training on its use undertaken.	Pop Health Pop Health PCCC PCCC

Obesity is a significant contribution to ill health and preventing it occurring in children will net significant health benefits.

PCCC Indicators / Measures 2007

Focus	Projected Outturn 2006	Target 2007
Primary Care		
Expand out of hours GP services Projected number of contacts	750,000	860,000
Development of GP Co-operatives (Indicator PC10) Percentage of GPs involved in GP co-operatives as a % of all GMS GPs (29 LHOs) Percentage of the total GMS population is covered by GP co-operatives (25 LHOs)	73% 80%	83% by Q4 90% by Q4
HSE National Information Line Number of calls received	55,000	60,000
Expand the number of GP Vocational training places in partnership with the ICGP Total number of GPs in training (July 1st 2006)	349	Plan to develop additional places over 2007/2008 completed
Access to dental screening services for children and adults (Indicator PC7) Percentage of school children in designated classes within national schools received dental screening (19 LHOs).	71%	Improve data collection on dental screening uptake in schools. (PC7)
Children & Families		
Family Welfare Conferences (Indicator CC9) Number of Family Welfare Conferences held.	155	155
Springboard projects (Indicator CC8) Number of families referred to Springboard Projects.	1,000	1,000
Standardising Residential and Foster care (Indicator CC7) Children In Care (31 LHOs - October 2006): Residential Foster Care Foster Care With Relatives Other	 423 3, 083 1,410 189	 423 3, 083 1,410 189
Percentage of Children in Residential care that had an allocated Social Worker.(31 LHOs).	92.4%	Work towards improved performance in this area.
Percentage of children coming into care that had a written care plan in place (28 LHOs).	31%	Prioritise written care plans for all children in the care of the HSE.
Implement a standardised pre-school monitoring framework (Indicator CC4) Pre-school Inspections provided up to Q3 (31 LHOs)	1,984	Begin making standardised reports available to the public by end Q2 2007. All reports available to public by Q4 2007.
Child Protection – New indicators have been identified for collation during 2007: • Number of notifications made of child abuse or neglect. • Number of assessments conducted following notification. • Number of children on waiting lists for assessments following notification of child abuse or neglect. • Average time spent on a waiting list for assessment following notification of child abuse or neglect.	Not applicable for 2006	
Mental Health Services		
Admissions to General Hospital psychiatric units / Psychiatric Hospitals (MH5)	17,194	17,194
First Admission rates to General Hospital psychiatric units / Psychiatric Hospitals (MH5)	4,472	4,472
In-patient re-admissions to General Hospital psychiatric units / Psychiatric Hospitals (MH5)	12,722	12,722
Discharges from General Hospital psychiatric units / Psychiatric Hospitals (MH5)	16,851	16,851
No. of Inpatient days utilised in General Hospital psychiatric units / Psychiatric Hospitals (MH5)	427,084	427,084

Focus	Projected Outturn 2006	Target 2007
Services for Older People		
Development of home and community based services and supports – Home Help Service Number of Home Help Hours provided Monthly average hours provided. Average number of clients in receipt of home help service. Note: the allocation of investment funding will affect this average as resources are applied.	 11,000,000 916,000 45,500	 11,780,000 981,000 (By End Q4) 45,500
Home Care Packages Equivalent number of Home Care Packages in place.	2,350	4,350
Development of day-care services. Number of additional places provided, bringing total places to 21,000. Approximate total number of places.	1,325 additional Total places 21,000	1,100 additional Total places 22,100
Uptake of Flu Vaccine *(Indicator OP3)* Percentage uptake of influenza vaccine among the GMS population aged over 65 years.	56%	Continued promotion of uptake of vaccine (OP3).
Nursing Home Subventions Persons in receipt of subvention (Oct '06): Medium High Maximum Number of above that were in receipt of Enhanced Subvention	 276 1,025 6,262 4,735	Continued provision of subvention in line with eligibility guidelines.
Residential Care (Indicator OP4) Percentage of the total population aged between 65-74 years are in residential continuing care settings (25 LHOs). Percentage of the total population aged 75 years and over are in residential continuing care settings (25 LHOs).	 1% 9%	Work towards the achievement of not more than 10% of the population aged 75 and over in residential continuing care.
Implementation of a standardised nursing home inspection process Number of Nursing Homes Inspections completed (Oct 2006 position).	798	100% of nursing homes to receive 1st and 2nd inspection.
Palliative Care		
Specialist Inpatient Units Average number of patients treated per month in 2006.	300	300
Home Care Services Average number of patients per month in receipt of home care services in 2006.	2,200	2,200
Intermediate Care Average number of patients per month accessing intermediate care.	100	100
Day Care Average number of patients per month accessing day care services. Note: new minimum data set may necessitate some adjustment to the measures outlined above due to changes in recording methodology. The allocation of investment funding may impact on the deliverable for 2007. Adjusted targets will be provided should resources be allocated to increased capacity in these areas.	200	200
Social Inclusion		
Traveller Health Units representation / cultural awareness training (Indicator TH1) Percentage of representatives on Traveller Health Units who are Travellers. Number of HSE personnel that completed cultural awareness and sensitivity training programmes, developed in partnership with Travellers and Traveller Organisations.	 49% 424	Target 50% representation for 2007. 550
Ethnic Minority Services (Indicator AR3) Number of HSE staff that completed Asylum Seekers / Refugees Awareness Training (20 LHOs).	330	Work towards an increase in numbers completing training programmes by year end
Improve access to mainstream health and social services for homeless people (Indicator HO5) Percentage of Local Health Offices with formal leaving and aftercare policy in place for young people leaving care. Percentage of Community Service Areas that have a system in place for fast-tracking access to the GMS system for homeless.	 78% 66%	Develop a new National Action Plan on Adult Homelessness through established consultative forum
Enhance Treatment Services with a particular focus on under 18's (ndicator AD3, AD4) Percentage of Adults (new clients) commencing treatment within one month: Heroin All other substances	 60% 95%	Work towards improved performance in these areas, in line with available resources.

Focus	Projected Outturn 2006	Target 2007
Approximate percentage of Under 18s (new clients) commencing treatment within one month.	65%	
Average no. of clients in methadone treatment per month.	6,800	6,800
Average no. of methadone treatment places utilised during the period per month	6,800	6,800
Disability Services		
Residential care provision for persons with an intellectual disability (Indicator ID3) No. of persons in residential care Additional no. of residential places being brought on stream in 2007	 8,181	 8,181 255
Day care provision for persons with an intellectual disability (Indicator ID3) No. of persons in receipt of day care services No. of additional day places being brought on stream in 2007	 24,386	 24,386 535
Respite care provision for persons with an intellectual disability No. of persons in receipt of respite services No. of additional respite places will be brought on stream in 2007	 4,242	 4,242 85
Transfer of clients inappropriately placed (Indicator ID5) No. of clients transferred	 38	 Numbers to be transferred in 2007 will be identified and prioritised in line with need and circumstances.
No. of persons in receipt of Domiciliary Care Allowance. Average monthly number of recipients of DCA	 19,000	 Promote uptake within eligibility guidelines
Projected no. of persons in sheltered work (monthly average)	6,900	6,900
Projected no. of persons in rehabilitative training(monthly average)	2,800	2,800
Environmental Health		
Food Control No. of Inspections of food premises carried out (* 2005 figures).	 51,995*	 51,995
Enforce Tobacco Control Legislation (Indicator PH1) No. of inspections carried out. (*2005 figures)	 35,042*	 35,042
Child Health		
Achievement of immunisation targets: *identify areas of low vaccine uptake and put in place strategies to increase uptake by 5% (Indicator CH5) - 26 LHOs* 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): D3 P3 T3 Hib3 Polio3 MenC3 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): D3 P3 T3 Hib3 Polio3 MenC3	 87% 87% 87% 87% 87% 86% 91% 91% 91% 91% 91% 91%	Work towards achievement of 95% National uptake rate by end of year.
PHN visits to new born babies (Indicator CH1) - 24 LHOs Number and percentage of newborn babies visited by a PHN within 48 hours of discharge	 81%	 81%
(Indicator CH7) - 24 LHOs The percentage of babies who are breastfed at PHN first visit The percentage of babies who are breastfed at 3 months	 28% 13%	Support new mothers to continue breastfeeding

Cancer

After diseases of the circulatory system, cancer is one of the leading causes of death in Ireland with 7,000 patients dying annually from cancer.

The most recent report published by the National Cancer Registry in 2006 predicts that cancer numbers will have increased from 22,000 a year at present to 42,000-43,000 by 2020. The number of potentially fatal cancers will more than double, from 13,800 to 28,800, in the same period. About two-thirds of this increase is expected to be due to the increasing number of elderly people in the population, and the remainder to upward trends in the incidence of some of the common cancers. Some of the largest increases are expected in cancer of the prostate (a 275% increase in numbers between 2000 and 2020), kidney (an increase of 160% for women and

Focus	Output 06	Deliverable 07	Lead Responsibility
Implementation of the Cancer strategy *(Transformation Programme 1.6)* *The new cancer strategy will provide the governance, integration and leadership to create the essential framework for cancer control. 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.*	Publication of the new national cancer strategy. Preliminary work carried out to put in place new cancer control structure. Development funding of €9m allocated inter alia for additional • Consultant posts nationally including posts in Oncology Haematology Radiology and • Additional support staff including nursing and allied health professionals • Support in preparation of national cervical screening programme.	Implementation of the Cancer strategy as outlined in Section 5 (page 103) – Targeted Investment Funding. Ongoing in 2007	NHO
Cancer needs assessment *(Transformation Programme 1.6)*		Map existing cancer services. Q4 Complete a needs assessment to inform priorities and to ensure an evidence based approach nationally for the Cancer Control Programme. Q4	Pop Health
National Radiation Oncology Plan *(Transformation Programme 1.6)*	National framework for radiation oncology services to be put in place by 2014 approved. Capital investment of €400m to be funded through PPP with €98m to come through capital program. Clinical Output Specification Group (COSG) progressing plan through 4 working groups. Clinical needs assessment complete. Provision of additional capacity in St. Lukes progressed through traditional procurement.	Progress national framework for radiation oncology as outlined in Section 5 (page 71) – HSE Targeted Investment Funding. Ongoing in 2007	NHO

Cancer

200% for men) and melanoma (130% increase in women and 170% increase in men).

Focus	Output 06	Deliverable 07	Lead Responsibility
Donegal/Belfast Radiotherapy Agreement *(Transformation Programme 1.6)*	The HSE reached agreement with Belfast City Hospital about access for Donegal residents to radiotherapy in Belfast. This will offer patients in Donegal a choice of location for radiotherapy, in addition to Dublin	The initial phase will run to 31 December 2007, following which a comprehensive review of the service agreement will be carried out. The level of referrals to Belfast City Hospital will be managed within agreed criteria during the initial phase, in order to ensure the clinical and technical infrastructure is matched to the demand. The agreement will be formally reviewed by the Project Team at three monthly intervals and by the Project Board at six monthly intervals. The service arrangements will be modified with the agreement of the Project Board as appropriate during the initial phase.	NHO
Communications		Development of a communications programme for the Cancer Control Programme.	NHO
ICT		Development of a high level outline specification for Cancer Control Programme which will, inter alia facilitate clinical audit.	NHO
Cancer Finance Model		Develop new finance control model.	NHO/Finance

Ireland, like most developed countries, has experienced a declining death rate from coronary heart disease (CHD) with 5,648 deaths in 2003 (141.9 per 100,000) compared with 8,326 in 1980 (244.8 per 100,000). Males accounted for 55.9% of deaths in 2003. 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.

Cardiovascular

Diseases of the vascular system, be it coronary (heart), cerebral (stroke) or peripheral vascular (limbs) accounts 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 EU 15.

Focus	Output 06	Deliverable 07	Lead Responsibility
AMI Improvement	Supported the implementation of "Improving the Delivery of Reliable, Evidence Based Care for Acute Myocardial Infarction", a collaborative pilot project with NHO and the Clinical Indemnity Scheme.	Implementation of the pilot programme in the 5 sites, moving towards evaluation of results from data collection in order to determine success prior to any roll out of the programme. Ongoing	NHO (Quality and Risk) / Pop Health
Cardiovascular Strategy *(Transformation Programme 4.2)*	Supported the implementation of the relevant aspects of the Cardiovascular Strategy.	Action Plan for Heart Health prepared. Q4 Preparations for a Stroke Strategy progressed in collaboration with the DoHC.	Pop Health / PCCC Pop Health / PCCC
Cardiovascular Information System	Scoping work progressed	First phase of plan completed.	Pop Health

The Population Health approach aims to provide integrated care based on people's needs and to reduce health inequalities. An essential part of this is to focus on delivering a best practice shared care approach to diseases such as diabetes.

The Department of Health and Children has developed policy guidance on diabetes. Implementation of this policy needs to be undertaken in the context of a planning and service delivery framework and the application of guidelines to support better quality care for patients with diabetes.

Diabetes

As 85% of type 2 diabetes can be managed in the primary care setting, it follows that the roles and responsibilities of healthcare practitioners providing services, should reflect an effective model of chronic disease management.

Focus	Output 06	Deliverable 07	Lead Responsibility
Expert Advisory Group on Diabetes *(Transformation Programme 12.4)*	Group established and membership agreed.	Work plan developed. End Q1 2007	Office of the CEO
Development of a National Framework for Diabetes *(Transformation Programme 1.2 and 4.2)*	Multidisciplinary, cross directorate working group set up.	Report on the epidemiology of diabetes prepared. End Q2 National Framework for diabetes with the following priorities prepared: ▪ National needs assessment including paediatric diabetic needs prepared. End Q4 ▪ National agreed shared care protocol between hospital and community sectors prepared. End Q4 ▪ Scoping and preparation of a diabetic registry. End Q4 ▪ Care guidelines prepared ▪ Preparations for Specific Health Promotion interventions progressed ▪ Action plan for structured patient education programme prepared. End Q4 ▪ Needs assessment for Retinopathy screening prepared. End Q4	Pop Health / PCCC / NHO
	Development of an effective systematic approach to the care and management of diabetic patients in local and social care communities.	Roll out of Self–Care Management Education Programme in each HSE Area in liaison with the Diabetes Federation of Ireland.	PCCC / Pop Health
	Department of Health and Children Policy Guidelines developed.	Local plans developed for implementation in response to guidelines.	PCCC

Other Conditions

Chronic diseases are those diseases which can only be controlled and not, at present, cured. The incidence of such diseases increases with age and many older people are living with more than one chronic disease. Approximately 25% of the population has a chronic disease and 60% of deaths are as a result of a chronic disease.

Focus	Output 06	Deliverable 07	Lead Responsibility
Rheumatoid Arthritis *Develop a strategy and action plan*	Steering Group established	Report and recommendations completed. End Q4	Pop Health
Respiratory *Develop the management of Chronic Obstructive Airways Disease (COPD)* *(Transformation Programme 4.2)*	Model of care developed	COPD rapid response teams in the community developed through PCCC. End Q4	(a) PCCC (b) Pop Health
Obesity *Continue implementation of the recommendations of the Obesity Strategy* *(Transformation Programme 4.1)*	Progress made in implementing national recommendations Project template for best practice around obesity surveillance project completed	Implementation of national recommendations furthered. End Q4 Multidisciplinary symposium held. Database recommendations prepared. End Q3	Pop Health
Hep C Services *Prioritise prevention, surveillance and control of Hepatitis*	Strategy developed	Scope and responsiveness of services enhanced through PCCC. End Q4	(a) PCCC (b) Pop Health

Emergency Planning

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.

Focus	Output 06	Deliverable 07	Lead Responsibility
Co-ordination/ standardisation and improvement of emergency plans across NHO/PCCC and Pop Health at national, area and local levels.	Cross Directorate groups established at national and area level. National project team established to consider the national strategies required for an influenza pandemic.	Strategic agenda for emergency management across all parts of the HSE established. HSE corporate plan in place for an influenza pandemic, which is reflected in plans at national, area and site levels in the NHO, PCCC and Pop Health Directorates.	Pop Health
Develop and implement the intersectoral framework for emergency management with the Garda and the Local Authorities	Framework agreed and launched by Government. Intersectoral agreement of actions to be progressed in 2007.	Achievement of actions agreed for 2007.	Pop Health
Development and implementation of generic emergency plans in accordance with the new framework	Membership of NHO/ PCCC and Pop Health on the HSE'S Emergency Management (EM) Teams at corporate and area level.	Update generic emergency plans for (a) NHO (b) PCCC (c) Pop Health At national/area/local levels to reflect agreed national targets set by the Emergency management corporate team. These targets will require all health care facilities and services to have written and tested plans in place by end 2007. Appoint a dedicated staff support to the lead ANDs in each directorate regarding emergency management.	(a) NHO (b) PCCC (c) Pop Health
Emergency Plan for Influenza Pandemic	NHO/ PCCC and Health Protection membership of the National project team on Influenza Pandemic Some scoping work completed National Workshop on Essential Services held in PCCC Staff available for redeployment in PCCC part identified.	**1. Development of specific emergency plans for an influenza pandemic in** (a) NHO and (b) PCCC (c) Pop Health **In particular, these plans should address:** **For NHO:** Bed Capacity, Ventilation capacity, role of Private Hospitals, Ambulance transport requirements, securing adequate supplies and managing staff absenteeism.	(a) NHO (b) PCCC (c) Pop Health

Emergency Planning

Responsibility for implementation of emergency plans in each Area of the HSE rests with the lead Network Manager.

Focus	Output 06	Deliverable 07	Lead Responsibility
		For PCCC: Redeployment of staff to support care settings and supports, securing adequate supplies and managing staff absenteeism **For Pop Health:** Plans for Surveillance, contact tracing, management of cases and staff absenteeism.	
		2. **Development of specific emergency plans for an influenza pandemic across all directorates and functions of the HSE to address:**	
		(a) Redeployment of staff, possible cross function, to deliver essential services such as the telephone hotline.	All Directorates
		(b) Business continuity issues arising from staff absenteeism of 25% to 40%.	All Directorates
		3. In addition to the above some Directorates have specific roles.	
		(a) National Procurement will manage the purchase, storage and distribution of the National Stockpile.	Procurement
		(b) HR will manage the industrial relations agenda arising from the influenza pandemic plan	HR
		(c) ICT will design, scope and implement the I.T solutions required. In particular around recording of vaccine and antiviral dispensing and set up of the phone hotline.	ICT

National Hospitals

The Acute services Outputs for 2007 are determined by key factors such as :

- *The NHO commitment to develop services in line with international based practice and to ensure that decisions regarding the operation and configuration of services are supported by evidence and objective service reviews.*
- *The overall HSE strategic direction towards the reorientation of services to primary, community and continuing care, providing for hospital services to concentrate on those who need more complex interventions*
- *The need to ensure continuation of services to the population over the period of implementation of the wider HSE reform programme*

Focus	Output 06	Deliverable 07	Lead Responsibility
Acute Hospital Configuration *Joint HSE/Department of Health and Children Group* *(Transformation Programme 3.1)*	Decision to establish 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.	Establishment of Joint HSE/Department of Health and Children Group. Track progress on individual regional reviews and generally ensure that plans emerging in one area, or for one service, are integrated with each other and are consistent with overall policy development and implementation. Ongoing 2007	NHO
Management of Emergency Patients *(Transformation Programme 1.1 and 3.4)* *A key priority for the HSE is to reduce the numbers waiting in ED Departments; reduce the length of time that patients wait; and improve the overall patient experience.* *In order to assess our performance in this regard during 2006, the PMU has monitored the following:* • Average number of patients on trolleys in Emergency Departments (ED) nationally per month. • Average waiting time for patients in ER departments nationally per month broken down by <6 hours; 6-12 hours; 12-24 hours and >24 hours.	In March, the HSE established a dedicated A&E Task Force, led by NHO, to facilitate the implementation of the HSE's Framework for addressing ED Services and to work closely with hospitals experiencing problems in the delivery of ED services. The Task Force focused on those hospitals that have persistent challenges in ED Departments and emphasised three goals to these hospitals. At Administrative Area level eight Local Implementation Teams (LITs) have been formed around Local Health Offices and Hospital Groups. Average number waiting for admission, October 2006: 111 Waiting time from decision to admit, October 2006: 0-6 hours: 41% 6-12 hours: 31% 12-24 hours: 21% >24 hours: 7%	The work initiated in reducing the ED waiting times for patients for admission will continue to be prioritised in 2007 at NHO national, network and hospital levels. The NHO Performance Monitoring Unit will continue to track ED Waiting times on a daily basis. Development of a monitoring system to track the total time patients spend in Emergency Departments, from registration to discharge. This includes all patients, those admitted and those discharged without being admitted. The NHO will continue to work in 2007 to address the issues identified in relation to the management of emergency patients in acute hospitals. Measurement of patient flow and waiting times will continue in 2007. A key outcome will be that no patient waits on a trolley for admission from ED, and that the length of time a patient is accommodated in an admission lounge does not exceed 24 hours. Ongoing in 2007	NHO

National Hospitals

- *The progress that can be made in 2007 in implementing strategic and operational reform in the acute system.*
- *The funding available for investment in specific initiatives to address the immediate pressures due to changing service needs and demands*
- *The continuing need to provide an increased comprehensive service as the numbers in the 0-14 age group continues to grow, for those in the middle years 45-64, where growth in numbers is also substantial, (and the burden of chronic diseases begins to emerge) and the most significant continuing impact on the services as the 65+ year age group also continues to grow.*

Focus	Output 06	Deliverable 07	Lead Responsibility
A new consultant contract is a core element of both the Government's Health Reform Programme and the HSE's Transformation Programme (Section 3.3). *The HSE's key objective regarding a new Consultant Contract is to achieve greater equity and increase productivity in a consultant-provided 24/7 hospital service.*	Negotiations were adjourned in February 2006 before resuming in November 2006. They are ongoing at sub-committee level.	New contractual framework agreed that includes: the introduction of clinical directorates and related systems of clinical leadership; teamworking; 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.	Office of CEO / NHO / HR / PCCC
National Acute Bed Capacity Review *to identify the acute bed capacity needs to the year 2020 and to identify at HSE Administrative Area level, the type of acute beds that are required and where the acute beds should be located.* *(Transformation Programme 3.1)*	Initiated Acute bed capacity review – Steering group and Project Group established with HSE/DoHC and external representatives.	Completion of the national acute bed capacity review. Q2 Commence implementation of Report recommendations by 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*		The NHO will convene twice yearly review meetings with national specialist service providers in March and September to provide an opportunity to review activity and outcomes and to plan for national specialist service development	NHO
Review of Mid West Hospital Group *to conduct review to examine the optimum configuration of acute hospital services and associated staff and supports for the Mid-West and to make recommendations on strategies to secure a sustainable configuration of health services in the Mid-West for the long term and to recommend how sustainability might be supported and enhanced through improved integration of care services.* *(Transformation Programme 3.2)*	Establishment of a Steering group and Project Group. Sign off on terms of reference for the review. Procurement process to engage external consultancy expertise initiated.	External consultancy commissioned. Review Completion. Q2 Initiate Implementation of Recommendations.	NHO

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
Southern Review of Acute Services *to identify the appropriate model for acute service provision in HSE South and to recommend how best to reconfigure acute hospital services in Cork and Kerry to deliver on this model. In doing this, the review will also advise on the overall governance arrangements within and between each hospital site in Cork and Kerry.* *(Transformation Programme 3.2)*	Establishment of a Steering group and Project Group. Sign off on terms of reference for the review. Procurement process to engage external consultancy expertise initiated.	External consultancy commissioned. Review Completion. Q2 Initiate Implementation of Recommendations.	NHO
Implementation of North East Review Report *(Transformation Programme 3.2)*	Steering Group and a Project Group structure established to progress these provisions within a project framework. Terms of Reference of the Steering Group agreed	Ongoing Implementation of near and medium term actions contained in the Teamwork Report. Establishment of a number of clinical networks in specified key areas. Focus on addressing the immediate safety and risk issues identified in the report. Identification of a location for the new regional hospital. Develop role of Advanced Nurse Practitioners. Ambulance Service development in line with the recommendations of the Report. Capacity and capabilities of the ambulance response to emergencies will be improved by increasing the deployment of advanced paramedics and ambulances, beginning with Cavan and Monaghan. Monitoring of implementation against milestones set out in the Project plan.	NHO
Development of the new National Paediatric Hospital *(Transformation Programme 3.5)*	A Joint HSE/DoHC Transition Group was established to progress the establishment of a new national tertiary paediatric hospital. Significant work progressed in 2006 in the preparatory work necessary for the: • Arrangements for the transfer of the site from the Mater Hospital.	Completion of the work programme set out for the Group and the establishment of the new Hospital Development Board. Q1	NHO

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
	• Preparation of a high level framework brief for the new Hospital. • Determination of the scope and location of the Urgent Care Centres. • Determination of co-ordination policies between the new Hospital and other Hospitals, including those outside Dublin. • Establishment of a Development Board for the new Hospital. • Advance considerations on the co-location of Maternity Services.		
Review of Maternity Service in the Greater Dublin Area *(Transformation Programme 3.6)*	As part of the Transition Group work Programme (outlined above) the NHO initiated a review of Maternity Services in Dublin to make recommendations on the optimum configurations of maternity services in line with international best practice.	Completion of report by Q1. Initiate implementation of report recommendations. To Q4	NHO
Critical Care Planning	Meetings undertaken with the Intensive Care Society of Ireland to discuss current services demands and arrangements that need to be put in place for critical care planning nationally.	Review future critical care requirements in line with international best practice in this area and drawing on the Best Capacity Review Work. Establish a multidisciplinary critical care planning group to identify priorities for development of critical care nationally and for the related transport services e.g. MICAS, Paediatric and neonatal transport services. Action plan to be developed in 2007.	NHO
Development of Paediatric Services *(Transformation Programme 3.5)*	Identified the need to develop policy and model of care for secondary paediatric services following on from the publication of the 'Children's Health First' report. Paediatric surgical services in particular have been identified as a priority. Discussions undertaken with the Dublin paediatric hospitals regarding the need to develop a joint paediatric surgical service.	Progress the development of a joint paediatric surgical service across the Dublin paediatric provider sites. Progress consideration of secondary paediatric service requirements nationally. Develop Action plan in 2007 to address key service needs.	NHO

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
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.*		Carry out a review. Completion of report. Q3	NHO
Development of Governance Arrangements in the Acute Sector *(Transformation Programme 3.3)*	Prioritised the need to identify and implement governance, reporting and accountability arrangements that support high quality service delivery and integrated, effective management structures in the acute hospital sector.	Paper on Governance will be finalised for discussion with HSE Board. Q1 Propose a code of governance for Hospital Networks. Propose ways of strengthening the capacity of boards of governance responsible for acute hospital services. Develop a framework for balancing governance autonomy with accountability to the HSE. Propose administrative, legislative or regulatory changes to give effect to the new framework, in the context of the overall corporate quality and risk framework. Ongoing in 2007	NHO
Establishment of clinical networks *(Transformation Programme 3.3)*	The review of services in the North East has provided a template for consideration of development of appropriate clinical networks to ensure continuity and quality of care for patients.	Establishment of a number of clinical networks, including a network between Letterkenny General Hospital and Galway University Hospital. Ongoing in 2007	NHO
Implementation of 100+ consultant post scheme *to reward hospitals that are maintaining high performing Emergency Departments* *(Transformation Programme 3.4)*	Scheme launched with End November deadline for applications.	Applications assessed against award criteria and ED Performance targets. Approval of new category I consultant posts for hospitals that meet the criteria, in line with funding available in 2007.	NHO
PET CT Services	HSE group established to commission PET CT in Cork University Hospital and St. James's Hospital.	PET CT Services available in St. James's and CUH by Q3.	NHO

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
Hospital Activity/Performance Data	NHO Performance Monitoring Unit established and began the process of standardising the data definitions and data collection across all hospital nationally. Development of activity reporting arrangements to provide details required for NHO, HSE Board and DoHC. The unit undertook the training of relevant staff in hospital networks nationally to comply with data requirements.	Continue to develop the reporting arrangements and to produce hospital based standardised reports. Focus on improving information turnaround time. Ongoing through 2007.	NHO
Allocation and Utilisation of funding in Acute Hospitals – VFM Review – Southern Hospitals Group	Steering group established with representatives from Dept. of Finance, DoHC, HSE and Southern Hospitals Group.	Production of report by Q3 2007.	NHO
Tender for Renal Services	Tendered for the provision of renal dialysis in the South East of the Country and in Dublin. Award made to a company in the South East and discussions ongoing to establish an interim facility pending opening of the long term unit. An award was not made for Dublin.	Issue tender notification for the provision of dialysis facilities elsewhere in the country, based on the findings of the National Renal Strategy Review. Q1	NHO
Development of Haematology Services	Meetings undertaken with Irish Haematology Society to discuss current service demands and arrangements that need to be put in place to develop haematology services nationally.	Work in collaboration with HIS to develop a framework, based on international best practice, that will guide haematology service developments.	
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.*	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. Report completed in 2006.	Implement the Laboratory Review Report recommendations. Ongoing in 2007	NHO

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
Conduct a review of CSSD (Central Sterile Supplies Department) services nationally *to determine the most appropriate arrangements for the delivery of CSSD services required by the HSE for both acute and community requirements.*		Conduct review. Report completed. Q3	NHO
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.*	Procurement process began under the Competitive Dialogue procurement rules to introduce private hospitals on up to 10 public hospital sites. The co-location project is first and foremost a Public Initiative which will significantly enhance access to health care for public and private patients alike. The Invitation to Tender was issued to short listed bidders in late November 2006 following evaluation of the Outline Proposals which were received on October 19th 2006. Short-listing of the proposals was completed by November 2006 following the bidder presentations.	Expected completion date of process and awarding of tenders on all successful sites April 2007.	NHO
Patient Transport Service	A group was established to develop Terms of Reference for the establishment of a national patient transport policy.	Patient Transport Service reviewed so that the needs of patients can be more equitably met. Q1 Agreement on national guidelines for patient transport policy. Ongoing	NHO
Pre Hospital Emergency Care			
Estate Strategy		An Estate strategy developed for the ambulance service in conjunction with the national Director of Estates. Q2	NHO / Estates
ICT Strategy		An ICT strategy developed for the National Ambulance Service in conjunction with the National Director of ICT. Q2	NHO / ICT

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
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. These courses are required on an annual basis for continual professional development and integration of services.	Training strategy will be developed in line with nationally agreed standards. Q1 All new recruits will undertake tours of duty with a clinical supervisor/ trainer. Ongoing	NHO
National Human Resource structure		National Human Resource structure for the ambulance service will be developed to provide consistent support in areas such as change management, selection and Recruitment, employee relations, and staff development and training. Q2	NHO
Fast Response Units	The roll out of fast response units commenced in 2006.	Additional 7 Emergency Response units commissioned. Q1	NHO
Ambulance Fleet management	A project team was established in last quarter 2006 to develop a new national fleet management system to improve national coordination and standardisation of fleet management.	Introduce a new national fleet management system in 2007. Q3	NHO
National ambulance fleet upgrade and replacement programme	A national ambulance fleet upgrade and replacement programme in line with National and European Standards has been established and the target set for new fleets have been achieved.	67 new Ambulances purchased from existing contract. Ongoing	NHO
Major Incident Plans	Participated in HSE Emergency Planning Team.	Develop National, Area and Local major incident plans specifically for the mobilisation of ambulance personnel and infrastructural support teams in conjunction with all relevant stakeholders. Q2	NHO – Ambulance Services
Tracking of Cystic Fibrosis service developments initiated in 2006.	Approval given for additional medical, nursing and clinical support staff in line with the recommendations of the CF Working Group. There was a delay in the full implementation of the developments for which funding had been allocated in 2007, arising from the need to ensure financial break even.	Continue to track the implementation of this service development originally funded in 2006. Ongoing 2007	NHO

National Hospitals

Focus	Output 06	Deliverable 07	Lead Responsibility
Tracking of New Unit service developments initiated in 2006.	Approval given for additional staff for units which were completed during 2006.	Continue to track the implementation of this service development originally funded in 2006. Ongoing 2007	NHO
Tracking of neurology service developments initiated in 2006.	Approval given for additional medical, nursing and clinical support staff in line with the recommendations of the Comhairle na nOspidéal report. There was a delay in the full implementation of the developments for which funding had been allocated in 2007 arising from the need to ensure financial break even.	Continue to track the implementation of this service development originally funded in 2006. Ongoing 2007	NHO
Tracking of renal service developments initiated in 2006.	Approval given for additional medical, nursing and clinical support staff to support the ongoing demand for the treatment of end stage renal failure. There was a delay in the full implementation of the developments for which funding had been allocated in 2007 arising from the need to ensure financial break even.	Continue to track the implementation of this service development originally funded in 2006. Ongoing 2007	NHO
Tracking of cancer service developments initiated in 2006.	Approval given for additional medical, nursing and clinical support staff to support cancer services nationally. There was a delay in the full implementation of the developments for which funding had been allocated in 2007 arising from the need to ensure financial break even.	Continue to track the implementation of this service development originally funded in 2006. Ongoing 2007	NHO

2006 has seen a slight increase in activity in the area of inpatients and emergency services, with a significant increase in day surgery procedures. The increase in day surgery is predominantly due to 2005 service developments coming on line in 2006, particularly in the specialties of cardiology, radiotherapy, and oncology. The projected activity for 2007 will continue to see increases in day surgery resulting from significant investment in this area during 2006 which will yield benefit to patients in 2007. The increases in activity in some hospital groups represented in the following tables are the direct result of investment. Investments include, CUH Maternity Hospital, bringing an additional 2,000 deliveries from the private sector, new day procedures unit at CUH, Radiotherapy in Limerick, new hospital opening in Tullamore, Cardiac Surgery Services at Galway etc. Activity will continue to be monitored closely through the PMU on a monthly basis through 2007 to ensure hospitals remain on target and on budget.

Inpatient Discharges	Projected Outturn 2006	Target 2007
South East Hospital Group	70,631	70,031
Southern Hospital Group	81,191	86,239
Western Hospital Group	105,257	108,769
Mid Western Hospital Group	46,554	46,554
North Eastern Hospital Group	48,785	48,785
Dublin North Hospital Group	69,249	69,249
Midlands Hospital Group	94,620	95,868
Dublin South Hospital Group	70,679	72,619
All Hospital Groups	**586,966**	**598,114**
Day Case Attendances		
South East Hospital Group	30,397	30,397
Southern Hospital Group	87,601	96,034
Western Hospital Group	105,099	107,895
Mid Western Hospital Group	31,008	31,008
North Eastern Hospital Group	27,475	27,905
Dublin North Hospital Group	85,097	85,097
Midlands Hospital Group	68,093	74,063
Dublin South Hospital Group	117,022	138,009
All Hospital Groups	**551,791**	**590,408**
OPD Attendances		
South East Hospital Group	250,870	250,870
Southern Hospital Group	315,485	320,085
Western Hospital Group	391,392	398,024
Mid Western Hospital Group	157,513	157,513
North Eastern Hospital Group	180,945	189,445
Dublin North Hospital Group	438,898	438,898
Midlands Hospital Group	502,277	512,643
Dublin South Hospital Group	475,447	499,133
All Hospital Groups	**2,712,827**	**2,766,611**

ED Attendances	Projected Outturn 2006	Target 2007
South East Hospital Group	154,950	154,950
Southern Hospital Group	156,970	161,307
Western Hospital Group	179,899	179,899
Mid Western Hospital Group	107,097	107,097
North Eastern Hospital Group	113,259	114,327
Dublin North Hospital Group	176,092	176,092
Midlands Hospital Group	222,862	229,308
Dublin South Hospital Group	160,135	160,135
All Hospital Groups	**1,271,263**	**1,283,114**
Numbers Admitted from EDs		
South East Hospital Group	49,211	49,211
Southern Hospital Group	35,063	35,503
Western Hospital Group	52,005	47,880
Mid Western Hospital Group	21,576	21,576
North Eastern Hospital Group	28,973	28,973
Dublin North Hospital Group	32,382	32,382
Midlands Hospital Group	48,714	48,115
Dublin South Hospital Group	28,592	29,610
All Hospital Groups	**296,514**	**293,248**
Births		
South East Hospital Group	7,181	7,181
Southern Hospital Group	10,491	10,491
Western Hospital Group	10,004	10,004
Mid Western Hospital Group	4,677	4,677
North Eastern Hospital Group	5,357	5,357
Dublin North Hospital Group	7,184	7,184
Midlands Hospital Group	11,921	11,921
Dublin South Hospital Group	8,000	8,000
All Hospital Groups	**64,812**	**64,812**

Outputs - Pre Hospital Activity Projections	**Previous Year (2006)**	**Current Year (Estimate)**
Emergency Calls (AS1)	195,000	205,000 (5% Increase)
Indicator AM6 : Number and % of emergency ambulance calls responded to within pre-determined time bands	158,730 (81.4%)	168,100 (82%)
Urgent Calls (AS2)	64,000	66,000 (5% Increase)
Non Urgent Calls (AS3)	253,000	192,000
Community Transport (AS3)	298,000	234,000

Population Health

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

Strategic Health Planning involves:

- *Planning for health and not just for health services.*
- *Adopting a formal needs assessment approach to identify gaps in services.*

Focus	Output 06	Deliverable 07	Lead Responsibility
Health Intelligence			
Management of population health related data and information resources *(Transformation Programme 1.3)*	Health Atlas Ireland deployment progressed on target; specialist demographics and other data analysis provided; joint work with Institute of Public Health in Ireland.	Breadth and depth of the health related data and information resources progressed. End Q 4	Pop Health
The use and development of the evidence base of health *(Transformation Programme 1.3)*	Launch and refinement of website, progress of All Ireland Electronic Health Library (AIeHL), provision of specialist examination of the evidence-base of health	Capacity for examination of evidence base of health provided. End Q3 Tailored access through further enhancement of the HI website provided. End Q3	Pop Health
National Eurocat Registry of congenital abnormalities	Preparation work underway	Preparation work further progressed. End Q4	Pop Health
Research and Development Strategy	Initial draft research strategy completed and consultation process undertaken	Strategy developed and implemented. End Q4	Pop Health
Health Technology Assessment (HTA)	HTA programme group formed and development progressed. Feasibility assessment of Deep Brain Stimulation for movement disorders in Ireland completed	Health Technology Assessment framework in consultation with HIQA developed. End Q4	Pop Health
Health Impact Assessment (HIA) *(Transformation Programme 4.6)*	Document on strategic HIA prepared by cross-directorate group. Inter-sub-directorate work on HIAs supports and development ongoing	Health Impact Assessment framework developed. End Q4	Pop Health
Health Atlas Ireland *(Transformation Programme 1.3)*	The programme was developed	Health Atlas further progressed. End Q2	Pop Health
Strategic Health Planning			
National bed utilisation review	Field work commenced	Report completed. End Q2	Pop Health
Winter initiative *to reduce pressure on emergency departments* *(Transformation Programme 1.1)*	Influenza media campaign launched	Report completed. End Q2 Influenza immunisation monitored Media campaign completed. End Q3	Pop Health
Develop an integrated and population health *approach to meeting the needs of people with a disability*	Approach progressed	Approach developed. End Q4	Pop Health

Population Health

- *Re-orientating the health system from hospital to primary care, particularly in the management of chronic diseases.*
- *Promoting equity as a strong value in the health system.*
- *Working with other sectors to improve health.*

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

Focus	Output 06	Deliverable 07	Lead Responsibility
Review of donor organ procurement services	Steering group established	Audit commenced. End Q4	Pop Health
National Strategy for Action on Suicide *Develop a plan for suicide research and information*	Reach Out programme progressed	Action 26 of Reach Out completed and evaluated. End Q4	Pop Health
Renal review report *(Transformation Programme 4.1)*	Report completed Q4	Integrated National Renal Programme established End Q2.	Pop Health
Neuroscience Services	Established a multidisciplinary national neuroscience needs assessment group and neurology needs assessment subgroup - to look at health information, the existing services and technology, training and Research and Development. Consultation exercise underway. The working group identified key priorities for 2007.	Production of a report and priority areas for investment over the next 3-5 years.	Pop Health
Health Promotion			
Lead the development of a national sexual health strategy and action plan	Scoping for strategy progressed	Scoping work further progressed	
Provision of Schools Training	Primary 1,377 hrs Post Primary 221 hrs SPHE 1,274 hrs	Primary 1,400 hrs Post Primary 200 hrs SPHE 1,300 hrs	Pop Health
Provision of Training to Health Care Workers, Management / Administration	Health Promotion 6,024 hrs Accredited HP 2,029 hrs **Number of persons trained** Medical/Dental 98 Nursing 2,366 Allied Health Professionals 810 Management / Admin 373 Support Staff 1001 GPs 8 Practice Nurses 114 Pharmacists 85 Others 282	Health Promotion 6,000 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	Pop Health

Population Health

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

Planning for 2007 and beyond will be supported by a range of national research surveys in linking to European studies.

Focus	Output 06	Deliverable 07	Lead Responsibility
Provision of training to other sectors	Statutory bodies 918 Private Sector 435 Community/Voluntary 3,406 Other 1,122	Statutory bodies 900 Private Sector 450 Community/Voluntary 3,500 Other 1,100	Pop Health
Participation in Health Promoting Hospital Network	a) Members of the Health Promoting Hospitals Network. No and %: 22 (79%) b) With a written Health Promotion policy No and %: 6 (21%) c) Engaged in Health Promotion Initiatives. No and %: 21 (72%)	a) Members of the Promoting Hospitals Network. No and %: 22 (79%) b) With a written Health Promotion policy No and %: 6 (21%) c) Engaged in Health Promotion Initiatives No and % 21 (72%)	Pop Health
Provision of support to Workplaces	HSE Worksites 143 Non HSE worksites Small 48 Medium 11 Large 28	HSE Worksites 150 Non HSE worksites Small 55 Medium 10 Large 30	Pop Health
Development of community based Health Promotion Partnerships	Based on community development approach 297 Organised by HP services 171 Clinical Dietetics No Smoking Cessation No	Based on community development approach 300 Organised by HP services 150 Clinical Dietetics No Smoking Cessation No	Pop Health
	Health Promotion/Public Health Campaigns 5	Health Promotion/Public Health campaigns 6	Pop Health
Support the roll out of SLAN *(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.***	Surveys progressed	Lifestyle trends monitored. End Q4	Pop Health
New Strategic Health Promotion Policy	Towards 2016 commitment	Scoping for strategy completed. End Q4	Pop Health

Population Health

Focus	Output 06	Deliverable 07	Lead Responsibility
Develop a National *Database to monitor prevalence trends of growth, overweight and obesity.* *(Transformation Programme 1.3)*	Scoping of project underway	Framework for database developed. End Q3	Pop Health
Development and expansion of Health Promotion Campaigns	Campaigns in relation to Flu Vaccines, Sexual Health, Breastfeeding, Alcohol, Tobacco, Drugs and Obesity developed	Campaigns in relation to Flu Vaccines, Sexual Health, Breastfeeding, Alcohol, Tobacco and Obesity further maintained	Pop Health
Action Plan on Alcohol	Developments of the joint HSE/DoHC Health Promotion Policy Unit progressed	Implementation of the recommendations continued. End Q 4	Pop Health
Development of a National Tobacco Framework in partnership with key stakeholders	Scoping for Framework progressed	Framework development progressed	Pop Health
Environmental Health			
Review of environmental health services	Review completed	Commence finalising and reconfiguration of transition phase. End Q3	Pop Health / PCCC
Health Protection			
Undertake surveillance on infectious diseases *in accordance with the infectious disease legislation*	Surveillance programmes progressed	Guidelines for optimum surveillance of each notifiable disease prepared. End Q3 Outbreaks of infectious disease detected and managed Guidelines for the management of infectious disease cases and outbreaks continued. End Q3 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. Recommendations of the STI surveillance report implemented. End Q4	Pop Health

The environmental health service protects, enhances and promotes the environmental health needs of the population.

Health Protection plays a critical role in protecting people from infectious diseases and in preventing harm when environmental hazards are involved.

Population Health

Focus	Output 06	Deliverable 07	Lead Responsibility
Flu vaccine campaign	Programme progressed	Expansion of flu vaccination campaign to include all those over 60 years of age. End Q4	Pop Health
Immunisation education programmes	Immunisation staff training programmes prepared	Commence the roll out of immunisation staff training programmes. End Q3	Pop Health
Cold chain delivery	Tender for new contract progressed	New contract of Cold chain delivery service implemented. End Q2	Pop Health
Develop a national environment/ public health strategy	Not applicable	Feasibility of the establishment of a national Environment and Public Health Unit/Centre explored and action plan developed Surveillance and management of environmental hazards developed	Pop Health
Targeted campaigns at specific Health Care Associated Infection (HCAI)	Health care workers education programme developed	Surveillance of HCAI continued Governance structures prepared Public education programme prepared. End Q2	Pop Health

Key Focus

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 & 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 & Research, Consultant Appointments, Cross-border Relations and Special Reform Projects.

Office of the CEO

*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, and which commenced operation in 2006. The members of the Forum are nominated by their respective Local*

Authority. The Forums can make such representations to the HSE as they deem appropriate.

Focus	Output 06	Deliverable 07
Engagement with the Political System		
Parliamentary Questions received	4,000*	4,400 *Indicator:* a) 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: b) for which an interim reply issued by the HSE within 20 working days of the date of the Ministers answer to the Dáil and c) for which a final reply has been issued by the HSE within 20 working days of the date of the Ministers answer to the Dáil.
Ministerial and Public Representations	2,500*	2,750
*Estimate extrapolated from total year to date.		
Regional Health Forums		
Number of questions submitted to Regional Health Forums	172	190
Number of Notices of Motions submitted to Regional Health Forum	46	50
Number of HSE updates /presentations to Regional Health Forums *(The HSE makes presentations on service related issues).*	45	56
Number of Regional Health Forum Meetings *(The Forums each meet 6 times per year)*	21	24

Office of the CEO

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.

Focus	Output 06	Deliverable 07
Number of Committee Meetings *(Each Forum has 2 committees, who meet up to 4 times per year)*	21	32
Number of briefing sessions with Directors/Chairs	3	4
Area Briefing Meeting	8	24
Internal and External Communications		
National Communications Unit (NCU)	NCU unit established. Appointment of all key senior personnel including: • Head of Communications • Head of Corporate Communications • Head of Press and Media Relations • Head of Internal Communications • Head of Public Communications • Area Communications Managers West, South, Dublin Mid Leinster and Dublin North East.	Develop and implement a comprehensive communications strategy for the HSE Continue to provide creative and dynamic support to the organisation in communicating the health transformation programme. Communicate the HSE achievement and objectives to all audiences. internal and external
		Support information sharing and consistency across our services through:
	4 editions of internal staff magazine Health Matters published.	4 editions of Health Matters national newsletter to be published.
	Continuing to develop upgraded internet and intranet sites.	Develop and expand public information programme and HSE intranet and website. Develop HSE policy on accessible health information, having regard to disability, literacy and language.
	Processed over 18,000 media queries, issued 140 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.
	Produced first HSE Annual Report.	Aid in production of second Annual Report in line with legislation. Publish and distribute service directories for each of our 32 Local Health Offices (LHOs).

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Focus	Output 06	Deliverable 07
	Developed communications strategy for pandemic flu.	Complete and communicate National Communications strategy for pandemic flu.
	Implemented and co-ordinated public information programmes including: Winter Initiative campaign. Clean Hands campaign.	Implement co-ordinated public information programmes including the HSE's Winter Plan and Child Protection campaign.
	Supported the preparation of regular updates and briefing documentation for public representatives.	Support the preparation of regular updates and briefing documentation for public representatives.
	Provided a 24/7 media and crisis management service.	Provide a 24/7 media and crisis management service.
	Provided and directed communications elements of consumer market research.	Provide and direct communications elements including publication of results of consumer market research.
Consumer Affairs		
Develop Consumer Strategy	Partnership based approach to strategy developed, and strategy agreed and approved by Management Team.	Implementation of strategy on a national basis
Implement statutory complaints framework *(Transformation Programme 12.2)*	Policies, procedures and protocols for statutory complaints framework developed and discussed with staff representative groups; implementation plan agreed; discussion and feedback on draft regulation with DoHC. Training plan developed. Train the trainers system put in place.	Statutory complaints framework fully operational in statutory and voluntary system; 2,000 staff trained by end Q4. Approximately 500 staff trained in each of Q1/2/3/4. Database developed to comply with statutory reporting requirements. Twice yearly reports on complaints to HSE Board. Report on complaints system included in Annual Report.

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 legislative based entitlements, we have developed a consumer strategy for engaging with members of the public. This strategy will be rolled out in 2007. In December 2006, the Minister for Health & Children signed regulations to fully implement from 01.01.07 the statutory complaints process provided for in Part 9 of the Health Act 2004.*

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The Code of Governance is a key element of the HSE's accountability Framework. The Code is an integrated suite of documents, which defines the HSE's responsibilities in key areas. It is a requirement under the Health Act.

Quality and Risk
During 2006 a dedicated ***Quality & Risk*** *division was established and commenced work on the development of a national strategy. A Quality & Risk committee of the HSE Board was also established, which will oversee the work of the division. During 2007 national standards for Quality & Risk will be introduced, and effectiveness will be monitored.*

Focus	Output 06	Deliverable 07
Code of Governance	Draft code developed, and submitted to Minister for approval.	Action plan developed end Q1. Consultation with staff organisations commenced Q1. Implementation programme commenced Q2.
Quality and Risk		
Corporate Safety Statement	Complete and signed off by Management Team. Implementation commenced.	Ancillary site Statements agreed June 2007. Evaluation October 2007.
Develop and commence implementation of a Risk Management Framework		Framework Developed. June 2007 Consultant appointed. Q1 2007 Consultation completed March2007 Draft Document. April 2007 Education and Implementation on Risk Identification Commence Q2. Risk Framework across all Directorates first phase completed September 2007.
Standard Operating Procedure (SOP) for Proactive Risk Management	Proposal for the development of the SOP completed and agreed with Head of Quality and Risk.	Completed mid-Q3 and implementation commenced end Q3.
SOP for the Investigation and Management of Incidents and Complaints	Proposal for the development of the SOP completed and agreed with Head of Quality and Risk.	Completed mid-Q3 and implementation commenced end Q3.
Integrated Risk and Quality Committee (National)	Set up and Terms of Reference agreed.	Structured programme of work agreed Q1 2007; monitor and evaluate monthly; Annual review Q3 2007 *based on Q3 2006 to Q3 2007).
Development of a Business Case for the procurement of ICT to support Quality and Risk		Appointment of Lead in Quality and Risk office February 2007; Steering Team March. Research consultation commenced March 2007.

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Focus	Output 06	Deliverable 07
Quality and Safety Week The HSE is committed to the continuous improvement of the quality and safety of our working environment. Annually the HSE plans and runs a Quality and Safety week, aimed at focusing people's attention on quality and safety issues, and showing excellence from our facilities.	2006 Quality and Safety week successfully completed; showcase conference held; and process evaluated.	Planning complete end February 2007; Consultation March; Communications to system April; Submissions August; Evaluations of submission September; October assessment and visitation; December conference and showcase.
Consultant Appointments Regulation of the number and type of Medical Consultant posts.	125 new and 63 replacement Consultant posts approved	Determine the number and type of new and replacement Consultant posts, in line with service needs and available funding
Research collaborative quality methodologies linkages with National groups ISQSH Accreditation Board.		Quality assurance and methodologies for all activities in Quality and Risk services agreed. Lead for quality enrichment appointed. February 2007 Framework and working protocols agreed. Communication and consultation. June 2007 Working protocols agreed and implemented. October 2007.
Medical Education, Training and Research		
Develop Governance Structure and Strategic Plan for Medical Education, Training and Research (METR) within HSE	An executive HSE-METR Committee was established in 2006 and charged with this responsibility. This Committee is chaired by an external expert in the field.	Recommend Governance Structure and agree Strategic Framework. Q1
Implementation of Strategic Plan for METR within HSE	An executive METR Unit established within the Office of the CEO to lead the implementation of the Strategic Plan.	Commence Implementation of Strategic Plan on a national basis. Q1 Review and evaluate delivery programme. Q4

Under Section 57 of the Health Act 2004, the functions of Comhairle na nOspidéal in relation to the regulation of the number and type of medical consultant posts transferred to the HSE.

The HSE is to develop and implement a strategy for medical education, training and research, arising from the Government decision relating to the Fottrell and Buttimer Reports. This will involve developing very close working relationships across

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a number of directorates and requires the establishment of a robust governance structure capable of driving forward the major reforms proposed in a co-ordinated manner.
Our strategy will also be influenced by the forthcoming Medical Practitioners Act.

Focus	Output 06	Deliverable 07
Continue to participate in the Inter Department Policy Steering Group (IDPSG) and National Committee on Medical Education & Training.	A high level Policy Steering Group, comprising of the Departments of Health and Children, Education and Science and Finance, the Higher Education Authority, and the HSE was established in 2006.	A National Committee, comprised of representatives from all key stakeholders in this area, will be established in 2007. This Committee will be chaired by an independent Chairman. Ongoing participation by HSE Staff in both IDPSG and National Committee. Provision on an on-going basis of administrative support to the National Committee in conjunction with the HEA.
Engagement by HSE with other stakeholders	To date, the HSE has engaged in a wide consultative exercise with other stakeholders in this area with a view to developing strong working relationships and common agendas.	Ongoing engagement and development of joint work plans– arrange structured meetings on a quarterly basis with stakeholders.
Agree funding priorities for developments of the Post Graduate Training Programmes for 2007 with the approved postgraduate Training Bodies.		Put in place Working Group with Forum of Irish Postgraduate Training Bodies by end Q1. Agree funding priorities by end Q2. Review and Evaluate funded programme. Q4
Expansion in Undergraduate Training Programme for Medical Students	Co-ordinated the HSE response to call for proposals for a new Graduate Entry Programme (GEP) to Medical Education to be issued by the Department of Education and Science.	Co-ordinate and ensure an integrated response from the HSE to the provision of clinical placements to support the GEP. Q1 – Q2
Audit of Capital and Revenue Funding	In 2006 under the direction of the IDPSG, a high level audit was carried out of physical facilities used in medical education and training on HSE sites. In 2007, a more in-depth and extensive audit is to be completed, focusing on "fit for purpose" aspects.	Appoint Project Team. Q1 Complete and finalise audit report. Q1-Q2 Prepare and get approval for full year capital investment framework for medical education and training facilities.
Review status of all medical training posts *This is a key action for the HSE as identified in the Buttimer Report and the draft Medical Practitioners Bill.*		Carry out a review to profile status of all NCHD posts and make recommendations on future status and structure. Q1 & Q2

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Each Expert Advisory Group provides a central platform within the HSE for the clinical and health communities, patients, clients, managers and carers to become actively involved in the development and transformation of specific health and social care services. The result will be improved care for patients and clients.

Focus	Output 06	Deliverable 07
Expert Advisory Groups on Older People, Diabetes, Children and Mental Health *Expert Advisory Groups act as the primary source of operational policy and strategic advice in the service area under their remit. They are responsible for proposing implementation protocols which have service integration within the organisation as a key component for identifying key measures of service performance.*	Groups established and membership agreed.	Work plan developed. End Q1 2007

Estates

Although Estates has not existed in 2006 in the HSE it had done so at health board level and was handled in a non uniform fragmented way throughout the country. As such 2007 will establish the baseline structures, processes and costs for estates.

A critical objective for the HSE involves optimising the extant estate value and delivering best value for money for the capital plan.

The Estates programme for 2007 is designed to support and complement the collective components that form the HSE National Service Plan.

Focus	Output 06	Deliverable 07
Development of national HSE structure and facilities/estates strategy *(Transformation Programme 11:1-6)*	National Directorate established	Populate Directorate structure. End Q1 Develop Estates Strategy. End Q3 Commence implementation. Q3
Primary Care Estate Roll out	Development and support of projects that reflect an integrated multi-practitioner base augmented by appropriate allied health professional capacity and care group elements	200 facilities in place. Q4
Mater Development	--	Site works advanced. Q1
National Paediatric Hospital	Site selected Framework specification developed Transfer of site	Design complete. Q4
Capital Plan on time	Multi-annual capital plan approved May 06 Delayed implementation of 2006 commitments of the plan	Timely implementation of agreed plan for 2007. Accurate Monthly Reports.
Uniform Property transactions	Property Committee established	Single national record established. Q3
One point estate support	Structures agreed and in place	Successful integration of all estates staff and establishment of help line. Q3

Key Focus

The key focus of the Finance Directorate during 2007 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 VFM Strategy.

Finance

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 these 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 CEO of the HSE becoming the Accounting Officer for the Executives

Focus	Output 06	Deliverable 07
Structure		
Staffing	Assistant National Director Posts filled. Senior finance management structure below Assistant National Director has been agreed and approved.	Complete recruitment of senior finance managers in Q1 2007.
Re-organisation	The appointment of Assistant National Directors with specific functional or geographic area responsibility facilitated integration of finance at a high level with service areas.	Re-organise existing finance units around these new senior finance posts with maximum integration pending implementation of a single national financial system. Ensure finance structures in place to offer maximum support to operational pillars. This will be completed by end Q2 2007.
Transformation		
Finance Function	In 2006 National Finance began the transformation process from 11 former health board directorates to a unified structure.	Complete the transformation of the finance function from the former board/ERHA structures to an integrated function, in line with HSE business objectives. This will be completed by end Q2 2007.
Relationships	Redefined the relationships as they applied in the old structures and transition to new service delivery model.	Further develop and cement relationships throughout the organisation to ensure the primary focus of supporting the service areas continues to assist the business of the HSE. At the national level this will be driven by further developing national reporting in line with the requirements of National Directors. At local level the area finance teams will develop more integrated working relationships with service heads. Achievement will be measured in terms of the level of interaction on financial management matters at national, regional and local level between the finance team and the service managers.

Finance

Vote. This 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 DoHC, the Department of Finance, the Comptroller and Auditor General and the Paymaster General.

Focus	Output 06	Deliverable 07
Systems *(Transformation Programme 7.4)*	Pending the recommencement of the project to implement a single financial management system for the HSE an interim Corporate Reporting Solution (CRS) was implemented in early 2006 to meet the national Expenditure Analysis reporting requirement.	Establish the infrastructure to support the implementation of a standardised national financial system in 2007. Develop and begin implementation of a single financial management system for the HSE. This system will be SAP based and will enable the HSE to establish a Finance and Procurement foundation. This is a first release of a long term programme to establish the following: ▪ Revitalised financial controls and budgetary framework. ▪ Establish the finance function as a business partner for the HSE pillars. ▪ 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.
Training	Training provided for finance staff on Expenditure Analysis reporting, Vote accounting, consolidation of annual financial statements, and new financial regulations	Establish a national 'Continuing Professional Development' programme by establishing links with the Professional Accountancy Bodies. In 2007 the Finance Directorate will continue and build on its interaction and association with the national accounting bodies to establish formalised programmes of continuing professional development for its finance staff. This programme commenced with the A.C.C.A. in 2006 and it is intended to expand this to all areas in 2007 and to establish formal links with the other Professional Accounting Bodies during this year.
Finance Shared Services *(Transformation Programme 7.6)*	Not applicable	Develop and implement a migration strategy for financial processes into Finance shared services.

Finance

Focus	Output 06	Deliverable 07
Leverage The Capital Base		
Relationships	Developed close working relationships with the Estates Directorate to ensure efficient management of the Capital Plan, and to assess strategic opportunities in the asset base.	Work closely with the incoming Assistant National Directors of Estates with responsibility for NHO and PCCC to have a strategic input in managing the NHO and PCCC Estates in order to leverage capital and realise VFM.
Support	Provided support to the various capital steering groups seeking to maximise the value of the capital base.	Continue to provide support to the Capital Planning Group in terms of enhanced financial management information. Report anticipated cash flows versus actual on monthly basis in order to identify lagged projects at an early stage with a view to maximizing use of the capital base.
Financial Control		
Reporting	Expenditure Analysis Reporting, Vote, Cash and AFS reporting processes were developed and improved in 2006.	These reporting processes will be further developed and standardised in 2007 to ensure that in terms of legislative requirement and meeting service objectives, they are fit for purpose.
Approval of capital projects	In collaboration with service partners, Finance contributed to the development of a capital approvals process.	Control processes on approval of capital projects and cashing of those projects will be further refined and developed during 2007.
Vote, Cash and I&E	Integration of Vote Cash and I&E issues was achieved in 2006	Enhance reporting, reconciliation and performance monitoring arrangements around Vote, Cash and I&E.
Cash Control	Not applicable	Ensure that Vote and Cash control requirements are understood by those implementing the National Financial System. This will be evidenced from the design of the vote accounting solution in the proposed single financial management system.
Expenditure Analysis Reporting	During 2006 the Expenditure Analysis reporting timeline was improved.	Further improve Expenditure Analysis reporting timescales. This will be undertaken in consultation with Area Assistant National Directors of Finance, by examining the monthly closing process to identify time savings.
Patient Private Property (PPP)	Work commenced in 2006 on implementation of a unitary PPP accounting system.	Progress Patient Private Property National Project including Central PPP Investment Unit, Final Guidelines and Past Interest Retained.

Finance

Focus	Output 06	Deliverable 07
Financial Regulations		
New Financial Regulations *(Transformation Programme 7.5)*	National set of financial regulations on purchase to pay was approved and implemented in 2006.	Support the implementation of New National Financial Regulations throughout the HSE through information and training at local level. Develop further modules beyond Purchase to Pay. Ensure that Vote and Cash management implications are addressed in national financial regulations.
Financial Reporting		
Corporate Reporting System (CRS)	Initial development of CRS system in 2006.	Refine and continue development of the CRS to ensure data from all HSE areas and voluntary agencies is available to Managers, Directors and the HSE Board.
Capital Reporting	Implemented the B-Plan capital projects cash management system. This system tracks cash payments by Project, Care Group, Pillar and HSE Area. This system was rolled out to Senior Finance and Estates teams in 2006.	Roll out the B-plan system nationally to LHO Managers and Network Managers.
Treasury Management		
Treasury Review	Banking and treasury review commenced in 2006.	Complete banking and treasury review. Recommend courses of action for short, medium and long term.
Streamline Banking Arrangements	Review of bank accounts nationally carried out in 2006.	Continue to engage with the National Treasury Management Agency (NTMA) and Pay Master General, with a view to streamlining existing banking arrangement and consolidating the existing treasury functions.
Budgeting		
Devolved Budgeting *(Transformation Programme 7.2)*	Not applicable	Develop and implement a model for the effective management of the health service budget on a devolved basis.
Funding Mechanism *Develop and implement a resource allocation model for the HSE.* *(Transformation Programme 7.1)*	A review of funding mechanisms was commenced in 2006.	Build on the recommendations of the review in terms of re-engineering the funding and resource distribution process.

Finance

Focus	Output 06	Deliverable 07
Appropriation Account		
Vote Returns	In 2006 the Vote accounting team worked closely with finance teams at area level to refine and standardise the vote returns and reconciliation statements.	Streamline the production process for Vote returns and the Appropriation Account. Develop IT based reporting system.
VFM Programme		
Assistant National Director	Approval received to recruit a head of VFM at Assistant National Director of Finance level.	Recruit Assistant National Director of Finance in charge of VFM, and establish a national VFM unit.
Relationships	Not applicable for 2006.	Build relationships throughout the HSE to establish VFM priorities.
VFM Strategic Plan	Not applicable for 2006.	Establish a Strategic Plan for VFM.
Implementation	Not applicable for 2006.	Oversee implementation of the plan.
Legislation		
Long Stay Repayments	The Health (Repayment Scheme) Act 2006 was enacted in June 2006 to provide a legal basis for the repayment of long stay charges. A separate vote of €340m was made available in 2006 for the purpose of making repayments and the scheme is expected to cost in the region of €1 billion in total. Repayments commenced in October 2006.	The vast majority of repayments under the Health (Repayment Scheme) Act 2006 will be made in 2007.
Donations Fund	In accordance with the Health (Repayments Scheme) Act 2006, Section 11, a Repayments Scheme (Donations) Fund was set up in 2006. Donations received will be allocated to the institution or service specified by the donor. Over 170 locations were set up on the HSE system for this purpose. Governance arrangements were put in place to ensure that funds from the donations account are allocated and spent in accordance with the terms of the Health (Repayments Scheme) Act 2006.	The HSE will submit a detailed annual report on the operation of the fund and particulars of the accounts of the fund to the Minister for the period up to 31st December 2006. This report is due within 6 months of the end of the 2006 financial year.

Human Resources

A critical objective for the HSE involves placing Human Resources (HR) at the centre of the business. The HR programme for 2007 is designed to support and complement the collective components that form the HSE National Service Plan. The priority areas for Human Resources for the coming year 2007 include:

Embedding the Transformation Change Programme of the HSE – *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*

Focus	Output 06	Deliverable 07
Primary Care Team Development - HR Support *(Transformation Programme 6.6)*	Finalise and agreed HR ODD / P&D support interventions appropriate to successful implementation of Primary Care Team strategy by end Q4.	Implement HR support interventions as previously defined to Primary Care Teams as they are established. Design of induction training and programme of support for PCCC Transformation Development Officers, Jan 2007. Research innovative development methods for PCTs needs March2007. Pilot a number of support mechanisms June 2007. Evaluate and mainstream as appropriate Sept 2007.
Develop & Implement an Employee Engagement Strategy. *(Transformation Programme 6.1)* *Undertaking of comprehensive Employee Attitude Survey*	Pilot sample survey in Q4 2006.	Complete analysis of pilot survey findings by end Q1 2007. Sample size and composition will be determined based on pilot review. Complete organisational survey Q3 2007. Analyse and report results in Q4 2007.
Create & implement leadership & management approaches which inspire *(Transformation Programme 6.2)* *Leadership Development Programme for top 150 managers.*	Complete phase 1 programme design. Finalisation of plans and selection of delivery partner for phase 1 by end November 2006.	Commence delivery of phase 1 programme to HSE senior leadership group – after roll out of Transformation Change Programme. Evaluate and expand programme deliverables by end Q3 Commence phase 2 programme delivery to identified 150 senior managers. Q4
Develop system wide intervention to ensure transition from old to new. *(Transformation Programme 6.3)* *Embedding Transformation Change Programme.* *Develop Support structures to implement Transformation Change Programme*	Development of strategy by end Q4 2006 to communicate the Vision and ensure engagement of line managers in implementing the Vision.	Commence implementation of roll out strategy. Q1 2007 Review and evaluate delivery programme. Q4 2007
Recruitment performance, metrics and quality standards monitoring	CPSA Licence requirement	Have a fully operational performance metric and service level management arrangement in place by Q2 2007.

Human Resources

support and further enhance managers who are moving into or who are currently in positions of leadership.

Team Effectiveness – *the HSE wishes 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 HSE staff, measuring their perception of cultural elements of the organisation and our ability to achieve our collective objectives.*

Focus	Output 06	Deliverable 07
Develop & implement a robust model of union engagement and partnership working. *(Transformation Programme 6.4)* *Update and renew the Health Service Partnership Agreement to enable the next phase of partnership development.*	Stand down previous Partnership structures.	Develop and agree clear statement of purpose, vision, interests, process and structures to consolidate the move into second generation partnership and to reflect the needs of the new HSE structures / additional committees, training plus specified national projects required to support the reform process.
Develop a comprehensive set of HR policies *(Transformation Programme 9.2)* *Development of HSE Superannuation Scheme*	Development of draft HSE Superannuation Scheme.	Quarter 1: Finalisation of overall draft and consultation with staff associations. Formal presentation of scheme to DoHC / Department of Finance. End Q2
National Disciplinary Procedure	Revised disciplinary procedure to be agreed in partnership with the staff representative bodies by end 2006.	Develop training module for HSE line management in the operation of the disciplinary procedure by end Q1. Continued roll out through the year.
Employee Handbook	Develop a national HSE Employee handbook to advise staff of responsibilities, entitlements, policies and procedures. Draft completed end 2006.	Handbook circulated. End Q1. Continuously updated.
Employee Induction	HSE Employee Induction Programme completed by end Q4 2006.	Commencement of roll out of HSE Induction Programme Q1 onwards.
Integrated Employee Wellbeing and Welfare Strategy	Establish a national steering group by end 2006 to develop a single, coherent integrated employee wellbeing and welfare strategy.	Set up National Steering Group representative of all stakeholders. Q1 Agree terms of reference. Develop project plan and set milestones. Q2 Research best practice. Consultation with key stakeholders. Q3/Q4 Identify key priorities for strategy.
Develop for HR metrics reporting *(Transformation Programme 9.3)* *Provide comprehensive set of organisational WTE reports on a monthly basis*	Establish organisational employment monitoring framework and mechanism for monthly reporting.	Provide ongoing support (monitoring and reporting) to allow service areas to meet WTE target requirements.

Human Resources

Focus	Output 06	Deliverable 07
Develop robust model for recording, reporting and tracking expenditure on training, development and education *(TDE) across HSE for performance measurement and benchmarking purposes.*	Exploratory work undertaken by P&D with HSE Finance on high level expenditure reporting and Area reporting requirements. Project plan in conjunction with Finance to be in place for Dec 2006.	Develop in agreement with Finance, uniform TDE expenditure coding across HSE. Research all existing approaches and testing requirements by end March 2007. Pilot by June 2007. Mainstream by Sept 2007. Full reporting by Dec 2007.
Develop and implement strategies and programmes to enhance HSE staff skills and skills mix. *(Transformation Programme 9.6)*		
Prepare National Plan for standard HSE general Learning and Development programme for 2008	Exploratory work completed with Corporate Learning and Development Managers (Area and Central) July to December 2006	Audit of existing area L&D activities by end March 2007. Plans for 2008 Prospectus to be ready by end June 2007.
Standardisation of a national academic study support scheme	Exploratory work September to December 2006	Prepare proposal by January. Reach agreement through partnership process by June. Implement Q3 2007.
Standardised contracts from January 07, following consultation and agreement with the trade unions		Smooth transition into the issuing of standard contracts.
Towards 2016 *Implementation of agreement and modernisation and change agenda.*		Maintain industrial peace whilst implementing the change agenda.
Health and Social Care *Develop a HSE strategy and policy statement for the professional education of Health and Social Care Professionals in consultation with key stakeholders.*		Q3/Q4
Development of Advance Nurse and Midwifery Practice (ANP) Resource	Not applicable	Prepare a policy of ANP. ANP resource throughout the service based on population and service. Q4
Develop programme for Post Registration Midwifery	Not applicable	Programme developed, accredited and participants in place. End Q3

Key Focus

The key focus of the ICT Directorate during 2007 is to create a national ICT organisation in conjunction with our staff and the other directorates, maintaining high levels of support to current installed ICT systems and services, improving governance and controls around programmes and projects, while working with the services to identify and commence implementation of their priorities in line with the transformation programme.

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 the service pillars and other 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.

Focus	Output 06	Deliverable 07
Engagement with HSE Programmes & Pillars		
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. This will continue in 2007 for all service and support areas.*	No loss of critical systems or services	Maintain and enhance existing systems and services throughout the year.
Structural Transformation *(Transformation Programme 10.4)* *A key ICT objective is the transformation of the ICT function from the former eleven Board/ERHA structure to an integrated function in line with the HSE business objectives.*	Consultant appointed to carry out review of ICT function Interim Head of ICT Operations appointed	Assessment of current position in ICT. Q2. Design of ICT Directorate function. Q2 Leadership roles will be assigned to develop and cement relationships throughout the organisation to ensure the primary focus of supporting the service areas continues to assist the business of the HSE. At local level the ICT leaders will develop more integrated working relationships with service heads. Q1 Achievement will be measured in terms of the level of interaction on ICT management matters at national, regional and local level. Q4 Develop and implement a migration strategy for ICT processes into ICT shared services. Q4
Deployment of Integrated Patient Management System	Phase 1 (Hospitals in counties Cork, Kerry, Cavan, Monaghan, Meath, Lough and Donegal).	Complete Phase 1(hospitals in counties Sligo and Offaly). Q2 Develop Phase 11 plan in conjunction with the NHO. Q3 Pilot assessment of the system for PCCC requirements with emphasis in 2007 on supporting Primary Care Teams. Q2
Improve information transfer and electronic communication across the HSE.	Strategic Review completed and report adopted by HSE.	National bandwidth rollout. Ongoing Development of an action plan from the HSE ICT Infrastructure Review and begin implementation. Q2

ICT

Focus	Output 06	Deliverable 07
		Development and adoption of an ICT Infrastructure Standards Policy. Q4 Provide single HSE Content Management System that will enable HSE staff in all locations populate the single HSE website. Q4
Development of Clinical Systems Strategy *(Transformation Programme 10.2)*	Identified as a priority project within HSE Transformation Programme.	Development of strategy and action plan to implement. Commence Q2
Improved ICT governance *(Transformation Programme 10.4)*	Consulted with key stakeholders.	Improved governance to ensure that approved projects have clear ownership and are fully resourced and risk assessed before commencement. Q4 Establish ICT governance group for the HSE and major service areas. Q1 Establish best practice in programme and project management. Q3 Work with the Departments of Finance and Health on implementing ICT financial control procedures and peer review of key projects. Q2
Compliance with Government IS Action Plan, EU, i2010	Single Point of Contact for web based services. Security and Privacy Directives.	Engage with key stakeholders regarding i2010 and Government Action Plan. Ongoing Co-ordinate activities with other Government Departments and Agencies. Ongoing
Staff Development ***ICT staff development*** *(Transformation Programme 10.6)*		A programme of work will be established with HR for training and development of staff within the ICT Directorate. Q2
Staff engagement *Transformation Programme has identified staff engagement as a key priority for 2006-2010.*		Transparent engagement with staff on the ICT assessment and Directorate design process leading to acceptance of the final design. Q3
Transformation Programme ***Development of Work Programme***		There are a number of ICT projects identified in the 2006-2010 Transformation Program for the HSE. During the first half of 2007 a programme of work will be developed against these priority areas for the four year horizon.

Internal Audit

Internal Audit is a key element of the HSE's governance framework. It is an independent and objective appraisal function established to provide assurance to the Board and to the Chief Executive Officer, as Accounting Officer, on the adequacy 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, Chief Executive Officer and 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.

Focus	Output 06	Deliverable 07
Develop Structures for Internal Audit Function	Development and agreement of HSE Internal Audit Structure in accordance with agreed HSE/IMPACT protocol	Development, agreement and finalisation of remaining HSE Internal Audit Structure in accordance with agreed HSE/IMPACT protocol. Q2 Final structures in place for entire HSE Internal Audit Directorate. Q3
Audit Training programme	Commissioning and implementation of a Certificate in Audit Skills training programme for HSE Internal Audit Staff	Deliver certificate in Audit Skills training programme. Q4
Audit Seminar	Annual audit seminar	Annual audit seminar. Q3
Audit Plan	Development, and approval by Audit Committee, of 2007 annual audit plan	Completion of 2007 annual audit plan. Q4
Internal Audit Reports	Completion of a substantial number of internal audit reports, identifying recommendations to management to improve the system of internal control	Delivery of a substantial number of internal audit reports, identifying recommendations to management to improve the system of internal controls.
Special Investigations	Special investigations carried out	Carry out special investigations as required.
ICT Audit Capability		Develop ICT audit capability. Q4
Management Support	Providing advice to senior management	Providing advice to senior management throughout the year.

Shared Services

The development of Shared Services for the HSE is a key element in the overall strategic objectives of the Health Service transformation Programme. Shared Services has the potential to deliver significant benefits to the HSE. Shared Services will be located at following designated sites:

- *Dublin ;*
- *Swords;*
- *Finglas;*
- *Manorhamilton;*
- *Kilkenny*

When fully operational Shared Services will provide the following functions;

- *Finance;*
- *Human Resources;*
- *ICT;*
- *Procurement;*
- *Primary Care Reimbursement Services;*
- *Foreign Travel*

To realise the full benefits of Shared Services, the following issues must be addressed:

Focus	Output 06	Deliverable 07	Lead Directorate
Shared Service Programme *(Transformation Programme 8: 1-7)* .	Implementation strategy agreed with HSE management Team	Ratification of the Implementation Strategy by the HSE Board. Jan '07	Finance / HR / ICT / Procurement
		New Governance structure agreed and in place, appropriate for implementation of shared services through functional Directorates.	Finance / HR / ICT / Procurement
	Conceptual Design Phase completed for Finance, HR, Procurement and Legal Services.	Handover of all documentation to relevant functional Directorates completed. Jan '07	Finance / HR / ICT / Procurement
	Detailed Design Phase status document completed for Finance, HR, Procurement and Legal Services.	Handover of all documentation to relevant functional Directorates completed. Jan '07	Finance / HR / ICT / Procurement
	Implementation principles agreed with HSE management team	Each functional directorate to incorporate principles into a finalised implementation plan. Q1'07	Finance / HR / ICT / Procurement
		Existing project teams for Finance, Procurement and HR transitioned into new reporting structure.	Finance / HR / ICT / Procurement
		Project team for ICT to be mobilised. Q1 '07	Finance / HR / ICT / Procurement
		Detailed Design Phase completed for Finance, HR, ICT and Procurement. Q1'07	Finance / HR / ICT / Procurement
		Commence Implementation Phase through pilots of national services. Q4 '07	Finance / HR / ICT / Procurement
	Live services introduced as part of agreed Quick Wins - Dec 06	Functional Directorates review of Shared Services Quick Wins completed as follows: • Tranche 1 completed Quarter 1, 2007 • Tranche 2 – Quarter 1, 2007	Finance / HR / ICT / Procurement
Finance Functional Directorate Shared Services	Business Case developed for Finance Shared Services June 06	Continue to refine business case during Finance Shared Services implementation	Finance Directorates

Shared Services

- *Resources – Availability of HR and financial resources;*
- *Recruitment – recruitment and retention of key personnel;*
- *Staff transition/training;*
- *Integration with other change programmes;*
- *Definition of Corporate and Local Operating Model;*
- *Sufficient site capacity in each of the Shared Services locations;*
- *Adequate IT infrastructure to support live operations.*

Phase II of the National Shared Services programme examined in greater detail, the conclusions reached in Phase I. These centred on scope of activities, operating models and implementation options. Phase 2 of the NSS Programme concluded that the optimum strategy for implementation should be based on developing Shared Services for the HSE through the functional Directorates.

Focus	Output 06	Deliverable 07	Lead Directorate
	Scope of activities agreed and process design commenced	Pilot national services established in Shared Services sites – Quarter 4, 2007	Finance Directorate
		Transition services of Shared Services Eastern Region into Finance Shared Services – Quarter 4, 2007	Finance Directorate
HR Functional Directorate Shared Services	Business Case developed for HR Shared Services June 06	Continue to refine business case during HR Shared Services implementation	HR Directorate
		Technology to be provided using legacy systems plus additional interim technologies (e.g. upgrade of recruitment legacy system, electronic employee files etc). Q4 '07	HR Directorate
	Scope of activities agreed and process design commenced	Controlled and phased deployment by staff category. Commence Q4 '07	HR Directorate
Procurement Functional Directorate Shared Services	Business Case developed for Procurement Shared Services June 06	Continue to refine business case during Procurement Shared Services implementation.	Procurement Directorate
	SAP Contingency Review completed June '06	Technology to be provided initially using legacy systems but integrated with Corporate Finance plans for development and subsequent rollout of SAP.	Procurement Directorate
	Scope of activities agreed and process design commenced	Following some piloting, services will be deployed on a national basis phased primarily on a spend category basis. Q4 '07	Procurement Directorate
Facilities Plan for all Shared Services sites		Define as part of the detailed design process, the total space requirement for Shared Services at each of the locations, Dublin, Kilkenny and Manorhamilton. Define requirements for the day to day running of buildings used by Shared Services. Transfer staff to the appropriate functional shared services organisation structure.	*Finance / HR / ICT / Procurement*

A key focus of the new Procurement Directorate during 2007 is the establishment of an integrated procurement organisation, the continued focus on standardising procedures throughout the legacy procurement functions, the implementation of the Procurement structure and optimisation of the multi-billion euro non-pay expenditure.

Procurement

The Procurement programme for 2007 is designed to support and complement the collective components that form the Health Service Executive National Service Plan. The priority areas for Procurement for the coming year 2007 include:

Implementation of a National Portfolio and Category Management approach – *ensuring that as new approaches and structures are put in place, we can support the services and directorates in the achievement of value for money in procurement*

HSE wide focus is required in respect of ***Supply Chain Management.*** *It will be necessary to review the*

Focus	Output 06	Deliverable 07
Implementation of National Procurement Strategy *(Transformation Programme 13.1)*	Ongoing implementation of elements of the Procurement Strategy for the Irish Health Sector.	Implement outstanding elements of the strategy in support the HSE transformation programme. Q4
Implement optimum Organisational Structure to support unified procurement approach	Assistant National Director Posts agreed and approved. Senior procurement management structure below Assistant National Director agreed.	Assistant National Director Posts will be appointed in Q1. Other senior procurement management posts will be populated throughout 2007.
Develop appropriate ***corporate governance structure*** *which underpins the integrated procurement requirement of the HSE.*	Not applicable	Establish cross directorate Steering Committee which will oversee implementation of the new directorate. Q1
National Portfolio and Category Management approach *(Transformation Programme 13.2)* *The ongoing challenge is to provide an integrated approach across the HSE in respect of all procurement expenditure. This will necessitate the implementation of a sector led category management approach which will ensure that the considerable non-pay expenditure of the HSE will be maximised in pursuit of value for money. Strong working relationships across Procurement have already been established through existing ways of working. These will need to be strengthened.*	Procurement function provided support and expert advice for in excess of 70 sector level procurement processes across the services and directorates, including: ▪ Co-located Private Hospital ▪ Hospital in the Home Service ▪ National Vaccine Supply Cold Chain ▪ National Ambulance Contract ▪ Insurance Service ▪ Renal Service ▪ Framework Agreement for Consultation	Implement a national portfolio and category management approach. A significant number of key sector level procurement contracts in place by end of Q4 which will increase the contract coverage by 10% and deliver additional value for money.
Develop and support a strategy for the effective migration of transactional procurement processes into Procurement shared services. *(Transformation Programme 13.3)*	Agreement reached in respect of the scope of procurement processes to migrate to shared services.	Work to identify and implement initiatives aimed at migrating high volume transactional procurement procedures. Q4

Procurement

current organisation and delivery of Logistics and Inventory across the sector with a view to introducing best practice where this currently doesn't exist.

Shared Services – *our goal is to implement initiatives aimed at migrating high volume transactional procurement processes to shared services*

Team Effectiveness – *provide appropriate, targeted training to staff working in procurement and develop, strengthen and enhance team working amongst newly established teams*

Focus	Output 06	Deliverable 07
Develop and implement high quality processes for each stage of the procurement cycle *(Transformation Programme 13.4)* *Significant work is required to be undertaken in the context of a standardised approach to procurement activity across the entire HSE. Standard operating procedures and documentation require to be developed immediately. This will provide for a coherent and integrated approach to procurement and eliminate duplication current in the system.*	Initial planning workshops conducted and data collection commenced.	Standard Operating Procedures in respect of a number of key procurement processes developed and implemented. Q4 Procurement Card strategy and processes complete. Q2
Develop and agree the policies and procedures for procurement *with respect to corporate social responsibility influenced by ethical procurement standards.* *(Transformation Programme 13.6)*	First HSE Procurement Policy developed and implemented.	Procurement Policy reviewed and republished to incorporate environmental and social inclusion polices. Q4
Develop a procurement management information technology t*o meet corporate requirements at a strategic and operational level.*	Carried out an assessment of a number of information technology based procurement and supply chain solutions. Continued development of a new standard catalogue of goods and services for implementation across entire HSE.	In the absence of an Enterprise Resource Planning (ERP) system: Develop a standardised approach for the use of the eTenders Website. Q2 Implement Business intelligence systems to support best practice procurement. Q3 Implement Equipping System to support. Q3 Implement a price benchmarking system for comparing costs with other buying agencies. Q4
Provide appropriate, targeted training to HSE personnel *engaged in procurement activity thereby improving and enhancing professional skills and organisational capacity and competency.* *(Transformation Programme 13.5)*	Completed large scale training programme in respect of new HSE Procurement Policies and new consolidated EU Procurement Directives. Participated in Department of Finance, Public Sector training and development initiatives.	Develop, implement and roll out Category Management training programme. Q2 Develop and implement Supply Chain Management training programme. Q3 Develop and implement, in conjunction with HR Directorate, SKILLS programme for staff involved in procurement. Q3

Procurement

Focus	Output 06	Deliverable 07
Optimise the supply chain management arrangement *to incorporate inventory management, logistics and customer service.*		Review of existing logistics and inventory management arrangements completed. Q3
Support the procurement activity of the Corporate Pharmaceutical Unit.	Provided procurement support and expertise in respect of negotiation of the drugs and medicine agreement – resulting in significant savings over the life of the agreement.	Continue to provide procurement inputs to the Corporate Pharmaceutical Unit. Develop and implement appropriate procurement strategies for each stage of the pharmaceutical supply chain. Manage all tender processes arising from the implementation of the procurement strategies. Provide full vendor management role for contractors and suppliers in the pharmaceutical supply chain. Q1 – Q4
Participate in or lead on public sector procurement initiatives *as they arise and are deemed appropriate to the organisation including e-procurement initiatives and aggregation.*	Worked with the National Public Procurement Policy Unit (NPPPU), Department of Finance on a range of procurement issues.	Participate in Public Sector framework contracts in 2007. Q1-Q4

Targeted Investment Funding

This section is where we detail the services for which we have received investment funding.

SECTION 5 – TARGETED INVESTMENT FUNDING

Primary Care

Primary Care Teams (PCT) will be the unit of service delivery for non-acute care and will be assigned to populations of between 7,000 and 15,000. They will be made up of a number of health professionals working alongside General Practitioners. The application of investment funding in 2007 will provide a further 115 PCT's and address the full year costs of the 100 teams in development from 2006 and the D-DOC Out of Hours service.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Primary Care Teams *(Transformation Programme 2.3)*	€ 12.5m (E)		Full implementation of the 2006 developments. (see Outputs section for details).	
	€12.0m (B)		Development of an additional 100 PCTs in 2007 (25 in Each Area). It is the intention of PCCC and NHO to work closely to implement the North East Transformation Plan. This will involve accelerated roll-out of PCTs in the North East Area with a target of 15 additional teams in 2007 (total 40), and reconfiguration of the totality of PCCC services. Development funding will be targeted to whole population outcome.	PCCC
	€24.5m (Total)	300 Est.		

Children and Families

The focus of 2007 investment funding will be on improving our responsiveness to the victims of sexual and / or domestic violence. We will also provide additional resources for the funding of Teen Parent Programmes in various locations.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Sexual/Domestic Violence *Improve response rates to the victims of sexual and / or domestic violence seeking practical and / or emotional support by:* *Addressing shortfalls in current funding for a number of voluntary organisations and the expansion of existing services, having regard to the strategic development of the sector and effective intervention in addressing sexual/domestic violence. Funding will be based upon service level agreements.* *Improved training of GPs and other frontline staff.*	€4.5m (B)	12 Est.	Increase level of services to clients. Develop improved responses to clients of these services. Improved uptake on training.	PCCC

Children and Families

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Teen Parent Programme *The €1m provided for this area will address the following priority needs:*	€1m (B)	20 Est.		PCCC
Dublin North / Louth Projects			Assuming funding responsibility from the Crisis Pregnancy Agency of two Teen Parents Support Projects in County Louth and Dublin North City and County.	
National Coordinator of the Teen Parents Support Programme.			Assuming funding responsibility from the Crisis Pregnancy Agency for supporting the work of the National Coordinator of the Teen Parents Support Programme. It is expected that there will be some further increase in expenditure in this area in the coming year based upon additional agreed activities.	
Addressing funding issues			Certain recently introduced projects received reduced funding in their start-up period and it is envisaged that additional funding and staffing will be required to bring them into line with other projects. Approximately €150,000 will be required for this purpose in 2007.	
Strengthening the linkages between Teen Parent Support projects and first-line preventative and family support responses delivered locally within community settings.			The remaining funding will be used to progress a small number of additional projects and to strengthen the linkages between Teen Parent Support projects and first-line preventative and family support responses delivered locally within community settings. An important context for such development and linkage will be the wider PCCC service transformation underway, including roll-out of multidisciplinary primary care teams.	

Mental Health

The focus of investment funding in 2007 will be on the continued implementation of a Vision For Change across a broad range of service priorities.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Child and Adolescent Psychiatry	**€7.95m (B)**			PCCC
Completion of CAMH multidisciplinary teams		30 Est.	The resource will be applied to bring 4 of the 8 teams initiated in 2006 from a 5 person team to a 12 person team, as described in the Vision For Change.	PCCC
Provision of an additional 8 CAMH Teams in development		40 Est.	Initiate the development of 8 X 5 person CAMHTs.	PCCC

Mental Health

The vision provides a very clear direction to establish a modern, high quality mental health service which can meet the needs of those affected by mental health issues.

In November, 2006 Part 2 of the Mental Health Act, 2001 was enacted. This Act represents the largest change in the rights of people with mental health illnesses for over a century.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Improved Inpatient Access		30 Est.	Increase inpatient bed capacity for Children and Adolescents (Cork, Galway, Dublin, Limerick).	PCCC
National Forensic Mental Health Service	€2m (B)	36 Est.	Address implications of the Criminal Law Insanity Act 2006 and the Mental Health Act 2001 through: • Improving standards of care and treatment in the Central Mental Hospital. • Opening of an additional 10 beds in male admission wards in the CMH and progressing other initiatives to release capacity.	PCCC
Eating Disorder Services	€0.75m (B)	16 Est.	Initial development of a dedicated eating disorder service in each area through a combination of reconfiguring existing services and commissioning services from agencies.	PCCC
Improve specialist mental health services for older people, the homeless and people with an intellectual disability.	€3m (B)			PCCC
Mental Health for Older People		20 Est.	Enhancement of existing teams / teams in development.	PCCC
Mental Health for Homeless		20 Est.	An analysis will be undertaken, on a population basis, to identify current deficits in provision and resources applied to address these.	PCCC
Development of Mental Health Intellectual Disability Teams		10 Est.		PCCC
Provision of Second Medical Opinions and Authorised Officers required under Mental Health Act; and to further develop the service of assisted admissions under the Act.	€3.1m (B)			PCCC
Second Medical Opinion		NIL	2, 840 Second Opinions provided. (Estimated).	PCCC
Assisted Admissions		NIL	Service to be provided in line with demand.	PCCC
Authorised Officers		NIL	Support and develop role of Authorised Officer	PCCC
Support Mental Health Promotion, Advocacy and Voluntary Organisations	€1.5m (B)	Nil	Support for Mental Health Promotion initiatives within the HSE, the community and the voluntary partners.	PCCC
		Nil	Supporting consumers and service users to be part of Area Mental Health Teams.	

Mental Health

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Support professional development and training	€1.1m (B)			
Clinical Psychology Training		10 Trainees	10 additional training places brought on stream	PCCC with HR
Professional Development for RPN		10 Trainees	10 additional training places brought on stream	PCCC with HR
Training for Multidisciplinary teams		Nil	Development and delivery of targeted training to enhance the team-working of newly created and existing multidisciplinary teams.	PCCC with HR
Liaison mental health service in acute hospitals, a national counselling service and a national service user council.	€3.75m (B)			
Development of a liaison psychiatric service		10	Work with NHO to develop an appropriate liaison psychiatric service in line with the Vision For Change.	PCCC with NHO
National Counselling Service (NCS)		10	Increase service provision (Estimate 960 additional hours per month provided).	PCCC
National Service User Council (NSEU)		0	Interim NSEU established early 2007.	PCCC
Multidisciplinary Team / Team Enhancements General Psychiatry	Incl. Above.	28 Est.	Resources will be applied to complete the 1:25, 000 burden population and complete teams where not all disciplines are in place.	PCCC

Older People

The focus of 2007 investment funding will be the expansion of a broad range of home and community supports designed to ensure as much care as possible is delivered to older people within their own homes. It will also be

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Home Care Packages *(Transformation Programme 2.5)*	€25m (E)		Full implementation of services commenced in 2006 – provide 2,000 Home Care Packages / providing assistive technology to older people. See Outputs section for details (page 30).	PCCC
	€30m (B)		Provide 2,000 additional home care packages benefiting approximately 4,000 people.	
	€55m (Total)	250 estimate		
Home Help *(Transformation Programme 2.5)*	€ 3m (E)		Full implementation of services commenced in 2006 - **Maintain existing levels of service** / increase levels of service in target Local Health Offices. See Outputs section for details (page 30).	PCCC

Older People

targeted at ensuring the highest standards of care in residential settings are addressed and that the cost of such care is affordable for all. The application of resources for the forthcoming year will also facilitate the consolidation of developments initiated in 2006.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
	€18m (B)		780,000 additional home help hours. A revised model of service delivery is also being implemented, involving home help organisers, public health nurses and other professional staff.	
	€21m (Total)	40 estimate		
Other Initatives in Primary / Community for Older People (Community Intervention Teams) *(Transformation Programme 2.5)*	€2m (E)	NIL	Full implementation of services commenced in 2006 – Consolidation of existing teams. See Outputs section for details (page 31).	PCCC
Elder Abuse *(Transformation Programme 2.5)*	€1m (E)	17.5	Full implementation of services commenced in 2006 - **Completion of work from 2006** and implement system to deal with elder abuse. See Outputs section for details (page 33).	PCCC
Day Care *(Transformation Programme 2.5)*	€2m (E)		Full implementation of services commenced in 2006. See Outputs section for details (page 30).	PCCC
	€3.5m (B)		1,100 additional places per week will be delivered in day care centres, with the creation of new places and the extension of opening hours to evenings and weekends in some day care centres.	
	€5.5m (Total)	30 Estimate		
Meals On Wheels ***Continuation of programme upgrading existing services, in particular food safety regulation requirements.*** *(Transformation Programme 2.5)*	€2.5m (E)	NIL	Work with the voluntary organisations to achieve improvement of existing services.	PCCC
Sheltered Housing *(Transformation Programme 2.5)*	€0.5m (E)	Nil	Full-year costs of 2006 developments. See Outputs section for details (page 31).	PCCC
	€0.5m (B)	Nil	Implementation of the recommendations of the Long-Term Care Group Report **-** Develop a new model with regard to sheltered housing. Q4	
	€1.0m (Total)	Nil		

Older People

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
To support improvements in subvention in 2007 *(Transformation Programme 2.5)*	€85m (B)	10 Est.	To support improvements in subvention in 2007 through the increase of the basic subvention rate to a maximum of €300 a week and the provision of extra support for enhanced subvention.	PCCC
Establishment of dedicated inspection teams *(Transformation Programme 2.5)*	€3m (B)	80 Est.	A national standardised approach to nursing home inspections is being implemented together with the establishment of full- time dedicated teams.	PCCC
Provide additional long stay care beds *(Transformation Programme 2.5)*	€60m (B)	500 Est.	Development of 860 public residential beds to be commenced in 2007, with 446 beds in 2007 and 414 beds in mid 2008.	PCCC
		80 Est. (Complex Discharge)	Provision of 360 additional private beds in 2007: • 220 in the greater Dublin area • 100 in the South and • 40 in the West	
		20 Est. (Contract Oversight)	Full year cost in 2007 of the implementation of the provision of 1,050 extra beds in 2006 concentrated in the greater Dublin area.	
Clinical Co-ordination of Patient Care pathways In the overall context of the significant investment in, and development of, community based acute and residential care services, there is a growing requirement to ensure effective clinical co-ordination of services across these domains. Service and Standards Improvement.	NIL	NIL	PCCC will, from within the overall investment package provided, target the development of effective arrangements to appropriately manage the risks involved and to ensure high quality and safe service provision to the highest standards. Enhance current service improvement through a standardised approach to service delivery and standards.	PCCC

* Note: Additional revenue funding of €360m has been provided in the Estimates for Health Repayment Scheme for Long Stay Charges

Palliative Care

The current delivery of palliative care services in the HSE varies between and within each PCCC area. The allocation of the 2007 investment funding for Palliative Care will be agreed following consultation with Area Palliative Care Development Committees, having regard to the inequities identified within the 2005 Baseline Study of Palliative Care. It will also facilitate the consolidation of developments initiated in 2006.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Specialist Palliative Care Services	€4m (E)		Full year costs of 2006 developments.	PCCC
	€5m (B)	70 Est.	This funding will support the development of additional services in each area, to be decided following consultation with Area Palliative Care Development Committees, and informed by the 2005 Baseline Study. The key elements which will be addressed in the prioritisation of development needs are: • Specialist Inpatient Palliative Care Services. • Specialist Services in Community and Home Environment. • Specialist Care in Acute General Hospitals. • Core statutory funding for services provided by voluntary agencies. • Paediatric palliative care. • Data management and improvement. Development of database and service intelligence capacity.	
	€9m (Total)	70 Est.		

Social Inclusion

The focus of 2007 investment funding will be the continued implementation of the HSE related elements of the National Drugs Strategy, the expansion of the HIV and sexually transmitted disease services and the continued implementation of the National Traveller Health Strategy.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
National Drugs Strategy *Addressing health-related aspects of the National Drugs Strategy through:*	€6m (B)			PCCC
Continued implementation of the report on treatment services for under 18 year olds presenting with serious drug problems, including the enhancement of consultant-led multidisciplinary teams.		50 Est.	Completion of teams in Dublin North East. Enhancement of teams in Dublin-Mid Leinster. Establishment of team in HSE South (Cork) Establishment of team in HSE West (Limerick)	
Expansion of harm reduction services, including needle exchange, to counter the incidence of HIV and Hepatitis C among intravenous drug users.		4 Est.	Continuation and expansion of programme that commenced in 2006.	
Reorientation and expansion of treatment services and the upskilling of HSE staff to address changing patterns of polydrug use.		4 Est.	Cocaine and Poly-drug use programme established, national coordinator in place. 2 pilot sites identified and established.	

Social Inclusion

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Detox facilities programme		2 Est.	To support the establishment of residential detox programmes throughout the country. Initial places and sites identified in 2007.	
A specific initiative for Homeless persons		10 Est.	Employment of 8 Counsellors to support addiction services targeted at homeless communities throughout the country.	
Cuan Mhuire, Athy *Once-off Allocation*	€0.7m (B) (includes €0.4m Capital funding)		This funding will complete the development of a residential service for older people and will address the shortfall in running costs for the Drug Unit.	PCCC
Drug & Alcohol Dependency *Aiseri & Hope House, Foxford* Once-off allocation	€0.3m (B)		This funding will complete the development of an Aftercare facility.	PCCC
HIV and sexually transmitted diseases *Expansion of services in relation to HIV and sexually transmitted disease including:*	€1m (B)			PCCC
Support for a campaign against stigma and discrimination.			A review of funding of voluntary organisations will take place in the first quarter of 2007. This will determine the distribution of the available resource to voluntary organisations.	
Progressing the implementation of the Report of the Care and Management Sub-Committee of the National AIDS Strategy Committee (NASC) on HIV/STI services.			Progress the implementation of the report of the care and management sub committee of the National Aids Strategy Committee on HIV/STI services.	
Traveller Health Commencement of the All Ireland Study on Traveller Health, with emphasis on the implementation of the recommendations of the Traveller Health Strategy.	€1m (B)	24 Est.	Support the roll out of the All Ireland Traveller Health Study. This will support the capacity building process amongst Traveller Health Units and Traveller Primary Care Projects and will support peer research. The Study will commence in 2007. Support the further development of Traveller Health Units and to develop new Primary Health Care Projects in 2007. This will also support the progression of individual projects in relation to areas such as mental health, addiction, etc. Facilitate the direct employment of travellers within the HSE in line with the DJELR Report. This funding will also support a social care training programme in Blanchardstown to commence in September 2007.	PCCC

Disabilities

The focus of investment funding in 2007 will be on the development of additional day, residential and respite places in line with the multi-annual investment programme supporting the implementation of the National Disability Strategy. It will also address our obligations under the Disability Act 2005 and the Education For Persons With Special Needs (EPSEN) Act 2004.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Intellectual Disability	€41m (B)	1,100 Est	255 additional residential places provided 85 additional respite places provided 535 additional day places provided. Transfer of persons with an intellectual disability from inappropriate settings: Numbers to be transferred in 2007 will be identified and prioritised in line with need and circumstances.	PCCC
Physical and Sensory Disability	€12m (B)		80 new Residential places provided. 250,000 additional hours of personal assistance / home supports.	PCCC
Disability Act and Sectoral Plan	€15m (B)	300 Est	Meet commitments arising from the Disability Act 2005 in respect of 0 – 5 year olds. Establishment of early intervention teams to support Primary care teams. Preparation of assessment of need and service statement for 0-5 year olds. Establish statutory framework for implementation of the Disability Act.	
Core funding deficits	€5m (B)	NIL	Identified cases of core funding deficits in voluntary organisations addressed	PCCC
Rehabilitation Training	€2m (B)	NIL	Increase in the Rehabilitation Training Capitation Rate to maintain parity with increases in FAS training rates: Capitation rate increased.	PCCC
St. Joseph's (Visually Impaired)	€0.25m (B)		Provide multidisciplinary support in the school setting.	PCCC

Cancer

Cancer control services are to be population based and will be organised primarily around the needs of patients with cancer rather than focussing on the settings in which care is delivered.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Implementation of the Cancer strategy *This will provide the governance, integration and leadership to create the essential framework for cancer control. 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.* *(Transformation Programme 1.6)*	3.5m (E)	50	Design, organize and position National Cancer Control Programme (CCP) which will be a new National Programme within HSE. Establishment of the leadership team to implement the Programme, including the National Cancer Control Programme Director and key medical leaders at network level. Identify cancer centres.	NHO

Cancer

The programme will bring together the following major functions:

- *Planning*
- *Needs assessment*
- *Evaluation*
- *Prioritisation*
- *Change management and organisational development*
- *Resource allocation*
- *Process and outcome performance management, audit and quality assurance (to include performance measures, targets and indicators for the short, medium and long term)*
- *Health technology assessment*
- *Implementation of national guidance, care pathways, etc.*
- *Workforce planning, education and training.*

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
			Define 2007 cancer priorities and allocate new cancer funding. Improved access to diagnostic services, including mammography, will be provided. Support additional medical oncology and improved transport services for cancer patients. Expansion of family risk assessment clinics is also planned.	
National Radiation Oncology Plan	€3.25m (E)	24	Progress provision of additional Radiation Therapy Services at St Lukes to include 2 new Linear Accelerators and 2 replacement linear accelerators. Appointment of the technical advisors for the Project. Completion of the Output Specifications for the project. Progression and completion of the design phase of the interim facilities by traditional procurement at St James's Hospital and Beaumont Hospital which will provide 2 Linear accelerators and associated support services on each hospital campus. Formal sanction from DoF/DoHC is forth coming. Address Workforce planning and training and accreditation issues necessary to support the National Plan. Interim Facilities at St. James's and Beaumont Hospitals to be provided by 2009, through traditional Procurement. Support the appointment of additional Consultant Radiation Oncologists, specialist registers and support staff.	NHO
Cervical Screening Programme	€5m (E)	____	Programme to be transferred on 1 January 2007 to National Cancer Screening Services Agency. Prepare for Roll-out of the national programme in 2008.	Pop Health

Other Conditions

Including Cardiovascular, Diabetes and osteoporosis.

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Chronic Disease				
Chronic Disease Management patient support programme	€1.75m (B)	Nil	Service framework developed and pilot commenced in 2 geographic regions.	Pop Health
Cardiovascular (including both Heart Failure and Sudden Cardiac Death	€1.5m (B)		Roll out programme development to targeted sites nationally.	
Heart Failure programme development		12.5	Enhance the first responder and resuscitation training programmes. Provide education and promote awareness.	
Implementation of the Sudden Cardiac Death Task Force Report		16	Develop the 1st Responder Template – Q3 Develop post-mortem reporting protocols - Q3 Develop risk assessment questionnaire – Q4 Develop datasets for a national AED Register and a national cardiac arrest register – Q4	
Diabetic Retinopathy Screening	€0.750m (B)	8	Plan and develop a diabetic screening programme in 2 geographic regions and build on the experience of the screening service in the North West.	
Hepatitis C				
Health Amendment Act (HAA) Cards	€1m (E)	3	To extend eligibility for HAA Cards under the compensation scheme.	PCCC
Administration of Insurance Scheme	€1.5m(E)	4	Administration of the Hepatitis C Insurance Scheme as per the Hepatitis C Compensation Tribunal Amendment Act 2006.	Finance
Osteoporosis Prevention	€0.25m		Osteoporosis prevention and health promotion services developed in partnership with the Irish Osteoporosis Society.	Pop Health

Emergency Planning

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Implement the new Intersectoral framework document	€1m (E)	16	Framework actions for 2007 Implemented.	Pop Health

National Hospitals

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
New Units *Facilitation of commissioning and funding of new units in acute sector*	€35m (E)	700	Support for revenue requirements associated with new units as follows: ▪ St Vincent's Hospital, Dublin Phase I (including treatment/diagnostic facilities) ▪ Midland Regional Hospital at Tullamore (new hospital development) ▪ Cork University Hospital (including new maternity hospital and day procedures) ▪ University College Hospital, Galway Phase 2 (development and radiotherapy) ▪ Our Lady's Hospital for Sick Children, Crumlin (MRI) ▪ Our Lady of Lourdes Hospital, Drogheda (ED) ▪ Cavan General Hospital (theatre and ward fit-out) ▪ Louth County Hospital, Dundalk (modular theatres).	NHO
Neurosciences Service Development *Neurosciences multidisciplinary review group has already identified key priorities for 2007 which reflect the recommendations of the 2003 Comhairle report. Priority areas have been identified and the introduction of additional consultant neurologists (and support teams) will ensure that no consultant works single handed and will enable neurology services to be delivered on a hub and spoke model providing outreach clinics to local hospitals from the identified regional centres.*	€4m (E)	40	Initiate organisational reform of Department of Neurosurgery in Beaumont. Ongoing Appointment of 2nd neurosurgeon post with special interest in paediatrics. Q3 Completion of neurosciences needs assessment Q1 Priority in 2007 will be the appointment of additional consultant neurologists to expand the neurosciences network nationally. Ongoing Stroke strategy produced. Q4	NHO Pop Health
Patient Safety *(Transformation Programme 3)*	€3m (E)	50		NHO
1. Lourdes Inquiry *Following on from the publication of the Report the HSE has given a commitment to examine all aspects of the report and to continue implementation of the report's recommendations as they apply to maternity units nationally.*			1. Commence the implementation of the recommendations of the report of the Lourdes Inquiry, with specific focus on implementation of effective clinical audit, risk management and clinical governance.	

National Hospitals

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
2. North East Hospitals *Steering group and project group have been established to oversee and implement the recommendations of the Teamwork Report published in June of 2006.* *(Transformation Programme 3.2)*			2. Continue implementation of the three stranded action plan designed to improve health service safety and standards in the N.E.	
3. Madden Reports on Post Mortems			3. Completion of Audit of currently retained organs and development of standards in conjunction with IHSAB.	
Cystic Fibrosis (CF) *The CF Working Group, with representation from the DoHC, HSE and the CF Association, have produced a report identifying the priority requirements for each of the CF Units providing care nationally. Initial funding allocated during 2006 (€4.78m) to initiate the agreed recommendations.*	€2m (E)	35	This funding will build on the investment of €4.78m provided in 2006 and will facilitate the recruitment of additional consultant, nursing and allied health professional staff to improve services for CF patients nationally.	NHO
Renal Services – Implement National Renal Review *Report of the National Renal Services Review completed late in 2006 and will be the blueprint for the development of renal services. It is acknowledged that there will continue to be significant growth in demand for renal services nationally for the future and that services will need to continue to be developed each year to meet this need. It is likely that the HSE will need to consider sourcing additional capacity through the private sector or through public/private partnerships in the short to medium term to meet demand as the planned infrastructural developments within the public sector will provide for limited expansion of renal capacity.* *Expected increase of c. 15% next year in the number of patients who will require renal dialysis services.*	€4m (E)	70	Initiate implementation of the National Renal Strategy including the development of additional consultant led renal services on a regional basis.	NHO

National Hospitals

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Implementation of 100+ consultant post scheme *to reward hospitals that are maintaining high performing Emergency Departments (EDs).*	€4m (E)	20	Applications assessed against award criteria and ED Performance targets. Approval of new consultant posts for hospitals that meet the criteria. Q2	NHO
Ambulance Services *Pre Hospital Emergency Initiative.* *Develop robust system of Clinical Governance for the ambulance services.* *Paediatric Transport Service.* *To develop a national paediatric retrieval programme for critically ill paediatric patients requiring transport from regional care to tertiary centres.* *Emergency Planning*	€4m (E)	25	Appointment of a Full time Medical Director. Appointment of a Clinical Audit Manager. System for effective clinical audit will be developed in conjunction with PHECC (envisaged that this would run on a pilot basis to assess user requirements and management requirement before full implementation). Enhancement of patient retrieval services including establishment of National Paediatric Transport Service. Appoint a national Paediatric Retrieval Transport Programme Coordinator. Research internationally renowned best practice. Develop a national policy and procedures required for the formulation, implementation and management of such a programme. Accelerated rollout of EMTA paramedic training. Appoint a dedicated National Emergency Planning Officer to support the lead ANDs in EM in Hospitals and the Ambulance service.	NHO Ambulance
Tissue and Cells Directive *Implementation of EU Directive 2004/23/EC on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells.* *The purpose of the Tissue and Cells Directive is to have a unified framework to ensure quality and safety with respect to the procurement, testing, processing, storage and distribution of tissues.* *In 2006 there was regular communication with DoHC personnel regarding approval of additional staff and employment ceiling implications.*	€2m (E)	34	Information sessions per network for the Implementation of the EU Directive 2004/23/EC (tissues and cells). Report on national configuration of facilities as defined in the EU Directive 2004/23/EC. Appointment of quality managers for implementing and overseeing the quality system.	NHO

National Hospitals

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
Haemophilia services	€1m (E)	15	To provide funding for the National Haemophilia Council and to meet gaps identified within hospital services for persons with haemophilia	NHO
Sexual Assault Treatment Units *A sub-committee of the National Steering Committee was convened to review the provision of sexual assault treatment services.* *The review group recommended, inter alia,* • *Expansion of SATU services* • *Pilot Programme on Forensic Nursing*	€1.5m (B)	25	Initial development of 2 new Sexual Assault Treatment Units (SATUs) Work with GPs to expand on-call services for both existing and new units. Initiate development of forensic nurse training programme.	NHO / PCCC

The Task Force Report on Violence against Women (1997) contained recommendations to address the needs of women who had been raped/sexually assaulted.

Note: Additional revenue funding has been provided in the Estimates for: National Cancer Registry €0.400m and Northern Ireland Cancer Consortium €0.350m

Population Health

Focus	Funding	HR Implications	Deliverable 07	Lead Responsibility
National Office for Suicide Prevention Implementation of Reach Out – the National Strategy for Action on Prevention of Suicide.	€1.85m (B)	10	Develop and implement national training programmes and complete the availability of self-harm services through ED Departments. Progress the implementation of a national positive mental health awareness programme through the National Office for Suicide Prevention.	Pop Health

FUNCTIONAL DIRECTORATES

Office of the CEO

Focus	Funding	HR Implications	Deliverable 07
Medical Education, Training and Research			
Appointment of 17 additional Academic Clinicians	€2.6m	17	Agree with the HEA and Medical Schools arrangements for the appointment of the academic clinicians in line with recommendations set out in the Fottrell & Buttimer reports. Q1 Progress appointments with HSE Consultant Appointments Unit & the METR Unit. Q3 & Q4
Development of research scholarships	€0.4m	5	In consultation with the Health Research Board, develop a programme for paid research training posts leading to the award of PhD. Q2 Fund participants Q3 & Q4
Subsidise medical training abroad	€0.3m	____	In conjunction with the training bodies, establish a grant programme for overseas training in specialty/ subspecialties in which shortages exist in the Irish health service. Q2 & Q3

Note: Additional funding of €1m has been provided in the Estimates for the Postgraduate Medical and Dental Board

Human Resources

Focus	Funding	HR Implications	Deliverable 07
Consolidation of new National Garda Liaison Unit	€0.483m	7	To advance the assimilation of Garda Vetting by HSE area, one per quarter to achieve full centralisation by end 2007.
Implementation of recent Superannuation circulars.	€0.297m	10	Information sessions and option generation to staff by end Q1. Service history capture and costings. Q2 and 3. Billing and income generation Q3 onwards.
To develop and resource a new three-year phase of ***North South Health Services Partnership activity****.*	€0.07m	____	Continued contribution to reducing health inequalities, North and South, through collaborative partnership.
Podiatry			
Assessment/Bridging programme for Podiatry, to *ensure current and future service demands can be met.*	€0.12m	1.5 (x 6 months)	Q1/Q2 – Implementation of a further assessment and bridging programme process.
Development of the proposals to develop a School of Podiatry, in association with the Higher Education Authority (HEA) and the Department of Education and Science (DES) and DoHC.	€0.15m	1	Development of business plan. Q1 Call for proposals and management at process in association with HEA, DES and DoHC. Q3
Radiography *Development of clinical placements in Radiography.*	€0.5m	8	Develop clinical places in approved Radiography Departments. Q4.
Nursing and Midwifery			
Plan (Q1), negotiate and implement (Q3) transfer of Post Registration Midwifery and Children's Programmes to third level sector.	€7.5m	9.5	Plan completed. Q1 Implementation. Q3
Complete the implementation of Pre-Registration Midwifery and Integrated Children's Degree Programme.	€4.2m	15	End Q3
Orientation Training – Skills Mix	€0.720m	____	End Q4
Develop Framework for Nurse and Midwifery Prescribing	€0.700m	5	Contribute to development of legislation and governance arrangements, education programme and education processes. End Q4
Paediatric Intensive Care Course for sick children at Great Ormond Street Hospital	€0.200m	8	End Q3
General, Psychiatric and Intellectual Disability Nursing Degree Programme	€5.710m	____	Provides for increase in funding in respect of the expected 7% increase in capitation fees.

Quality Initiatives

While quality is inherent and embedded in all our actions and daily practices, this section of the service plan outlines some of the initiatives that are planned in each directorate as part of the HSE's commitment to improving quality.

SECTION 6 – QUALITY INITIATIVES

We are committed to delivering high quality services to all our patients and clients and to creating a quality promoting workplace for staff.

We do this through constantly seeking to identify opportunities to improve our existing services and by consciously building quality into all aspects of the new services we plan.

We recognise that quality improvement initiatives can make a significant contribution to the transformation process, and therefore we have sought in this service plan to identify a number of projects specifically focused at improving quality.

This section of the service plan, therefore, outlines some of the initiatives that are planned in each directorate as part of the HSE's commitment to improving quality. The initiatives outlined in this section will create opportunities for innovation, and proactively seek opportunities for change, in line with international best practice.

Focus	Target Timescale	Target Outcome	Lead Responsibility
Winter Initiative *(Transformation Programme 1.1)* *The purpose of the Winter Initiative is to ensure that the health and personal social services required to address the particular demands of the winter season are in place and operating optimally.* *A key element of the Winter Initiative is to ensure that patients requiring care are treated in appropriate settings away from acute hospitals, unless it is otherwise deemed clinically necessary.* *This initiative involves Primary Care, Population Health, Hospitals and Communications in a co-ordinated and sustained project, at national and local levels.* *The three headline elements of the Winter Initiative are promotion, and prevention, hospital avoidance and capacity.* ***1. Promotion and Prevention :*** • *Immunisation* • *Public Information Campaign* • *Patient Involvement (24 hour telephone information service, Self Care)* ***2. Hospital Avoidance*** • *Primary Care – Out of Hours; Community Intervention Teams; Role of Pharmacists; Access to Hospital;* • *Intermediate Care – Hospital at home (COPD, chronic illness); Walk in Centres; Hospital Outreach Initiative; Intensive Rehab* • *Social Care – Engagement with statutory and voluntary organisations*	Ongoing throughout 2007	***The Winter Initiative will:*** • *Improve system wide integration to ensure patients will have ease of access to appropriate care in a timely and responsive manner;* • *Improved local service integration;* • *Support patient care in the home and community based settings where possible;* • *Improve public awareness regarding health maintenance and well being during the winter months;*	NHO / PCCC / Pop Health / Communications

Focus	Target Timescale	Target Outcome	Lead Responsibility
3. Capacity • *Access – facilitated points of access / admission (emergency and electives)* • *Delayed Discharges – Shared hospital / community discharge teams housed together* • *Streamlining of patients in ED* • *Elective surgery – protection of elective surgery and reducing cancellations; routine referral of patients waiting over 3 months to NTPF* • *Critical care* • *Patient flow management; Tuesday/Wednesday spike in admissions;* • *Continuing Care Initiatives and Infrastructure Project: home supports; intermediate care; continuing care* • *Each Hospital and LHO required to have a plan to ensure maximum operational capacity in this period and a written escalation plan for use in the winter period, vetting by NHO and PCCC.*			
*The **100,000 lives campaign** aims to implement best evidence-based practice for a number of conditions, including the care of patients with chest pain.* *(Transformation Programme 1.3)*	Ongoing 2007	Further roll out of the 100,000 lives campaign.	NHO
*Over 40% of people die in hospital. There are no national **standards for end of life care**. The Ombudsman has identified this as an important issue*	Ongoing 2007	Development and implementation of standards for end of life care in partnership with the Irish Hospice Foundation.	NHO
***National Service User Executive** (NSUE) Mental Health Services – an independent group to advise relevant stakeholders on the views of service users.*	2007	Establishment of interim NSUE in conjunction with voluntary partners. Development of work programme.	PCCC
Enhancement of services to people with continence problems	End 2007	Develop a continence strategy in co-operation with voluntary groups, to improve awareness of and provision for continence issues, which have a significant effect on quality of life for many, particularly women and older people.	PCCC (in partnership with NHO)
Falls Prevention Strategy for Older people	End Q4	Reduction in fractures, acute hospital admissions and health costs following implementation of the strategy. This will be measured through the corporate PI system.	Pop Health
Progressing the Partnership toolkit "Better Partnership for Health"	End Q4	Manual disseminated and training delivered to key health professionals	Pop Health

Focus	Target Timescale	Target Outcome	Lead Responsibility
Development of Strategic Action Plan for Health and Wellbeing for HSE staff.	End Q4	Scoping completed and research commenced	HR/Pop Health (in partnership with key Directorates)
Improve capacity for evaluation in Health Promotion	End Q3	Evaluation framework developed in identified areas	Pop Health
Hospital hygiene *is important for patients, their families and staff. Improving hygiene is an important measure in building confidence in the hospital system.* *The NHO has been liaising with the health services accreditation board in the development of validated standards*	Q3 2007 ———	Third Report on hospital hygiene Hospitals nationally will begin implementing standards laid down by IHSAB in ensuring best practice in hospital hygiene.	NHO
Hospital acquired infection *Responsibility for the implementation of the Guidelines for the Control of MRSA in Ireland, is a major issue for the Acute Hospital service. The prudent use of Antibiotics, good professional practices and routine infection control precautions are the main measures in controlling and preventing healthcare associated infections.*	On going 2007	Provision of standardised data on incidence of hospital associated infection by each hospital. MRSA bacteraemia notification rate per 1,000 admissions by hospital network. (PH19)	NHO
Healthcare Associated Infection	On going 2007	Finalisation of a request for tenders for development of an infection control education package for healthcare workers, including e-learning resources. Q2 07 Development of a public information campaign on HCAI and prudent antimicrobial use. Q2 07 Provision of additional staff at Health Protection Surveillance Centre to deliver national surveillance of HCAI. National roll out of a GP educational initiative on prudent antibiotic prescribing, to begin early 2007. Development of national GP antibiotic prescribing guidelines. Q2 07	NHO / PCCC / Pop Health
Completion of 1st baseline hygiene audit *in PCCC facilities using an audit tool which has been adapted for PCCC*	2007 End Q1 End Q1 End Q1 Q4	Pilot of audit tool. Establishment of PCCC Quality and Risk Steering Group. Work plan agreed and prioritised. Priority Areas for Hygiene Audit agreed. Hygiene Audit undertaken in priority areas.	PCCC
Participate in Regional SARI/ HCAI Committee *to develop appropriate responses to this important area.*	Q2 07	Work with Regional SARI Committees to identify needs analysis in PCCC.	PCCC
Hospital Health and Safety *Set up NHO Working group in 2006 for health and safety.*	Ongoing 2007	Continue the work of the NHO working group for health and safety.	NHO

Focus	Target Timescale	Target Outcome	Lead Responsibility
Decontamination facilities ***Due to the importance of decontamination in preventing infections and the underlying legislative requirement, current practices are being reviewed.*** *National working group set up to review decontamination facilities. There are no national standards at present.*	Ongoing 2007	Complete audit of decontamination facilities nationally. Agreement on national standards on decontamination of reusable invasive medical devices in the NHO.	NHO
Currently different hospitals use different ***emergency call numbers****. This is a risk issue as NCHDs and nurses, including agency nurses, may inadvertently dial a wrong number if they have recently changed hospitals.*	Q2 2007	Implementation plan for national cardiac bleep number.	NHO
Establish a National ICU Audit System	One year	National All Ireland ICU Audit scheme in place.	NHO
Complete the publication of the nursing home inspection reports on the HSE Website *to allow the public access to their findings.*	2007	All inspection reports to be publicly available	PCCC
Accreditation	End year	NHO will continue to support hospitals in working towards high level accreditation.	NHO
Evaluation of HSE National Information Line	2007	Evaluation complete	PCCC
Structured reliable medical records *help to improve patient safety and quality of care*	Q1 2007	Standardised agreed approach to Medical Records Management in the NHO	NHO
Directive 2004/40/EC and 2006/25/EC: *These are part of a sequence of Physical Agents Directives that amend the European Commission's original 1933 proposal for a Physical Agents Directive covering noise, vibration, electromagnetic fields and optical radiation.*	Q4 2007	Setting up working group to examine the Implementation of **2004/40/EC and 2006/25/EC** (Directives in relation to EMFs and artificial optical radiation)	NHO
The ***Blood Directive*** *has implications for every hospital which practices transfusion medicine in relation to personnel, procedures, traceability, adverse events, storage, transport and confidentiality.* *In 2006 workshops were held nationally to inform and educate staff on EU Directive.* *Analysis carried out regarding minor capital needs and human resource needs.* *Regular communications with DoHC personnel regarding approval of additional staff and employment ceiling implications.*	Ongoing 2007	One information session will be held per network (Q1) and a national workshop will be held regarding the implementation of the EU Blood Directive in Q3. Appointment of quality manager for implementing and overseeing the quality system.	NHO

Focus	Target Timescale	Target Outcome	Lead Responsibility
Implementation of SI478 across all directorates. *SI478 places responsibilities on the CEO of the HSE, holders of radiological equipment, on individuals prescribing and administering ionising radiation and on medical physicists in relation to safety of medical radiography.*	Ongoing 2007	All directorates will have undertaken audit of equipment to comply with the implementation of the SI478 (medical ionising radiation protection.	NHO/PCCC
Palliative Care *Development of a quality framework for specialist inpatient, intermediate and home care.*	Commencing January 1st 2007	Framework developed and disseminated to stakeholders	PCCC
Emergency Service *Develop robust system of Clinical Governance for the ambulance services*	Ongoing 2007	System for effective clinical audit will be developed in conjunction with PHECC (envisaged that this would run on a pilot basis to assess user requirements and management requirements before full implementation.	NHO – Ambulance Services
To achieve new performance standards *and enhance the current level of service, new dimensions of delivery will need to be adopted.*	Ongoing 2007	Development of emergency care networks through the country, with particular emphasis on the North East. Development of immediate care services involving General Practitioners. Community based first responder schemes. The introduction of rapid response vehicles to augment traditional emergency vehicles. Forge allegiances with the Air Corps to provide inter hospital air ambulance services.	NHO – Ambulance Services
Conduct patient satisfaction surveys	May 2007 November 2007	Survey of Clients' experience of OPD services will be conducted during a one week period, twice a year in the Mid Western Group – outcomes to be analysed with a view to implementing improvements in the service. Viable recommendations will be implemented within 6 months of each survey.	NHO
Implementation of standard based Performance Measurement and Management *(Transformation Programmes 5 1-5)* *One of our key challenges is the development of the HSE as a high performing organisation, providing service excellence for best value.* *In order to achieve this, robust systems and processes need to be developed that support the development of meaningful performance measurement and management.* *A number of projects have been identified to support these objectives and include:*		Ethos of continuous improvement supported by robust performance management Introduction of meaningful performance measurement at all levels Evidence based decision making	CPCP / CEO's Office

Focus	Target Timescale	Target Outcome	Lead Responsibility
Business Planning: *One of the key components in an organisation's success is the strength of its business planning processes.* Develop and roll-out a business planning framework that meets the needs of the HSE as a single organisation that supports and empowers local delivery and accountability	Develop – Q1 Roll-out – Q2 onwards	Robust information that is integrated and aligned to the business; Outputs used effectively as a management tool; Improved performance measurement while ensuring we are achieving the best possible outcomes for the funding which we have been allocated. Streamlining of structures and processes to support good practice and improved performance in business planning	CPCP / CEO's Office
Corporate Performance Measurement: *Corporately, the HSE needs to focus on what are the important measures of success.* Develop and implement a Corporate Performance Measurement system that provides traction in the system	Implement – Q1	Integration and alignment of Performance Measurement while ensuring the information is used effectively as a core management tool to leverage standards of performance, ongoing improvement and innovation.	CPCP / CEO's Office
Corporate Intelligence: *Organisations require key information and analysis about their surroundings. It is important that there is a focused approach to converting information into knowledge by providing strategic value added analysis and evaluation.* Develop the HSE Corporate Intelligence capability	Throughout 2007	Provision of strategic cross directorate analysis	CPCP / CEO's Office
Development of measures / output indicators		The NHO has developed, in consultation with the DoHC, a number of measures / output indicators which show results of activity across the system. These will, when collation and quality assurance systems are refined, become indicators of performance which will improve the quality of service provision and subsequently health outcomes.	NHO
• *Number of public, adult and child, elective inpatient and day case discharges. (AS1a & b)* • *Number of adults waiting for inpatient and day case treatment longer than >3 months; >6 months; >12 months. (AS1c)* • *Number of children waiting for inpatient and day case treatment longer than >3 months; >6 months. (AS1d)* • *Adults waiting >6 and >12 months as % of public elective discharges. (AS1e)* • *Children waiting over >3 months and >6 months as % of public elective discharges. (AS1f)*	Quarterly	The length of time spent on the inpatient waiting list for admission to hospital can influence patient satisfaction/experience. The public elective activity in the previous quarter provides some context for additional capacity needed to meet long waiting patients. Any decrease in public elective activity and increase in numbers waiting will provide early indication of difficulties in specific specialities.	NHO

Focus	Target Timescale	Target Outcome	Lead Responsibility
• *Average length of stay (ALOS) – based on total bed days used and inpatient discharges (AS9) for:* ***Adult Service:*** • *Chest Pain (F74Z)* • *Bronchitis and Asthma Age >49 or WCC (E69B)* • *Appendicectomy W/O Catastropic or Sever CC (G07B)* ***Paediatric Services:*** • *Otitis Media & URI w/o CC (D63B)* ***Obstetrics*** • *Vaginal Delivery W/O Catastrophic or Severe CC (O60B)*	Bi-annual	ALOS for AR-DRGs and changes on previous year ALOS can be an indicator of efficiency. The AR-DRGs for this measure are selected on the basis of: • high volume • representative of various specialties • can be used to monitor quality • resource intensive (relatively) • tracer conditions	NHO
• *% of patients treated as day cases for specific list of procedures as follows (AS13):* ▪ *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)* • *Ratio of day cases to inpatient admissions, Diabetes without catastrophic or severe cc, by hospital network (K60B) (PH16c)*	Bi-annual	Patients having day surgery rather than inpatient surgery often have shorter waiting times because more patients can be treated and they are not subject to last minute cancellations by the hospital (as long as Day Surgery facilities are separate from those for emergency patients); spend less time in hospital; and receive care that is better suited to their needs Also, hospital costs are lower because day surgery is more efficient than inpatient care and there is little or no additional community support required.	NHO
• *Number of patients discharged in the reporting period (inpatient and day case – elective and non-elective). (AS14a)* • *% of public patients discharged in the reporting period (inpatient and day case – elective and non-elective). (AS14b)*	Quarterly	It is necessary that each hospital maintains its activity within the agreed levels. Number of discharges can provide an early indicator of possible increase in waiting lists (e.g. increase in non elective discharges and decrease in elective discharges).	NHO
a) *Number and direct age-standardised procedure rate per 100,000 female population for the following procedures (PH14a):* 1. *'Local Excision of Lesion of Breast' (ICD-10-AM 31500-00,31515-00)* 2. *'Mastectomy' (ICD-10-AM 31524-00, 31524-01, 31518-00, 31518-01) with a primary diagnosis of breast cancer.* b) *For surgeons conducting ANY of the above procedures: average total number of procedures conducted by all surgeons, within the hospital network. (PH14b)*	Annual	Quality assurance (QA) is an important aspect of the overall health services process. Tracking volume of activity by surgeon is an important aspect of the QA process within the NHO.	NHO

Focus	Target Timescale	Target Outcome	Lead Responsibility
c) Percentage of consultant surgical staff conducting > 30 of listed procedures, by hospital network. (PH14c) *d) % of total cases (see above list) conducted by surgeons conducting >30 procedures. (Ph14d)* *e) Total no. procedures by hospital type by region (i.e. are > 100 procedures conducted in each hospital). (PH14e)*			
• *The number of patients over 65 years on a waiting list for cataract surgery; ENT surgery; Orthopaedic surgery (OP2)*		*Monitoring of these waiting lists is important in assessing older persons quality of life which may be enhanced significantly by these procedures*	
• *No. of boys 0-4 years (inclusive) with undescended testes undergoing orchidopexy (ICD–10AM3780301,37803-00) as a % of all boys 0-15 years (inclusive) with undescended testes undergoing orchidopexy. (CH2)*		*Screening for undescended testes is an important part of child health surveillance.*	

FUNCTIONAL DIRECTORATES

Focus	Target Timescale	Target Outcome	Lead Responsibility
Development and adoption of an Information and Communications Technology [ICT] Infrastructure Standards Policy *that will assist to ensure protection of the HSE network and data, as well as assure reliable, quality service.*	Q3	Publication of Policy	ICT
Conduct the necessary assessment and prepare a detailed ***implementation plan for the HSE to address the implications of the Health and Social Care Professionals Act 2005.***	End Q3	Assessment complete	HR
Participate in review of Dietetic Services together with PCCC, Population Health, the Department of Health and Children and the HEA *to examine the supply of dieticians to the health services and the implications for any additional training places.*	Q2	Review complete	HR (in partner-ship with PCCC, Pop Health, DoHC and the HEA)
Through projects commissioned with the Irish Association of Speech and Language Therapists, Irish Society of Chartered Physiotherapists and Association of Occupational Therapists of Ireland develop the following: *a. A framework for identifying clinical competencies of therapists.* *b. A standardised student assessment tool.* *c. Guidelines for the accreditation of practice education sites.*	End Q4	Projects completed.	HR

Focus	Target Timescale	Target Outcome	Lead Responsibility
d. Proposals for an overall CPD framework. *e. A draft audit tool to identify CPD needs of therapists.* *f. Map good practice in practice education and investigate alternate models of training.* *g. Scope the requirements of back to work courses in the public sector.*			
National ISO qualification	End Q4	Existing regional ISO certificates are achieved nationally.	Estates
Establish Help line	End Q2	Monthly reports to all customers.	Estates
Establish Web based Customer Satisfaction Survey	Q3	Publish results.	Estates
Uniform Property Records	Q2	Single national database.	Estates
Systems	Beginning Q1 2007 and continuing in 2008.	Establish the infrastructure to support the implementation of a standardised national financial system in 2007.	Finance
Information	Ongoing	Enhance the quality of information made available to the key stakeholders by developing and enhancing comprehensive Management Information Systems and integration of disparate legacy systems.	Finance
Service	Ongoing	Finalise the finance structures and integrate further with other Directorates to deliver on service delivery finance requirements.	Finance
Conduct the necessary assessment and prepare a detailed implementation plan for the HSE to ***address the implications of the Health and Social Care Professionals Act 2005.***	End Q3	Assessment complete.	HR
Establish with PCCC ***a review group to look at the current arrangements and future needs for training Clinical Psychologists.***	End Q2	Review group in place.	HR
Through projects commissioned with the Irish Association of Speech and Language Therapists, Irish Society of Chartered Physiotherapists and Association of Occupational Therapists of Ireland develop the following:			HR
• *A framework for identifying* ***clinical competencies of therapists.***	End Q4	Project completed.	HR
• *A standardised* ***student assessment tool.***	End Q4	Project completed.	HR

Focus	Target Timescale	Target Outcome	Lead Responsibility
• *Guidelines for the* ***accreditation of practice education sites.***	End Q4	Project completed.	HR
• *Proposals for an overall* ***CPD framework***	End Q4	Project completed.	HR
• ***A draft audit tool*** *to identify CPD needs of therapists.*	End Q4	Project completed.	HR
• ***Map good practice in practice education*** *and investigate alternate models of training.*	End Q4	Project completed.	HR
• *Scope the requirements of* ***back to work courses in the public sector.***	End Q4	Project completed.	HR
Review existing arrangements for ***Centres for Nurse Education (CNE) arising from the 2003 agreement***	Q2	Develop a policy and framework for CNE in general, mental health and intellectual disability nursing.	HR
Develop ***Centres for Midwifery and Children's Nurse Education***		Develop a policy and framework for CNE in Midwifery and Children's Nursing.	HR
Continued involvement of ***Health Services National Partnership Forum*** *(HSNPF) in supporting Health Services Innovation Awards.*	Ongoing	Reward innovation through partnership to encourage more people to assist in modernising the service they provide.	HR
Contracts	Q2 Q4 Q3	Commence process to ensure that all contracts completed under current ICT Directorate have integral Quality of Service measurement and evaluation mechanisms inbuilt. Develop procurement specialists/capability for ICT in conjunction with the procurement directorate. Ensure HSE maximises the benefits of framework agreements established by the Department of Finance.	ICT
Development and adoption of an Information & Communications Technology standards and policy.	Q4	Initiate work on development and adoption of an Information & Communications Technology Infrastructure Standards Policy that will assist to ensure protection of the HSE network and data, as well as assure reliable, quality service.	ICT
Development of automated work papers	Q4	Appropriate IT package procured and piloted by Internal Audit.	Internal Audit
Agree and implement professional training and development programme for internal audit staff	Q4	Professional training and development programme for internal audit staff agreed and implemented.	Internal Audit
Continuous Improvement Programme	Q1	Development of Key Performance Indicators for Shared Services.	Finance/ HR/ ICT/ Procurement
Improved and more consistent quality of service through establishing "portal" based services	Q2	Elements of core services deployed on HSE Intranet.	Finance/ HR/ ICT/ Procurement

Focus	Target Timescale	Target Outcome	Lead Responsibility
Customer Service	Q3	Finalise the procurement structures and continue to integrate with Services and Directorates to achieve high level service delivery of procurement requirements across HSE.	Procurement
Product and service specifications database Continued development of a standard catalogue of products and services for use across the organisation.	Q3	Establish with Services and Directorates the optimum arrangements for achieving agreement in respect of specifications to be implemented across the organisation.	Procurement

Value for Money

Value for Money initiatives are those which ensure that resources are used economically and efficiently and that where economies of scale or sharing of best practice can achieve these principles, initiatives are implemented accordingly to ensure the most effective outcome. Specific initiatives planned for 2007 are included here.

SECTION 7 - VALUE FOR MONEY

Value for Money (VFM) initiatives are those which ensure that resources are used economically and efficiently and that where economies of scale or sharing of best practice can achieve these principles, initiatives are implemented accordingly to ensure the most effective outcome. Achievement of sustained value for money requires a whole system approach and should not be seen solely as a finance function.

The HSE came into existence on 1st January, 2005 and is the first ever Body charged with managing the operation of the health service as a unified system, bringing together the roles of many agencies that previously operated as separate entities. This process has involved merging 11 organisations and the specialist agencies to be streamlined into one organisation. The benefits of a unified health system are many, including a reduction in the level of fragmentation that has existed in the management and delivery of health care while promoting the harmonisation and equity of all services nationally and providing best care for patients. The merging of formerly autonomous organisations into one national entity offers the potential to leverage increased economies of scale, thereby facilitating maximum return on health investment.

As indicated earlier in the NSP, during the past four years our population has increased by more than 8% and is becoming increasingly diverse. There are now 4.2 million people living in Ireland, the highest since 1861. Some forecast that this will increase beyond 6 million in 10 years. Comparing with our European neighbours, we have a relatively young population; 11% are over 65 (in the UK, 18% are over 65). By 2030, one in four of the population in Ireland will be over 65. These changes are significant because health costs increase dramatically as people get older. A recent study by NHS Scotland (Report of the NHS Scotland Resource Allocation Committee – Technical Report C) shows that health costs increase by 100% for people aged 50-54, 213% for people aged 65 – 69 and 400% for people aged 75-79. The patterns emerging in the USA and UK give us some indication of what lies ahead. 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 most recent OECD health data refers to 2004 and estimates that Ireland spends approximately 7.1% of GDP on health compared to an OECD average of 9.0%. In most countries GDP and GNP are fairly close. Ireland is unusual in that a substantial difference exists between its GDP and GNP with GNP in Ireland being 18% greater than Irish GDP in 2004. Therefore, expressing the total health spend in Ireland as 8.4% of GNP is also an appropriately comparative figure. The HSE is delivering value through meeting the health and social care needs of the expanding Irish population. We recognise the additional target investment funding received which we have addressed separately within the NSP. However, while we are not directly funded for population growth, ageing and technological advances in medical treatment, we continue to endeavour to deliver increased amounts of service at higher costs reflective of these larger trends.

The HSE is developing an active VFM and cost reduction plan for 2007-2010. During this period savings of €500m are being targeted. These savings will be ring fenced and redeployed to frontline services. This section sets out the HSE strategy and listed initiatives to progress the development and delivery of VFM in 2007. The strategic initiatives include the appointment of a head of VFM at Assistant National Director level in the Finance Directorate. A Senior Management cross directorate group led by the head of VFM will drive the agenda and promote the development of a VFM culture across the HSE. The development of a shared services and the implementation of a single national financial management and procurement system are critical to successful implementation of the VFM strategy. A final component of the strategy is the implementation of a funding mechanism which best supports the strategic objectives of the HSE. The listed initiatives include procurement initiatives, service reviews and cost reviews to be carried out during the year.

Focus	Target Timescale	Target Outcome	Lead Responsibility
Value for Money Group			
To oversee and promote initiatives in the area of VFM/cost effectiveness. This group has been established with high-level representation from the HSE (CEO), DoHC (Secretary General), HIQA (CEO) and the Department of Finance (Senior Official).	Ongoing	To ensure that VFM is achieved in a coherent and effective way. This overarching group will receive reports/briefing on actions being taken, and progress being achieved, in relation to value for money/cost effectiveness across the full spectrum of the health service delivery system, thus assisting in the flow of information to respective Ministers and Boards. It will have a role in suggesting and driving further VFM initiatives.	Finance
Strategic Initiatives			
Head of VFM *Recruit Assistant National Director with responsibility for preparing and implementing the VFM strategic Plan.*	Beginning Q1 to end Q2.	Recruit Assistant National Director of Finance in charge of Value for Money, and establish a national VFM unit. Build relationships throughout the HSE to establish VFM priorities.	Finance
VFM Strategic Plan *(Transformation Programme 7.3)* *The key elements of the Plan are set out below under the following headings; Procurement Initiatives, Service Review and Cost Reviews. The financial and other benefits arising annually from each of these initiatives will be set out in the detailed Plan to be prepared by the incoming head of VFM.*	End Q2	Establish a Strategic Plan for VFM.	Finance
Implementation of Strategic Plan *(Transformation Programme 7.3)* *The HSE is putting in place a senior management group representing each of the Directorates with a specific responsibility to drive the VFM agenda. This group will be led by the head of VFM and will develop annual and three year VFM targets for the organisation.*	Group will be in place Q1 2007	Oversee implementation of the plan to deliver quantifiable VFM savings.	Finance
Shared Services *(Transformation Programme 8)* *Implementation of Shared Services – Initial planning phase completed.*	Ongoing process.	To deliver on improved value for money and efficiencies in processing functions by consolidating existing distributed functions and operations.	Finance / HR / ICT / Procurement
Single Financial Management System *(Transformation Programme 7.4)* *The H.S.E intends to commence the implementation of a standardised national financial system in 2007. This system will be SAP based and will enable the HSE to establish a Finance and Procurement foundation.*	Ongoing process.	The implementation of a single financial management system will assist in the integration of financial management and control processes and information within the Executive. This is a first release of a long term programme to establish the following: ▪ Revitalised financial controls and budgetary framework. ▪ Establish the finance function as a business partner for the H.S.E. pillars.	Finance

Focus	Target Timescale	Target Outcome	Lead Responsibility
Implementation of organisation wide financial and procurement processes and systems – going to tender in Q4 2006.		▪ 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.	
Funding Arrangements *Move to output / outcome based funding.*	Early 2007	The strategy will provide the appropriate" road map" for the future development of funding consistent with the achievement of the HSE's objectives. The initial strategy will be presented to the Board in early 2007 based upon work currently underway	Finance
Procurement Initiatives			
Drugs *– partially completed and now being quantified*	Q1 2007	The new agreement will deliver VFM savings.	National Pharmaceutical Unit in association with Procurement
Medical/surgical devices *– contracts currently being aggregated.*	Q1 2007	Will facilitate negotiation of national contract.	Procurement
Utilities *– national tender for electricity.*	Q1 2007	National agreement will deliver VFM savings.	Procurement
Legal services *– national tender pending.*	Q1 2007	National contract will deliver VFM savings	Procurement
Patient transport – ambulances *A National Contract will result in increased availability of ED Fleet and consequently reduce overtime.*	Q2 2007	Development of National Contract for Private Ambulance Hire.	NHO
National Contracts *- will generate savings due to economies of scale.*	Q2 2007	Development of National Contracts for Fuel Uniforms and Equipment Development of National Maintenance / Servicing Contracts	NHO
National insurance procurement	Q1 2007	National contract will deliver VFM savings	Finance and Procurement
PET Scanning *The NHO will be tendering for competitive rates for PET scanning services from the private sector where this is necessary to supplement the availability of scans in the public system.*	Q2 2007	The establishment of a list of preferred providers of PET Scans nationally will result in a more cost effective procurement process for scanning services.	NHO

Focus	Target Timescale	Target Outcome	Lead Responsibility
Radiotherapy *The NHO will be tendering for competitive rates for radiotherapy services from suitably qualified providers in the private sector where this is necessary to supplement the service currently available in the public system.*	Q2 2007	The establishment of a list of preferred providers nationally will result in a more cost effective procurement process for Radiotherapy services.	NHO
Dialysis *Following on from the successful awarding of a tender for the South East, the NHO will undertake a national tender to establish a list of suitably qualified providers with whom it will contract for the provision of haemodialysis at competitive prices where the need for additional capacity is identified in line with the national renal strategy report.*	Q2 2007	The establishment of a list of preferred providers nationally will result in a more cost effective procurement process for dialysis services.	NHO
Schemes Modernisation *(Transformation Programme 2.7)*	Q4 2007	Work has commenced and will continue in 2007 on the modernisation and rationalisation of schemes within PCCC. The potential of a unified system have 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. The focus for 2007 will be: ▪ Completing the integration of local schemes systems with the National Schemes Index on a real time basis. ▪ Completing the process of populating schemes registration systems with verified PPSN's for the registered population ▪ Implementing National Data Management and Control Programme during 2007. ▪ 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".	PCCC
Review of the Primary Care Reimbursement Service	Q4 2007	These Schemes have an annual approved allocation in 2006 of €2bn approx. PCCC will undertake a review of the usage of this money to establish potential savings. This will include; • Enhancement of probity assurance structures and processes across the range of contracted services. • Review of the probity assurance arrangements including the "examining dentists" function under the DTSS.	PCCC
Funding of Voluntary/ Non Statutory Sector/ Governance Arrangements	End Q4 2007	A new framework will be developed for the governance of relationships with the non-statutory and voluntary organisations funded by the HSE.	PCCC / NHO / Office of CEO

Focus	Target Timescale	Target Outcome	Lead Responsibility
Approval of Non Drug Items under GMS	Q4 2007	Current arrangements for approval and reimbursement of non drug items under GMS will be reviewed in 2007. A new structure and processes for appraising non drug items for inclusion on the approved list will be put in place. In addition the process of reviewing prices with suppliers of non drug items will be oriented towards a more formal competitive tendering process resulting in a more transparent and cost effective approach to the reimbursement of such items.	PCCC
Review of Demand Led Schemes	Q4 2007	An action plan based on the recommendations contained in the review of the Demand Led Schemes will be formulated during 2007 and will be implemented on a prioritised basis in accordance with available resources. Building on the work carried out during 2006 a team will be put in place to identify and implement value for money and cost containment measures in relation to Demand Led Schemes. This will include; ▪ Ensuring that HSE maximises VFM gains from recent IPHA agreement as it pertains to the "Demand Led" Community Drug Schemes. ▪ Revising the range and quantum of items which the HSE is approving, supplying and reimbursing through the Hardship Scheme. ▪ Identifying and putting in place the most cost effective system and processes for approving, supplying and reimbursing items under the Hardship Scheme. ▪ Enhancing the Probity Assurance Structures and processes which were established during 2006.	PCCC
Review of the efficiency and effectiveness of Long Stay Residential Care for Adults in Mental Health Services	It is anticipated that the Review will be complete in early/mid 2008 with a significant component completed by Q4 2007.	• Identify the objectives of the provision of Long Stay Residential Care and examine the extent to which, and the *effectiveness* with which, those objectives have been achieved in terms of overall quality and costs. • Examine the current validity of those objectives in light of the current changes in health service provision and their compatibility with the overall strategy of the DoHC, the Mental Health Act 2001, 'A Vision for Change', other relevant Government and EU policies and strategies and currently available evidence based practice. • Examine and define the inputs, outputs, trends, activity levels and patient outcomes associated with Long Stay Residential Care. • Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care and thus comment on the *efficiency* with which it has achieved its objectives. • Identify the infrastructural design which best supports a high quality service model of Long Stay Residential Care.	PCCC

Focus	Target Timescale	Target Outcome	Lead Responsibility
		• Review client care pathways with regards to the selection process, the selection criteria and the alternative options explored in determining the need for Long Stay Residential Care as well as the criteria for discharge and mechanisms in support of discharge planning. • Review user satisfaction with the provision and overall management of Long Stay Residential Care. • Evaluate the degree to which the objectives of the provision of Long Stay Residential Care warrant the continued allocation of public funding. • Examine and evaluate likely alternatives to the provision of Long Stay Residential Care in achieving these objectives on a more efficient and/or effective basis including making use of all potential synergies with other services. • Examine the probable outcomes which would arise from the discontinuation, reduction or expansion of the provision of Long Stay Residential Care. • Specify potential future performance indicators that might be used to better monitor the performance of Long Stay Residential Care for Adults within the Mental Health Services.	
Allocation and Utilisation of funding in Acute Hospitals – Southern Hospitals Group *A VFM Review is currently underway in the Southern Hospitals Group.*	Completion of VFM review by Q3 2007	Completion of this review will provide an outcomes evaluation of the programme of care based upon the original policy objectives.	NHO
Picture Archiving and Communication System (PACS) *Introducing PACS on a national basis, beginning 2007*	Ongoing throughout 2007. Will commence Q1.	PACS offers well recognised benefits in relation to improved quality for radiology and avoidance of the need to print films. 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.	NHO
Private Sector Collaboration *The NHO will liaise with the private sector to explore the potential for involvement of private sector in the delivery of health and support services in acute hospitals*	Ongoing 2007	Introduction of SLAs/contracts between the NHO and the private sector where services can be provided or outsourced competitively while ensuring provision of quality services.	NHO
Facilitate Forums for intersectoral working on National Health Promotion Campaigns *(e.g. advertisement campaign in relation to smoking cessation).*	Bi annually Evaluation of the process. End Q4 2007	Increased intersectoral planning and commissioning of campaigns which are publicly funded, resulting in more integrated and cost effective campaigns	Pop Health

Focus	Target Timescale	Target Outcome	Lead Responsibility
Development of Health Information Project *which aims to provide health information and education material across the HSE*	End Q4 2007	Increased intersectoral development of cost effective health information and education materials.	Pop Health
Review of Aids and Appliance Scheme nationally	End Q4 2007	Development of a national policy in relation to the funding, allocation, storage and recycling of aids and appliances, complete with national action plan for implementation.	PCCC
Cost Reviews			
Travel and subsistence expenses *– commencing quarter 4 2006.*	Q3 2007	The review will identify the potential for savings through VFM initiatives.	Finance
Telephony costs *– national tender and utilisation review*	Q4 2007	The review will identify the potential for savings through VFM initiatives.	Finance
Non fixed (no capital) pay elements review *– to commence in Q1 2007.*	Q2 2007	The review will identify the potential for savings through VFM initiatives.	Finance
Treasury management *Revised patient private property arrangements including consideration of outsourcing the entire process.*	Q4 2007	Implementation of efficient and cost effective arrangements.	Finance

FUNCTIONAL DIRECTORATES

Focus	Target Timescale	Target Outcome	Lead Responsibility
Single approach to property transactions		Satisfy all requirements of board audit committee re property transactions.	Estates
		Property staff in place.	
	June 07	Uniform process for property transactions.	
	Oct 07		
Clear capital monitoring		Accurate monthly reports and spend as per plan. Q1	Estates
Primary Care Estate Strategy – provision on a PPP basis		Quality, HSE branded health centres throughout the country.	Estates
	Q1	Pilot centres completed.	
	Q3	100 centres in place.	

Focus	Target Timescale	Target Outcome	Lead Responsibility
Further develop and implement integrated multidisciplinary team working and effectiveness *(Transformation Programme 6.6)* *Team Based Performance Management* *This initiative will support the reform agenda by enabling better team working and improved organisation performance* Establish high level national steering group on partnership basis by December 2006.	End March 07 End June 07	Strategy completed. Implementation plan.	HR
Develop and implement strategies and programmes to enhance HSE staff skills & skills mix. *(Transformation Programme 9.6)* *Training of Mediators* *A national panel of trained mediators is being established which will reduce the HSE's dependence on external mediators.* HSE staff continue to be funded to participate on the IPA mediation skills training programme which is accredited to the Mediation Institute of Ireland.	End Q4		HR
Develop and implement strategies and programmes to enhance HSE staff skills & skills mix. *(Transformation Programme 9.6)* *Review current provision of Post Registration and Post Graduate Nursing and Midwifery Programme and develop future policy for the HSE in this area.* Work has continued in conjunction with the Department of Health and Children, An Bord Altranais, the Education Providers and other stakeholders.	Q3	Develop an improved policy and support scheme for the funding of post registration specialist programmes.	HR
Develop a comprehensive set of HR policies *(Transformation Programme 9.2)* *Review nursing fees initiative scheme*	Q3	Improved policy on nursing fees initiative.	HR
Application of Peer review process for significant ICT projects		All significant value projects will go through this process to ensure that they are objectively assessed as delivering VFM.	ICT

Focus	Target Timescale	Target Outcome	Lead Responsibility
ICT budget control	Through Q3 & Q4	It is proposed to ensure there is visibility of all ICT budgets, both at a corporate and service unit level, to meet the revised accountability. This means budget holders will have greater clarity and responsibility on their ICT expenditure, supported by the ICT Directorate.	ICT
	Q4	An ICT Financial Management unit will be put in place in conjunction with the Finance Directorate to achieve this target.	
*Key aspects of the work of the HSE 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**. These recommendations are designed to improve HSE effectiveness and to ensure HSE achieves Value for Money in its operations. Value for Money is an intrinsic part of the audit process.*	Ongoing	Areas of the system of internal control requiring improvement identified.	Internal Audit
	Ongoing	Recommendations to assist management improve the system of internal control formulated.	
		Establish good working relationships with new HSE VFM group.	
Transactional Cost Savings	Commence Q1	Consolidation of transactional processing.	Finance / HR / ICT / Procurement
	Q4	Commence Implementation Phase through pilots of national services.	Finance / HR / ICT / Procurement
Improved decision making through more consistent information	Q4	Consolidate elements of transaction processing using existing multiple systems.	Finance / HR / ICT / Procurement
Procurement Initiatives	Q1 to Q4	Implement a significant number of sector level procurement contracts which will deliver Value for Money and contribute to the overall HSE target for Value for Money (see main value for money section for specific initiatives).	Procurement

Consistency and Social Inclusion

Consistency of service provision relates to those initiatives being pursued which ensure geographical equity and equity of access to treatment and care. Specific initiatives planned for 2007 are included here.

SECTION 8 – CONSISTENCY AND SOCIAL INCLUSION

The establishment of a unified health system provides us with opportunities to promote the harmonisation and equity of all services nationally while providing best care for patients. Our population health model of health and social care has a primary focus on promotion and protection of the health of the whole population and / or its subgroups, with particular emphasis on reducing health inequalities. As outlined within the Introduction to the NSP, a number of population health priorities were used to guide the preparation of the NSP for 2007. In the context of consistency and social inclusion, a number of these are particularly relevant and are identified below.

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

By seeking to improve the health and well being of the whole population, and in particular the health of population sub groups, the HSE is seeking, for example, to improve survival rates from heart disease, five year survival from cancer, the social well being of older people and disadvantaged groups.

Promoting equity as a strong value in the health system

There is a strong social class gradient in health status where those in the lowest socio-economic group have the highest death rates for all causes of death. The HSE is working to narrow this gap by influencing all the major factors which determine the health and well being of the population and by targeting resources to those most in need.

Developing services based on 'identified need' and evidence

By adopting a 'formal needs assessment' approach to identifying service shortfalls, the HSE can establish the most appropriate investment options based on anticipated outcomes and cost. This approach, which makes its planning process more explicit, also ensures that evidence based interventions are put into practice.

Measuring investment returns

By ensuring that specific and measurable health outcome targets are measured against achievements, the HSE can identify the health and social return accruing from its health investments. For example, in the implementation of the newly published Cancer Control Strategy, five year survival rates for different cancers will be monitored and compared to the level of investment provided for cancer services.

While these principles have been utilised in the identification of our deliverables for 2007, a sample of some specific initiatives being pursued which ensure geographical equity and equity of access to treatment and care are included within this section.

Focus	Target Timescale	Target Outcome	Lead Responsibility
Cancer needs assessment *(Transformation Programme 1.6)* *Implementation of the Cancer Strategy will provide the governance, integration and leadership to create the essential framework for cancer control. 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.* *Map existing cancer services – Q4* *Complete a needs assessment which will inform priorities - Q4*		Ensure an evidence based approach nationally for the Cancer Control Programme to inform service delivery based on identified need (see pages 50 and 105).	Pop Health
Services for Persons with Disabilities *The application of resources contained within the multi-annual investment programme for persons with disabilities will be allocated on the basis of need. Information from both National Disability Databases will play an increasing role in informing the planning of services from 2007, having regard to current data quality issues.*	Ongoing	An evidence based approach is taken nationally to develop and deliver services in response to identified need.	PCCC
Palliative Care Services *The Area Palliative Care Development Committees will priorities the application of resources in 2007 having regard to the 2005 Baseline Study.*	Ongoing	An evidence based approach is taken nationally to develop and deliver services in response to identified need.	PCCC
Equity and equal access to Service: *The availability and distribution of ambulances and crews reflect the variations in patterns in temporal demand.* *Different working and deployment arrangements will be essential, including a move away in some areas from the traditional concept of ambulance vehicles being permanently based in static ambulance stations.*	2007	Current methods for the delivery of patient transport and development of new concepts, procedures and policies for a national patient transport service reviewed (to include intermediate care and the various National Retrieval Programmes e.g. National Neo-natal transport programme).	NHO
Continue to work with representatives of PCCC to enhance access for individuals with disabilities *and people with higher support needs, in the implementation of the Disability Act*	Ongoing	NHO represented on Cross Directorate Disability Group. Agree and implement a process to identify and train Access Officers as set out in the Disability Act. Participate in audit of HSE buildings, services and information to ensure compliance with the Act	NHO (in partnership with PCCC and Estates)
Staff and management training on intercultural issues *Intercultural health project commenced in 2006*	Ongoing 2007	A programme of staff training will be undertaken in a minimum of 13 health care settings nationwide.	Office of the CEO
Enhancement of services to Ethnic Minorities.	End 2007	National Inter-Cultural Strategy completed. Learning, Training and Support Framework for staff rolled out across Local Health Offices to facilitate the delivery of appropriate health service responses to minority ethnic communities.	PCCC

Focus	Target Timescale	Target Outcome	Lead Responsibility
		Roll out the Ethnic Identifier question across appropriate data collection systems within the HSE. Complete review of approaches to translation services within PCCC with a view to having a unitary approach to the provision of this service. Develop a National Framework for Interpreting Services.	
Improve and enhance access by Travellers to mainstream health services.	End 2007	Integrated implementation of Traveller Health Strategy and the Primary Care Strategy. Traveller Health Units reconfigured in line with revised HSE structures and in consultation with stakeholders. All Ireland Traveller Health Study completed. Increased take-up of mainstream health services amongst Travellers. Greater uptake amongst Travellers of employment opportunities within the HSE.	PCCC
Integration of National Anti Poverty Strategy (NAPS) within PCCC.	End 2007	NAPS integrated within PCCC through a targeted approach with Primary Care Teams/Networks, Older People, Mental Health, Children and Families, and Disability Services. Strategic alliance developed with Combat Poverty to ensure that their work on participation and primary care informs the roll out of the primary care strategy.	PCCC
Promote HIV/AIDS Awareness	Ongoing	Work with Population Health to ensure an integrated approach to education, prevention and awareness raising strategies for all communities at risk and affected by HIV/AIDS. Ensure HSE active participation on both the European and National Monitoring Groups on AIDS.	PCCC
Enhance Community Development and Partnership	Ongoing	Community Development embedded as an important approach and effective tool to marginalised and isolated communities. HSE representation on City and County Development Boards is supported.	PCCC
Develop links with Lesbian/ Gay/Bisexual/ Transgender Communities (LGBT)	Ongoing	Key service developments e.g. within Primary Care, Older People, Mental Health and Children and Families are responsive to needs of these communities.	PCCC
The development of a unified health system necessitates significant work on the standardisation of many elements of our services. Within ***PCCC governance groups have been established*** *and will work in 2007 to ensure that maximum standardisation is achieved.*	2007	Develop Work plan. Quarterly updates from the governance groups.	PCCC
HSE to cooperate with NTPF	Ongoing	The Planning and Development unit of the NHO will liaise closely with the NTPF and the network managers to ensure that any public patient waiting longer than three months for surgery will be offered the option	NHO

Focus	Target Timescale	Target Outcome	Lead Responsibility
		of referral to NTPF. Monitoring of waiting lists will be carried out by Performance Monitoring Unit, in conjunction with NTPF.	
Public access to elective treatment	Ongoing	Continue to monitor public/private activity profile to ensure appropriate access to elective procedures for public patients.	NHO
Regional Self Sufficiency	Ongoing	Development of services to ensure geographical equity. In 2007 decision making on allocation of additional service developments will be influenced by the need to improve geographic equity in accessing services (for example funding provided to enhance local provision of services thus reducing the need for people to travel long distances for care).	NHO
Treatment Abroad Scheme	2007	Agreed standard application policy and procedures for those applying for treatment abroad under E112 and standard guidelines for travel and subsistence nationally.	NHO
Development of equality framework *The framework aims to confirm the HSE's commitment to equality and to identify it as one of its key priorities. The principles of this framework apply to all who avail of our services, participate in our programmes and who work with us as employees. This also includes relatives and associates of services users, and contractors and suppliers of services.*	End Q4	National Equality Programme Steering group supported.	Pop Health
	End Q3	Equality initiatives mapped.	Pop Health
	End Q2	Design of an equality action plan prepared.	Pop Health
	End Q4	Ongoing collaboration with Equality Authority.	Pop Health
	End Q4	Flagship player with Equality Authority in supporting the *European Year of Equal Opportunities for All.*	Pop Health
	End Q4	Policy framework for addressing transgendered health needs prepared.	Pop Health
Health Inequalities *The HSE Corporate Plan, 2005-2008, and its subsequent 'Model of Health Care Document' and the Transformation Priorities advocate a Population Health approach to the planning and delivery of health services. This approach seeks to promote and protect the health and well being of the population and of specific groups in the population. It aims to provide integrated care based on people's needs and to reduce health inequalities. An essential part of this approach is working in collaboration with key stakeholders internal and external to the organisation.*	End Q1	Establishment of project group.	Pop Health
	End Q3	Preparation of action plans.	Pop Health

FUNCTIONAL DIRECTORATES

Focus	Target Timescale	Target Outcome	Lead Responsibility
Develop and implement strategy for rollout of infrastructure requirements to comply with Disability Act 2005.		HSE estate in compliance with Act.	Estates
	Q1	Educate all estate staff on requirement of act.	
	Q2/Q3	All project plans revised to accommodate compliance.	
	Q4	All new projects meet requirement.	
Develop a comprehensive set of HR policies		Defined actions to meet 3% target for employment of people with disabilities.	HR
(Transformation Programme 9.2)			
Develop and implement strategy for employment of people with disabilities	Q1	Completion of strategy.	
	Q2/Q3	Awareness training.	
	Q4	Work with managers to implement strategy.	
Developing structure with Assistant National Directors of HR to deliver Equality Agenda	Q3	Appropriate HSE strategy in the area of equality and training commenced.	HR
	Q1	Assign responsibility for Equality within each area.	
	Q2	Audit existing equality programme and develop HSE training programme.	
	Q3	Commence delivery of training.	
	Q4	On-going training. Monitor and evaluate progress for 2007.	
Standardisation of a national academic study support scheme		Equality for staff in accessing support for academic study.	HR
	January	Prepare proposal.	
	June	Reach agreement through partnership process by.	
Procurement Policies	Q4	Develop and implement procurement policies which will support consistency and social inclusion objectives.	Procurement

Outcomes

This section outlines some of the key health impact areas which will influence health outcomes, and are by definition long-term.

SECTION 9 – OUTCOMES

A significant objective for the HSE is to improve the overall health status of the population. In order to facilitate this objective, there is a constant focus on how to integrate service delivery to achieve maximum health and social gain for the population. Whilst the HSE can significantly impact on the health status of the population, many factors outside the control of the HSE can also impact and need to be taken into account when analysing the changing nature of the health status of the population. Below are some key outcome areas where measurable changes or outcomes can affect health status. During 2007 the HSE and the DoHC will work together to set agreed targets in those areas where they do not exist at present.

Focus	Target Timescale	Target Outcome
Primary Immunisation rates *The World Health Organisation and National Policy recommends an uptake rate of at least 95% to ensure that herd immunity is achieved in a community and to provide individual protection. Information on childhood immunisation rates will indicate if this target is being achieved.* *Indicator (CH5):* 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). 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) c) Number and Percentage of children who have received MMR at 24 months of age.	Quarterly	Increase immunisation rates in all regions to that pertaining in the best region. Increase immunisation rates to 95% nationally
Cancer *Survival from cancer is dependant on, amongst other things, stage of presentation and stage of detection. In general the earlier cancer is detected the greater the chances of survival and early detection is related to public knowledge of the significance of signs and symptoms which may be associated with cancer, professional awareness, the possibility of cancer in individual cases and appropriate early interventions. Data on the stage of presentation and survival for common cancers will be utilised to assist in assessing cancer services.* *Indicator (PH4):* Uptake of Breast Cancer Screening by Women in the appropriate age group.	Annually	

Focus	Target Timescale	Target Outcome
Number and Percentage of cancers diagnosed at various stages (PH2): a) Lung Cancer % early, % late b) Breast Cancer % early, % late c) Prostate Cancer % early, % late d) Colorectal Cancer % early, % late	Annually	Increase uptake rates in all regions to that pertaining in the best region. Increasing percentage trend year on year of cancers diagnosed early. Identify best outcome in the EU and monitor progress in trend towards same.
5 year Relative Survival Rate for various cancers (PH3): a) Lung Cancer b) Breast Cancer c) Prostate Cancer d) Colorectal Cancer	Annually	Improving trend year on year. Identify best outcome in any EU country and monitor progress in trend towards same.
Tobacco Consumption *Smoking is a key risk factor for cardiovascular diseases, respiratory diseases, many cancers and a wide range of other debilitating conditions. Multiple strategies, including price increases on tobacco products, health promotion campaigns, enactment and enforcement of tobacco control legislation and smoking cessation services all play a role in reducing the prevalence of smoking. A key measure is the year on year prevalence of smoking in the population.* *Indicator (PH11):* Cigarette smoking prevalence - % of population smoking, % population non smoking.	Annually	Improving trend year on year. Identify best outcome internationally and monitor progress in trend towards same.
Cardiovascular Diseases *Cardiovascular diseases contribute significantly to the health status of the population. The various measures outlined below, monitored over time, give an indication of the impact of the totality of the health services in dealing with the burden of cardiovascular disease.* *Indicator (PH8):* Number and age standardised hospital discharge rate per 100,000 population of Acute Myocardial Infarctions (ICD-9-CM 410) by gender and by county of residence.	Annually	Identify best outcome nationally and thereafter internationally and monitor progress in trend towards same.

Focus	Target Timescale	Target Outcome
Indicator (PH13): Number and direct age-standardised hospital procedure rate per 100,000 population by county of residence of: Coronary arteriography CABG procedures PTCA procedures		
Other measures *Comparative hospital activity data on selected procedures (outlined below) can reflect the quality of preventative and treatment services for these conditions.*		
Direct age-standardised discharge rate, fracture neck of femur, per 100,000 population by network of residence. (PH15b) Number and direct age-standardised hospital procedure rate per 100,000 population cataract procedures by gender and county of residence. (PH13(5)) Number and direct age-standardised hospital procedure rate per 100,000 population of renal transplant procedure by gender and county of residence. (PH18) Number and direct age-standardised hospital procedure rate per 100,000 population (age < 15yrs) of Grommet procedures) by county of residence. (PH20a) Number and direct age-standardised hospital procedure rate per 100,000 female (age < 40yrs) population of D&C procedures (ICD) by county of residence. (PH20b) Direct, age-standardised discharge rate, per 100,000 population, diabetes (ICD-10-AM:E10-E14) by county. (PH16c)	Annually	Identify best outcome nationally and thereafter internationally and monitor progress towards same

Appendix 1

Indicators / Measures 2007

For 2007, the following are the Indicators and Measures which we have identified to enable us to assess our performance in relation to our National Service Plan.

PRIMARY CARE

Reference	Indicators / Measures, 2007
PC3	a) The percentage of GMS GP Practices with Information/Communication Technology links to hospitals. b) The percentage of GMS GP Practices that transmit and receive information via email c) The percentage of GMS GP Practices using certified software packages as recommended by the National General Practice Information Technology Group.
PC7	Percentage of school children in designated classes within national schools who have received dental screening within the reporting period.
PC10	a) The number of GMS GPs involved in GP co-operatives as a percentage of all GMS GPs. b) The GMS population covered by GP co-operatives as a percentage of the total GMS population.
New	Average waiting time by L.H.O area for 1. Orthodontic assessment (Category A: Category B:) (See Appendix) 2. Orthodontic treatment (Category A: Category B:) (See Appendix)
	HSE National Information Line – calls received
	GP Vocational training places in partnership with the ICGP
	Expand out of hours GP Services - Projected number of contacts

CHILDCARE

Reference	Indicators / Measures, 2007
CC4	a) Total number of notified current operational pre-school centres in the HSE Area during the quarter. (Not Cumulative). b) Number of new pre-school centres notified during the quarter. (Not Cumulative). c) Number and Percentage of notified current operational pre-school centres in the HSE Area where an Annual Inspection took place during the quarter. (Not Cumulative). d) Number of pre-school Review Visits/Follow Up Visits that took place during the quarter. (Not Cumulative). e) Number of pre-school Advisory Visits that took place during the quarter. (Not Cumulative). *(Review/Follow Up visits take place when an inspection has found a significant breach of regulations which needs to be rectified, or a complaint has been made against a service. Advisory visits take place when a provider requests advice on setting up, changing or extending a service.*
CC7	a) The Number and Percentage of children in: i. Residential care (Note: Include Special Arrangements). ii. Foster care (Note: Do not include Day Fostering). iii. Foster care with relatives. iv. Other Care Placements/At Home under Care Order. Note: Please take figures for number of children in care from the Interim Dataset (e.g. number of children in residential care, number of children in foster care, other etc). 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). ii. Foster care (Note: Do not include Day Fostering).

Reference	Indicators / Measures, 2007
	iii. Foster care with relatives. iv. Other Care Placements/At Home under Care Order. c) Percentage of children in care i, ii, iii & iv who have an allocated named social worker. d) The number and percentage of children who came into care during the reporting period who had a care plan drawn up prior to placement. e) The number and percentage of children for whom a review was due during the reporting period and the review took place. f) The number and percentage of children for whom a review was due during the reporting period and the review did not take place. Note: If the previous review date was late, the next review date should be based on the actual review date rather than the planned review date.
CC8	Total number of families referred to Springboard Projects in the reporting period.
CC9	a) Total number of referrals to Family Welfare Conferences in the reporting period b) Total number of Family Welfare Conferences convened in the reporting period c) Number of Family Welfare Conferences convened i) within 28 days of referral ii) 28 - 35 days following referral iii) 35 days or more following referral 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 ii) recommend to HSE to apply for Special Care Order iii) recommend to HSE to apply for Care Order iv) recommend to HSE that Voluntary Care Order is required v) recommend to HSE to return to Relative Care vi) recommend to HSE that child remains at home and Community Based Support Plan is implemented with format supports from HSE services vii) recommend to HSE that child remains at home and Community Based Support Plan is implemented with informal supports viii) No plan agreed ix) Other (Please specify in commentary) e) Number of prepped/planned Family Welfare Conferences not convened in the reporting period f) Number of Review Family Welfare Conferences: i) held during the reporting period ii) planned for the reporting period iii) cancelled during the reporting period Commentary: This is a new PI for 2006. Further validation work is required across Local Health Offices to provide a robust return.
New PI	For each HSE region, the a) number of notifications made of child abuse or neglect b) number of assessments conducted following notifications 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
	High-Support Units

Reference	Indicators / Measures, 2007
	• Total available bed nights • Actual no. of bed nights • Beds occupied as a % of beds available
	Special Care-Units • Total available bed nights • Actual no. of bed nights • Beds occupied as a % of beds available

MENTAL HEALTH

Reference	Indicators / Measures, 2007
MH5	a) Number of inpatient places by 100,000 population. b) Admission rates to acute units, per 100,000 population. c) First admission rates to acute units (that is, first ever admission), per 100,000 population. d) Inpatient re-admission rates to acute units per 100,000 population. e) Median length of stay.
	No. of discharges from secondary to primary care
	No of inpatient days utilised in General Hospital Psychiatric Units / Psychiatric Hospitals

OLDER PERSONS

Reference	Indicators / Measures, 2007
OP2	The number of patients, over 65 years, on the waiting list for • Cataract surgery • ENT surgery • Orthopaedic Surgery
OP3	Percentage uptake of influenza vaccine among the GMS population aged over 65 years.
OP4	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 & 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 & voluntary, as a percentage of the total population aged 75 years and over.
	Home Help Hours • Total No. of Home Help hours • No of hours monthly No of clients in receipt of home help Hours
	No. of home care packages in place
	Total number of day care places
	Number of Community Intervention Teams fully operational
	Total no. of registered Nursing Homes No. and % of nursing home inspections completed within the reporting period
	No. of persons in receipt of nursing home subventions (monthly):

Reference	Indicators / Measures, 2007
	• Medium • High • Maximum • Total • Enhanced

PALLIATIVE CARE SERVICES

Reference	Indicators / Measures, 2007
	No. of patients treated in specialist inpatient units/month
	No. of patients accessing Home Care services/Month
	No. of patients accessing intermediate care in community hospitals/Month
	No. of patients accessing day care/Month

SOCIAL INCLUSION:

TRAVELLER HEALTH SERVICES

Reference	Indicators / Measures, 2007
TH1	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.
	Percentage of representatives on Traveller Health Units who are Travellers. (Previously TH2)

ASYLUM SEEKERS

Reference	Indicators / Measures, 2007
AR3	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

SERVICES FOR HOMELESS PERSONS

Reference	Indicators / Measures, 2007
HO5	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. 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. 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.

ADDICTION SERVICES

Reference	Indicators / Measures, 2007
AD3 b)	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.
AD 4 c)	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. (If the frequency of services provided on the ground affects the outcome of averages, it should be noted in the commentary i.e. if a clinic is only held once a fortnight).
	Average number of clients in methadone treatment per month
	Average number of methadone treatment places utilised in the reporting period

DISABILITY SERVICES

Reference	Indicators / Measures, 2007
ID3	a) The percentage of clients on the intellectual disability database who have been assessed as requiring day* services. b) The percentage of clients assessed as requiring day* services, as identified in ID3 (a), and who are receiving the service. c) Percentage of clients identified in ID3 (b) that require a further* day service. d) The percentage of clients assessed as requiring a day service and are receiving an appropriate day service. e) The percentage of clients on the Intellectual Disability database who are assessed as requiring residential* services. 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. g) Percentage of clients identified in ID3 (f) that require further* residential services. h) The percentage of clients assessed as requiring a residential service and are receiving an appropriate residential service.
ID5	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.
	Number of persons in receipt of respite services
	No. of persons in receipt of Domiciliary Care Allowance/Month
	No. of persons in sheltered work/Month
	No. of persons in rehabilitative training

ENVIRONMENTAL HEALTH SERVICES

Reference	Indicators / Measures, 2007
PH1	Number of inspections carried out to investigate compliance with Section 46/47 of the Public Health Tobacco Act
PC6	Number of water fluoridation schemes inspected
	Number of inspections of food premises carried out

CHILD & ADOLESCENT HEALTH

Reference	Indicators / Measures, 2007
CH1	Number and Percentage of new born babies visited by a Public Health Nurse (PHN) within 48 hours of hospital discharge.
CH2	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.
CH5	a) Number and Percentage of children 12 months of age who have received three doses of vaccine against Diphtheria (D_3), Pertussis (P_3), Tetanus, (T_3), *Haemophilus influenzae* type b (Hib_3), Polio ($Polio_3$), Meningococcal group C ($MenC_3$). b) Number and Percentage of children 24 months of age who have received three doses of vaccine against Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3), *Haemophilus influenzae* type b (Hib_3), Polio ($Polio_3$), and an age appropriate number of doses of Meningococcal group C ($MenC_3$) c) Number and Percentage of children who have received MMR at 24 months of age.
CH7	a) The percentage of babies who are exclusively breastfed on discharge from hospitals. b) The percentage of babies who are breastfed (not exclusively) on discharge from hospitals. c) The percentage of babies who are exclusively breastfed at the PHN first visit. d) The percentage of babies who are breastfed (not exclusively) at the PHN first visit. e) The percentage of babies who are exclusively breastfed at three months. f) The percentage of babies who are breastfed (not exclusively) at three months.

ACUTE SERVICES

(this section includes population health indicators which are measured through activity within the acute hospitals)

Public Inpatient and Day Case (Discharges and Waiting Lists)

Reference	Indicators / Measures, 2007
	Total activity presented by hospital group: • Inpatient Discharges • Day Case Attendances • Outpatient Department Attendances • Emergency Department Attendances • Numbers Admitted from Emergency Departments • Births
AS1	<u>Speciality level detail should be submitted</u> a) Number of Public, Adult, Elective In Patient and Day Case Discharges. b) Number of Public, Child, Elective In Patient and Day Case Discharges. c) Number of adults waiting for both In Patient and Day Case treatment at end of quarter (Public Waiting List Only): • over 3 months • over 6 months • over 12 months d) Number of children waiting for both Public In Patient and Day Case treatment at end of quarter (Public Waiting List Only): • over 3 months • over 6 months

Reference	Indicators / Measures, 2007
	e) Adult Patients Waiting over 6 months and 12 months as % of Public Elective Discharges in Reporting Period. f) Child Patients Waiting over 3 months and 6 months as % of Public Elective Discharges in Reporting Period.
AS9	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 In Patient Discharges <u>Adult Services</u> • Chest pain (F74Z) • Bronchitis and Asthma Age >49 or W CC (E69B) • Appendicectomy W/O Catastrophic or Severe CC (G07B) <u>Paediatric Services</u> • Otitis Media & URI w/o CC (D63B) <u>Obstetrics</u> • Vaginal Delivery W/O Catastrophic or Severe CC (O60B)
New ED PI	a) average number of patients on trolleys in A & E departments nationally per month b) average waiting time for patients in A & E departments nationally per month broken down as follows a) < 6 hours b) 6 - 12 hours c) 12 - 24 hours and d) > 24 hours
AS13	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)
PH 16 c)	b) Ratio of day cases to inpatient admissions, Diabetes without catastrophic or severe cc, by hospital network (K60B)
AS14	Elective/Non Elective and Public/Private Discharges a) Number of patients discharged in reporting quarter: • In Patient • Elective • Non Elective • Day Case b) Percentage of Public Patients discharged in current quarter: • In Patient • Elective • Non Elective • Day Case
PH2	Stage of Presentation of Common Cancers
PH3	a) 5 year Relative Survival Rate for Breast Cancer (ICD-10-AM C 50) patients. b) 5 year Relative Survival Rate for Lung Cancer (ICD-10-AM C 34) patients. c) 5 year Relative Survival Rate for Prostate Cancer (ICD-10-AM C 61) patients. d) 5 year Relative Survival Rate for Colorectal Cancer (ICD-10-AM C18 – C21) patients.
PH4	Uptake of Breast Cancer Screening by Women in the appropriate age group.
PH11	Cigarette smoking prevalence - % of population smoking, % population non smoking.

Reference	Indicators / Measures, 2007
PH13	a) Number and direct age-standardised hospital procedure rate per 100,000 population of: 1. Coronary arteriography (ICD-10-AM 38215-00, 38218-00, 38218-01, 38218-02) 2. CABG procedures (See Appendix for list of ICD-10-AM codes) 3. PTCA (ICD-10-AM 35304-00, 35305-00, 35310-00, 35310-01, 35310-02) 4. Hip Replacement (See Appendix for list of ICD-10-AM codes) 5. Cataract Procedures (See Appendix for list of ICD-10-AM codes) by county.
PH 15 b)	b) 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.
PH 16 a)	c) Direct age-standardised discharge rate, per 100,000 population, Diabetes (ICD-10-AM: E10 - E14), by county
PH 18	d) 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
PH 20 a)	e) 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.
PH 20 b)	f) 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.
PH 8	g) Number and age-standardised hospital discharge rate per 100,000 population of Acute Myocardial Infarctions (ICD-10-AM I21 - I22) by gender.
PH14	a) Number and direct age-standardised procedure rate per 100,000 female population for the following procedures: 1. 'Local Excision of Lesion of Breast' (ICD-10-AM 31500-00, 31515-00) 2. 'Mastectomy' (ICD-10-AM 31524-00, 31524-01, 31518-00, 31518-01) with a primary diagnosis of breast cancer. b) For surgeons conducting ANY of the above procedures: average total number of procedures conducted by all surgeons, within the hospital network. c) Percentage of consultant surgical staff conducting > 30 of listed procedures, by hospital network. d) % of total cases (see above list) conducted by surgeons conducting >30 procedures. e) Of the hospitals performing the procedures outlined in a) above, the %, analysed by hospital network which are performing > 100 procedures
PH19	MRSA bacteraemia notification rate per 1,000 admissions by hospital network.
NEW PI	a) Case-mix adjusted hospital base prices expressed as a proportion of the overall group hospital base price b) Case-mix adjusted average length of stay - length of stay is closely correlated with cost

AMBULANCE SERVICES

Reference	Indicators / Measures, 2007
AM6	Number and Percentage of emergency ambulance calls responded to within pre-determined time bands.
	Pre Hospital Activity: • Emergency Calls • Urgent Calls • Non Urgent Calls • Community Transport

POPULATION HEALTH : Health Promotion

Reference	Indicators / Measures, 2007
HP6	Provision of Schools Training • Primary • Post Primary • SPHE
HP4	Provision of Training to Health Care Workers, Management / Administration: Number of Training Hours • Health Promotion • Accredited HP Number of persons trained • Medical/Dental • Nursing • Allied Health Professionals • Management / Administration • Support Staff • GPs • Practice Nurses • Pharmacists • Others
HP4	Provision of training to other Sectors: • Statutory bodies • Private Sector • Community/Voluntary • Other
HP3	Participation in Health Promoting Hospital Network a) No. and % of members of the Promoting Hospitals Network. b) No and % with a written Health Promotion policy c) No and % engaged in Health Promotion Initiatives
HP5	Provision of support to Workplaces: • HSE Worksites • Non HSE worksites o Small o Medium o Large
HP7	Development of community based Health Promotion Partnerships • Based on community development approach • Organised by HP services • Clinical Dietetics • Smoking Cessation • Health Promotion/Public Health campaigns

CORPORATE AFFAIRS

Reference	Indicators / Measures, 2007
NEW PI	a) 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:
	b) for which an interim reply issued by the HSE within 20 working days of the date of the Ministers answer to the Dáil and
	c) for which a final reply has been issued by the HSE within 20 working days of the date of the Ministers answer to the Dáil

APPENDIX OF TERMS
Intellectual Disability Services

Reference	Indicators / Measures, 2007
AS 12 c), d), and new	Category A: Patients who require immediate treatment and include those with congenital abnormalities of the jaws such as cleft lip and palate and patients with major skeletal discrepancies between the sizes of the jaws Category B: Patients with less severe problems than Category A and are placed on the orthodontic treatment waiting list. Category C: have less severe problems than those in Category B.
ID3	*Day service: This includes all day services as per the database, excluding codes 28 & 30. The indicator is relevant to: 1. Those who have a day service and require another service. 2. Those who have a day service and need an enhanced service. 3. Those who have no day service and need one. 4. Those in a day service who have no further/alternative requirements for a day service. *Further day service: People in part time services (which is less than five days) and need a full time service of the same service. *Residential service: Residential centre or group home as per Database definitions and codes 115 - 172. This indicator is relevant to: 1. Those who have a residential service and require another service. 2. Those who have a residential service and need an enhanced service. 3. Those who have no residential service and need one. 4. Those in a residential service who have no further/alternative requirements for a residential service. *Further residential service: This refers to: 1. Those in a 5-day community group home requiring a 7-day group home or 7-day residential centre placement. 2. Those in a 5-day residential centre requiring a 7-day group home or residential centre placement. 3. Those in a 5-day community group home or residential centre requiring part-time care at weekends. *Large institutional settings: Formally de-designated units.
ID5	* Psychiatric hospitals: to be identified as residential code 170. * Large institutional settings are de-designated institutions and will be identified to the HRB by Directors of Disability Services.

PI No.	APPENDIX of ICD-10-AM Codes
30 a) No. 2	**Coronary Artery Bypass Graft (CABG) Procedures**
	• 38497-00 [672] Coronary artery bypass, using 1 saphenous vein graft • 38497-01 [672] Coronary artery bypass, using 2 saphenous vein grafts • 38497-02 [672] Coronary artery bypass, using 3 saphenous vein grafts • 38497-03 [672] Coronary artery bypass, using > 4 saphenous vein grafts • 38497-04 [673] Coronary artery bypass, using 1 other venous graft • 38497-05 [673] Coronary artery bypass, using 2 other venous grafts • 38497-06 [673] Coronary artery bypass, using 3 other venous grafts • 38497-07 [673] Coronary artery bypass, using > 4 other venous grafts • 38500-00 [674] Coronary artery bypass, using 1 LIMA graft • 38500-01 [675] Coronary artery bypass, using 1 RIMA graft • 38500-02 [676] Coronary artery bypass, using 1 radial artery graft • 38500-03 [677] Coronary artery bypass, using 1 epigastric artery graft • 38500-04 [678] Coronary artery bypass, using 1 other arterial graft • 38503-00 [674] Coronary artery bypass, using > 2 LIMA grafts • 38503-01 [675] Coronary artery bypass, using > 2 RIMA grafts • 38503-02 [676] Coronary artery bypass, using > 2 radial artery grafts • 38503-03 [677] Coronary artery bypass, using > 2 epigastric artery grafts • 38503-04 [678] Coronary artery bypass, using > 2 other arterial grafts • 38637-00 [680] Reoperation for reconstruction of coronary artery graft • 90201-00 [679] Coronary artery bypass, using 1 other material graft, not elsewhere classified • 90201-01 [679] Coronary artery bypass, using 2 other material grafts, not elsewhere classified • 90201-02 [679] Coronary artery bypass, using 3 other material grafts, not elsewhere classified • 90201-03 [679] Coronary artery bypass, using > 4 other material grafts, not elsewhere classified
30 a) No. 4	**Hip Replacement**
	• 47522-00 [1489] Hemiarthroplasty of femur • 49312-00 [1489] Excision arthroplasty of hip • 49315-00 [1489] Partial arthroplasty of hip • 49318-00 [1489] Total arthroplasty of hip, unilateral • 49319-00 [1489] Total arthroplasty of hip, bilateral • 49324-00 [1492] Revision of total arthroplasty of hip • 49327-00 [1492] Revision of total arthroplasty of hip with bone graft to acetabulum • 49330-00 [1492] Revision of total arthroplasty of hip with bone graft to femur • 49333-00 [1492] Revision of total arthroplasty of hip with bone graft to acetabulum and femur • 49339-00 [1492] Revision of total arthroplasty of hip with anatomic specific allograft to acetabulum • 49342-00 [1492] Revision of total arthroplasty of hip with anatomic specific allograft to femur • 49345-00 [1492] Revision of total arthroplasty of hip with anatomic specific allograft to acetabulum and femur • 49346-00 [1492] Revision of partial arthroplasty of hip • 90607-00 [1489] Resurfacing of hip, unilateral

PI No.	APPENDIX of ICD-10-AM Codes
	• 90607-01 [1489] Resurfacing of hip, bilateral
30 a) No. 5	**Cataract Procedures**
	• 42698-00 [195] Intracapsular extraction of crystalline lens
	• 42702-00 [195] Intracapsular extraction of crystalline lens with insertion of foldable artificial lens
	• 42702-01 [195] Intracapsular extraction of crystalline lens with insertion of other artificial lens
	• 42698-01 [196] Extracapsular extraction of crystalline lens by simple aspiration (and irrigation) technique
	• 42702-02 [196] Extracapsular extraction of crystalline lens by simple aspiration (and irrigation) technique with insertion of foldable artificial lens
	• 42702-03 [196] Extracapsular extraction of crystalline lens by simple aspiration (and irrigation) technique with insertion of other artificial lens
	• 42698-02 [197] Extracapsular extraction of crystalline lens by phacoemulsification and aspiration of cataract
	• 42702-04 [197] Extracapsular extraction of crystalline lens by phacoemulsification and aspiration of cataract with insertion of foldable artificial lens
	• 42702-05 [197] Extracapsular extraction of crystalline lens by phacoemulsification and aspiration of cataract with insertion of other artificial lens
	• 42698-03 [198] Extracapsular extraction of crystalline lens by mechanical phacofragmentation and aspiration of cataract
	• 42702-06 [198] Extracapsular extraction of crystalline lens by mechanical phacofragmentation and aspiration of cataract with insertion of foldable artificial lens
	• 42702-07 [198] Extracapsular extraction of crystalline lens by mechanical phacofragmentation and aspiration of cataract with insertion of other artificial lens
	• 42698-04 [199] Other extracapsular extraction of crystalline lens
	• 42702-08 [199] Other extracapsular extraction of crystalline lens with insertion of foldable artificial lens
	• 42702-09 [199] Other extracapsular extraction of crystalline lens with insertion of other artificial lens
	• 42731-01 [200] Extraction of crystalline lens by posterior chamber sclerotomy with removal of vitreous
	• 42698-05 [200] Other extraction of crystalline lens
	• 42702-10 [200] Other extraction of crystalline lens with insertion of foldable artificial lens
	• 42702-11 [200] Other extraction of crystalline lens with insertion of other artificial lens